

**The Experience of Gay Male Undergraduate Nursing
Students: A qualitative exploration of professional
lives**

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Abstract

This thesis examines the experience of gay male student nurses during their university course, which leads to registration as a nurse with the Nursing and Midwifery Council. Using in-depth qualitative interviews I focus on the student's choice of nursing as a career and their performance of sexuality within the differing spaces of their clinical placements and the university. This thesis explores how these gay student nurses negotiate their gender, masculinity and gay sexuality within the professional boundaries of nursing. Furthermore, it identifies how these students negotiate issues of caring and the formation of therapeutic relationships with their patients, as men and gay men. The theoretical framing of the thesis draws upon Goffman's theories of presentation and performance of the self and Rubin's 'charmed circle'. Alongside analysis of interview material, I explore the space of the hospital from a personal perspective and interrogate its gendered and desexualized organization through the lens of human geography. Moving between these two analytical frameworks, I examine and draw together the experiences of these students and examine their negotiation of the nursing role as gay men. I argue that the experience of these students and the negotiation of their sexuality as student nurses is fraught and precarious due to the complexities and boundaries of professional nursing roles in contemporary healthcare. Within the conclusion I address the implications of my research for gay nurses, patients, educators and for those who recruit nursing students.

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Prologue

From a very young age, probably around four years old, I knew that I was going to become a nurse. My fascination with all things ‘medical’ began when my mother’s best friend became a student nurse and my father occasionally offered her a lift to and from work. Two years later she completed the course and became a State Enrolled Nurse (SEN). This was in 1974 and I recall fond memories of waiting in the grand Victorian entrance hall of the Leicester Royal Infirmary, relishing the smell of cleanliness (hospital disinfectant) and being in awe of the doctors and nurses in their crisp white uniforms - at the time I did not realise that I would spend thirteen years of my career walking those same Victorian corridors. As I grew older, television programmes such as ‘Their Life in Your Hands’ captivated me as I watched babies being born and hearts being transplanted, not realising at the time how innovative these programmes were for the 1970’s and 80’s.

Towards the end of the 1970’s a new programme grabbed my attention, ‘Angels’, described in Wikipedia¹ as: ‘...dealing with the subject of student nurses (1975-1983) ... tackled issues such as contraception, alcoholism and promiscuity. Angels received criticism for its unglamorous depiction of the nursing profession and was a hard hitting portrayal of young nurses facing up to the demands of the profession’. For me, there was a particular significance in this programme as one of the main characters was a male student nurse, which further inspired my desire to become a nurse when I left school. The uniforms in the picture below, from the BBC television series, are very traditional compared with the androgynous scrubs of modern healthcare. This style of nursing uniform endured into the early 1990’s and I remember my female colleagues being issued with capes like these when I commenced my nurse training in 1989.



The student nurses in Angels 1975-1983.

¹ I have relied on Wikipedia as a source due to the fact there is little information now available on Angels due to its age: [http://en.wikipedia.org/wiki/Angels_\(TV_series\)](http://en.wikipedia.org/wiki/Angels_(TV_series)). Accessed: September 2013.

Some thirty years later another television programme, 'No Angels' (2004-2006), seized my attention. Produced by Channel 4 the television series was described as: 'A critically acclaimed comedy drama following four young nurses struggling to cope with life, death and lunacy on the wards of St Margaret's Hospital.'² The programme centres on the lives of four nurses in the city of Leeds. The four main characters are Kate (the Ward Sister), Lia (Staff Nurse), Beth (Staff Nurse) and Anji (Nursing Auxiliary). The show dealt with their lives both in and out of the hospital and portrayed what could be described as 'real life' - for example, staffing issues. However, the programme also perpetrated stereotypical images of nurses; Beth, for example, was more interested in obtaining a rich husband than her career and she had sexual relationships with the medical doctors that she worked with. The image below, a promotional one for No Angels, depicts a much more modern nurse, although the uniform is an NHS standard which was first introduced in the 1970's; these nurses are no longer wearing caps, frills or aprons. They are now wearing make-up and the Ward Sister (dressed in blue) has even let her hair down.



The nurses in No Angels (2004-2006).

No Angels is of specific importance in introducing this thesis to the reader because, as well as portraying nursing in modern healthcare, in season three the series introduced a gay male nurse. The episodes where the gay male nurse is transiently present is a hyper-reality that, like much of dramatized television, contains only small glimpses of real life (as does much of the series).

² <http://www.channel4.com/programmes/no-angels> Accessed: January 2014.

Two episodes in the Channel 4 series introduced Justyn, the gay, agency nurse. Predictably, he fulfilled the general gay stereotype of being good looking. Justyn is described in the series synopsis as 'handsome' and 'gay'. The following synopsis from Series 2, Episode 8 explains the plot:

'Beth, "Beth doesn't date nurses, Beth never will date nurses and even if she did, she wouldn't date you," she told temporary nurse Justyn. Everyone else knew he was gay. "You've got shit gaydar," Anji told her. That made Justyn seem more appealing, so she went with him to a gay club (dancing to 'It's Raining Men') and they even shagged. "Only you could turn your gay best friend on the first date," Anji told her. "You must give out a signal that deactivates gayness." But then Beth found out that he was a mere bisexual and she felt she'd been conned. "It cheapens the whole thing," she complained.'

<http://thecustardtv.blogspot.com/2008/03/no-angels-channel-4.html>
Accessed August 2009.

Beth has a reputation for being promiscuous. This episode turned the stereotyped Justyn, the purportedly gay nurse, into a character who could not resist womanising with one of his colleagues. What this show really failed to do was portray male nurses (and specifically gay male nurses) as embodying any sort of professionalism or ability to care. Everyone assumes Justyn is gay, which reinforces the 'gay nurse' stereotype, and then subsequently as a bisexual he is portrayed as a (bi)sexual predator and womaniser, traits associated with Connell's (2005) notion of the hegemonic heterosexual man. Ironically Beth's character further exacerbates the use of gay stereotypes when she finds out she hadn't 'converted' Justyn to heterosexuality as he was bisexual, her comment being somewhat degrading - 'It cheapens the whole thing'. Beth's disappointment is related to her expectations of hegemonic masculinity, she would have been pleased to convert Justyn from being gay to straight, but finding out that he is bisexual destroys her masculine image of him and she is disappointed that she really is not able to 'convert' gay men.



Tom Ellis, who played the irresistible Justyn, the agency nurse in *No Angels* and who subsequently, became the love interest in the situation comedy *Miranda*.

This thesis explores the real lives of eight gay male undergraduate nurses within the space of the university and that of their clinical placements. They share with me their experience of entering the profession of nursing and of being a man in what is a predominately female dominated profession. The experiences of these gay men and how they negotiate a 'performance' of being a student nurse takes place against a backdrop of nursing's long history, the struggle for professionalisation and stereotypes that have been and continue to be portrayed.

Chapter 1: Introduction to Nursing, Men, and Sexuality

Jack (Father in law): Greg's in medicine too.

Bob (Jacks friend): What field?

Greg (future son in law): Nursing.

Bob: Ha ha ha ha. No, really, what field are you in?

Greg: Nursing.

Meet the Fockers (Robert De Niro and Ben Stiller 2000)³

1.1 Introduction

The above extract shows how male nurses are typically portrayed in films and media more generally. Ben Stiller plays the part of male nurse Greg, who has to convince demanding ex-CIA agent and future father in law that he is worthy of marrying his daughter Pam. Greg is ridiculed for being a male nurse throughout the film and spends much of his time attempting to convince his father in law of his masculinity. The relationship is only secured when it is shown that Greg could have been a doctor, but chose not to do so (Gordon and Johnson 2004). Feature films predominantly portray male nurses negatively and knowing the popularity of feature films, there could be negative effects on recruitment (Stanley 2012) and furthermore I suggest the working lives of male nurses and upon the public's perception of a male nurse.

In this chapter I introduce my research, which examines the experiences of eight gay, male, undergraduate nursing students. I explore the context of male nurses in modern healthcare and explore how I have situated myself within this research and how my experiences as a gay man, a clinical nurse and a nursing academic have formed the lens through which I view nursing. I then explore the theoretical frameworks that I have drawn upon. Here, I make clear links to the male/female workplace binary that is present in nursing and the influence of feminism on nursing, as well as exploring Goffman's (1959) notions of performance and Rubin's (1984) charmed circle. Following this I offer a detailed synopsis of each thesis chapter.

³ Source, International Movie Database (IMDB) <http://www.imdb.com/title/tt0212338/quotes>
Accessed: September 2013.

1.2 Researching Gay Nurses – A Personal Perspective.

From an early age I have been certain about two things in my life, that I was gay and that I wanted to be a nurse. I came out at secondary school in 1983, which in retrospect was somewhat foolish, especially considering that I attended a Catholic school. I had been called poof, gay and bender since I commenced secondary school and one day I just started agreeing with the bullies. Amidst an increasing level of verbal and occasional physical abuse I started to miss school and, while completing my O-levels, I spent much of my time hiding in a local library revising. One of my major achievements of the time was receiving a school report for sports that simply stated: 'I have not seen David in any of my classes'. Despite school being a somewhat miserable place, I joined a Lesbian, Gay, Bisexual and Transgender (LGBT) youth group in a local city and started to explore what being a gay man in the mid 1980's was about. I left school aged 16 years having been advised that the 6th form may not be the place for me (being the only openly gay pupil). I completed compulsory education having achieved the O-level grades that I required to become a nurse and I commenced work as a care assistant while I applied to nursing schools for entry when I became 18 years old.

Since the age of five I have always wanted to become a nurse and I have explored the influence of family and television in the prologue to this thesis. I trained as a nurse at Charles Frears College of Nursing in Leicester (now a part of De Montfort University) and registered as an adult nurse in 1992. I undertook some further training and later registered as a Registered Sick Children's Nurse (RSCN) in 1995.

My life as a registered nurse has been exciting, rewarding, demanding and at times very sad. My final placement as a student was on the intensive care unit and although anecdotally this is an environment that is very masculine and technological, I decided to work there when I qualified. Throughout my training I had been open about my sexuality, not in a 'screaming queen' kind of way, but by being confident in discussing my personal life when others did the same. As a registered nurse I was always open about my sexuality with my nursing and medical colleagues, which was

always met with support and acceptance. However, I still remember everyone's shock when I arrived at our intensive care unit summer BBQ (always hosted by one of our medical consultants at his home) with my partner of the time and with us both wearing leather biker jackets. To this day I am not sure if it was my male partner accompanying me or the wearing of biker jackets that caused some raised eyebrows.

During my time as a clinical nurse I was always very acutely aware of appropriate professional boundaries and only very rarely would I discuss my gay sexuality with a patient or their family. When I became a children's nurse, this sense of professional boundaries became even more acute as at the time being gay was for some people linked to child abuse.

Despite the many reports of homophobia and heterosexism in the National Health Service (NHS) (Burke and White 2001, Stonewall 2009) I enjoyed a fulfilling career where I was respected and promoted for the contribution I made. Following 15 years in a clinical career, where I was promoted from staff nurse to charge nurse to nurse educator, I gradually moved into formal nurse education and this is where my questions about the experience of LGBT nurses and specifically gay men developed. What surprised me, as an openly gay nursing lecturer with experience of working in two large universities, was the lack of openly LGBT students and the general lack of engagement with issues of LGBT sexuality within the curriculum.

More recently, my experience of family member's hospitalisation while undertaking this research has influenced my perception of healthcare and hospitals as social spaces. Sitting in a waiting room with my partner feeling hyper-visible and being accepted as the 'son-in-law', following those difficult introductions to nurses and doctors at the bedside, are experiences that have made me think about the construction of hospitals as a social space.

I conceptualise space within the hospital environment as linked to identity; that is, people make spaces but the constitution of space also shapes the people who use it. This is achieved by both constraining them, not just in a physical sense, but also in relation to their behaviour and relations with others and by offering opportunities for the construction of identity within certain performances such as the professional performance of the nurse (Keith and Pile 1993, Lefebvre 1991). Space is not merely a 'frame' or 'container' for lived experience, but is rather a 'tool of thought and action' (Lefebvre 1991, P26), through which individuals may 'give expression to themselves' (Lefebvre 1991, P33). In this way, institutions such as hospitals 'rather than containing particular subjects (may) actually and actively create them' (Pile and Thrift 1995, P4). Furthermore, the construction and performance of nursing and nurse's workplace identities are influenced by the history of the profession, as well as contemporary professional demands and the public nature of wards. Thus, the organisational space of the hospital is a stage on which to construct and perform identity (Halford and Leonard 2003). I explore these issues in more depth in Chapter 4.

1.3 Nursing in the United Kingdom (UK)

In this section I highlight to the reader key information concerning nurses, nursing roles and education. By briefly outlining these issues I begin to set out the context that this research has taken place within.

In March 2013 there were 673,567 nurses and midwives registered with the Nursing and Midwifery Council (NMC) (NMC 2013) and of these 369,868 work in the NHS (NHS Confederation 2013), who are the largest UK employer of nurses. Nurses are also employed in the private sector, for example in private hospitals, nursing homes and in people's own homes, but data on this type of employment is not easily available. The nursing section of the NMC register contains four separate sub-sections or fields: adult nursing; mental health nursing; children's nursing and learning disability nursing.

Nurses in all four fields can undertake varied roles and responsibilities, for example, staff nurse, nurse practitioner, ward sister/charge nurse, nurse consultant and they can earn between £21,388 and £67,805 a year within the NHS (NHS Careers 2013). Nursing roles are not restricted to hospitals and there continues to be a shift in the delivery of care from large acute hospitals and institutions to community and home based care.

In the year 2011/2012 there were 22,275 nursing and midwifery training places available in the UK, these being made up of: 17,405 in England; 3060 in Scotland; 1150 in Wales and 660 in Northern Ireland (RCN 2012). Applications to nursing and midwifery university programmes are at an all time high with 58,123 applications being made by UK domiciled residents in 2011/2012 (UCAS 2012). The NMC currently validates 79 UK universities to educate nurses and midwives, with programmes leading to initial registration as a nurse taking three years to complete. Nursing programmes are split with 50% of the student's time being spent in university undertaking formal learning activities and 50% of the time in clinical placements. At the time of undertaking this research the first year of nursing programmes was the Common Foundation Programme where all fields of nursing are taught together, the remaining two years were then field specific. Nursing education moved into Higher Education in the 1990's with programmes being mainly diploma level. Within Wales nursing education became exclusively degree level in 2005 and in 2010 the remainder of the UK followed suit. Labour market reviews have noted a distinct change in the age profile of nursing applicants since 2008, with the proportion of applicants aged over 30 rising to equal that of the under 20s (RCN 2012). Having set out the current context of nursing in the UK, in the following section I specifically explore men and nursing careers.

1.4 The Context of Men in Nursing

In this section I further contextualise the background of this study by briefly discussing men in nursing and then proceeding to discuss sexuality in light of changing societal attitudes and then proceeding to discuss gay sexuality and nursing. Following this I explore my choice of gay male nursing student nurses as the participants of this research, before presenting my research questions in section 1.5.

This research intersects three distinct areas of theoretical discussion: masculinities, sexualities and nursing. This is nursing research, based within a social sciences framework. The personal lens that I view issues of masculinity, sexuality and nursing through has changed and developed over the course of undertaking this research – I discuss more of this later in the chapter and in Chapter 4. So, this thesis is about gay men in nursing and with men making up only 10% of the Nursing and Midwifery Council Register⁴ (NMC 2011) we are clearly working in a profession that is female dominated. While research has investigated gender in nursing from the perspective of female nurses (Celia Davies' 1995 book *Gender and the Professional Predicament of Nursing* is a seminal example of this), relatively little has been written about men and masculinity in nursing. This is surprising; being a minority gender in a feminised profession I would have thought male nurses would be interesting to explore, especially when taking into account the fact that men occupy a surprisingly high number of senior nursing positions (Evans 1997). I suggest that a number of complex and competing concerns have prevented investigation of masculinity in nursing, in the same way that recruitment of men into nursing has remained static and the profession appears to be ambivalent to this fact. These concerns (explored in Chapter 2) are related to the binary of power and gender and the feminised perception of caring which is entrenched in our private lives, but pervades our perception of public caring roles, coupled with a real lack of male visibility within the profession.

⁴ To be a registered nurse in the UK you have to be registered with the NMC. The NMC publish yearly statistics from the register and are the regulator of the nursing profession, with the power to remove those nurses and midwives guilty of misconduct from the register.

In addition to masculinity, this research is concerned with gay sexuality within the nursing profession. Sexuality has been somewhat taboo in nursing (Caitrian 2001) and it is only in recent years that nursing research has explored lesbian, gay and transgender (LGBT) sexualities in any depth. Research exploring lesbian and gay sexuality in nursing has in the past been based in the field of psychology and has focussed almost exclusively on the attitudes of nurses and nursing students towards lesbian and gay clients and how interventions, such as education, can increase levels of tolerance and understanding towards us. Social sciences research concerned with LGBT issues and nursing has concentrated on the patient experience of health and healthcare, with academics such as Professor Tamsin Wilton (Wilton 1999 and 2000, Wilton and Kaufmann 2001) contributing to this field. Furthermore, the rise of Acquired Immune Deficiency Syndrome (AIDS) in the mid-1980's brought about a focus on gay men, sex and nursing, as the profession struggled to mobilise an appropriate response. Literature at the time (Simonoff 1991, Jemmott et al. 1992 and Snowden 1997) was extremely negative and tended to explore nurses' attitudes towards those with AIDS, one example of many is this article entitled: Stigma, AIDS and quality of nursing care: state of the science, published in 1991 by Siminoff et al. Nursing does now engage with issues of sexuality far more than ever before; nurses have developed pioneering roles to enhance sexual health not only in relation to sexually transmitted diseases, but also in much wider areas such as sexual dysfunction and diabetes. Additionally, more recent research demonstrates that nurses' attitudes towards patients with HIV and AIDS is more positive than before (Pickles et al. 2009). However, contemporary nursing remains relatively conservative (see Chapter 2 for more detailed consideration of this point).

Attitudes towards lesbian and gay sexuality within contemporary western society have changed considerably over the last 25 years. Weeks (2007) cites civil partnerships and LGBT people being allowed in the military as two of the many achievements of the LGBT political movement and an indication of the more permissive views UK society has on sexuality. With this change in attitudes there has

also been an increasing willingness to fund research exploring LGBT people's lives in sociology and psychology. However, within nursing the professional lives of LGBT nurses have remained relatively unexplored. I think the problem here is visibility. Men in nursing continue to be stigmatised and constructed as gay (Harding 2007) and for those of us who are actually gay nurses there continues to be a silence in relation to our existence. For example, there are no public LGBT nursing role models that I can think of (while I acknowledge that there are more general LGBT role models, for example in the media, than ever before). Furthermore, the issue is largely ignored in the nursing press except for one article in LGBT history month, which in the UK takes place in February to coincide with the 2005 abolition of Section 28. To illustrate the lack of positive role models and information I Googled 'gay nurse' and the top three sites I retrieved were:

1. An article on Mightynurse.com, where the author says: *I'm not sure why or where this stereotype came from, but it annoys the hell out of me.*⁵
2. A YouTube link that is headlined: *'Gay nurse seduces patient.'*
3. A post on Allnurses.com from a gay male nursing student who feels isolated: *I'm aware that the words 'Gay' and 'Nursing' may somehow go hand-and-hand for some, and others may find it comical, but I've found it quite uncomfortable being gay and a male, nursing student simply because people tend to treat you differently-whether that is not being taken seriously or socially treated like one of the women nurses.*⁶

Repeat this exercise using the search term 'lesbian nurse' and you are confronted with links to pornographic web sites.

Having briefly introduced men and gay sexuality in the context of nursing I now need to explain my choice of gay male nursing students as the participants in this research, as opposed to registered nurses or asking registered nurses about their attitudes to LGBT colleagues. First, I consider student nurses to be at the beginning

⁵ <http://www.mightynurse.com/tag/nurse-stereotypes/> Accessed: September 2013.

⁶ <http://allnurses.com/male-nursing-student/being-gay-male-714040.html> Accessed: September 2013.

of their career as nurses, they do not enter the profession until they have registered with the NMC at the end of their course and as such they may not be as culturally immersed in the practices of nursing and the National Health Service (NHS) as registered nurses. I see student nurses as not having fully constructed their identity as a nurse. However, I do have to accept that some students may have previously worked as a nursing auxiliary and may have some cultural identity within the NHS. Second, current research exists that explores the attitudes of nurses and nursing students towards LGBT patients (Röndahl et al. 2004, Smith 1993) and student nurses' attitudes towards LGBT peers (Dinkel et al. 2007), but there is no research exploring the experience of being a gay student nurse.

So, this research explores a field in which men, sexuality and nursing are relatively poorly researched and in a context where attitudes towards LGBT people have become more accepting than ever before, while LGBT nursing role models are difficult to identify. It is this paradox that makes the experience of gay male nurses a critical site for exploration. I now present my research questions.

1.5 Research Questions

The primary questions are:

- 1a. How do gay male student nurses negotiate their sexuality within both the education and clinical context
- 1b. What effect does being gay have upon the experience of being a nursing student?

These questions attempt to differentiate the different work environments the gay nursing student works within, as the social acceptability of homosexuality may be different for example in the university, compared to the clinical placement. For example a student may have come out at university where meaningful and lengthy relationships may be formed, but closeted in the placement area that he will visit for a period of eight weeks. If negative attitudes are encountered they may be different

depending upon the context in which they take place, for example in university it may be a comment from a student or content of a lecture. Within placement it may be nurses' attitudes towards an individual patient.

2. Why do gay men choose to study nursing?

This question stems from stereotypical ideas that as nursing is a female dominated profession and that heterosexual females have more positive attitudes towards gay men (which some literature shows is far less than imagined) that nursing can be chosen as a socially acceptable and accepting professional pathway.

1.6 Theoretical Underpinnings

I will now introduce the major theoretical thoughts that underpin this thesis and which have assisted in forming the lens through which I view my research.

The dominant sociological discourse of women concerning caring work is that of subordination, oppression and being undervalued (MacDougal 1997, Kessler 2008). To some extent women continue to be viewed as housewives and mothers, and although women may have working or professional lives, their true value is seen in caring for their family and spouse (MacDougal 1997, Garmarnikow 2013). It is clear that generally in contemporary society caring roles continue to be gendered to a great extent, in that women are viewed as carers and men are not (Gordon 1992). The level of women's subordination in relation to caring could be viewed as changing. However, it is still mainly women who tend to the home and childcare. Indeed some consider the government's moves during the last twenty years towards community-based care for the disabled and elderly, as a further way of reinforcing women's oppressed position in society. Poole and Isaacs (1997) clearly articulate this position around the time community care was being introduced:

In reality it is generally the female relatives of the sick, the elderly or the disabled who usually provide the labour-intensive care. They do this

with assistance from women in the community in the guise of volunteer workers or home helps and the plethora of women in the helping professions... (Poole and Isaacs 1997, P530)

Feminist theoretical views of women and the role they play in the home, especially in relation to the work of caring, have developed in two directions. The first understanding of caring is that women are subordinated:

..a recognition that women are in subordinate position in society, that oppression is a form of injustice and hence is intolerable, that there are further forms of oppression in addition to gender oppression (and that there are women victimised by each of these forms of oppression), that it is possible to change society in ways that could eliminate oppression, and that it is a goal of feminism to pursue the changes necessary to accomplish this. (Sherwin 1992, P29, note 6)

Sherwin's assertions on feminism can be related to care, in that the work of caring is linked to the notion of oppression, emphasising that caring labour does not have any value and women who care, as being subordinate to men. The notion of oppression is central to this ideological standpoint and implicit to this is the need to change societal views of women and achieve gender equality. In relation to caring it is difficult to envisage if the goal of women's freedom would be the equal sharing of child and home care activities with male partners (a heterosexist viewpoint) or changing attitudes towards caring roles in order to engender notions of value. Fundamentally, the rejection of caring as a feminine role is central to this ideology.

Feminist ethical theory has developed an alternative viewpoint to understanding caring, the notion of care focussed ethics, primarily developed by Gilligan (1982). Here the focus is not upon justice and the achievement of equality, but a critical approach to the acceptance that care is gendered and women devalued. Inherent in

this understanding of care and women, is the focus on care and caring as a positive attribute that should be celebrated by women and valued by society.

Care-focused feminists regard women's capacity for care as a human strength. (Tong 2009, P162)

Gilligan's theories have become a philosophical viewpoint of caring undertaken by women and these theories attempt to re-construct women's caring role as a positive and celebratory strength of womanhood. However, for some, attempting to distinguish women's care-taking strengths from socialised subservient weakness flirts with sexism itself (Puka 1993). The problem here is that these notions are based on ideas of gender essentialism, discussed further in Chapter 2, which suggests that both women and men possess innate or essential qualities, in this case women being caring. Crompton and Lyonette (2005) argue that accepting gender essentialism means there would be no reason to change the subservient position of women in society:

If it can be demonstrated that the differences between the sexes (which would include persisting patterns of inequality) rest upon the innate or essential qualities of women and men, then not only may these inequalities be rendered legitimate, but also, there can be little justification for change. (Crompton and Lyonette 2005, P602)

Within the profession of nursing and healthcare generally, care is a heavily debated issue, more so recently in the wake of the Mid-Staffordshire Enquiry, which revealed poor standards in a UK hospital. Latimer (2000) suggests that nurses are 'knowledgeable women, doing important work that goes far beyond the stereotypical picture of them' (P122). Furthermore, she acknowledges how contemporary medical and health policy agendas have transformed care at the bedside and how nursing work at the bedside is becoming less visible as nurses are forced to relinquish these

roles to unqualified care staff. So, caring in the context of nursing is something that is a central tenet to the profession, based on knowledge. However, nurses may be undertaking less and less of what could be seen as direct caring at the bedside of patient and clients.

Within this thesis my underlying assumption is that women undertake the majority of paid and unpaid caring work in this society — professionally and informally, as mothers, wives and daughters, as well as care workers in the various professions. Additionally, men also care, in lower numbers and often in very specific circumstances, such as a spouse looking after their wife, or a man choosing a career in the caring professions. Caring roles are gendered, not through subordination of women by men, but through the constructed identities and roles that men and women enact in different times and spaces, including the private, the public and the professional, which I explore in Chapters 4 and 5. Additionally, the power of masculinity and patriarchy has to be recognised in the ordering of caring, identities and organisational practice (Davies 1995).

Forming part of the lens through which I have viewed this study, the participants and the data are two main theoretical concepts: Goffman's notions of performance and Rubin's Charmed Circle, which I now explore in turn.

1.7 Identity Work and Performance

Goffman (1922 – 1982), a sociologist of the Chicago School was criticised for his controversial approach towards research methods (which I discuss in further detail later in this chapter). Goffman's primary concern was the interaction of people and the social rules and rituals that are practised by people during interactions. He is described as one of the greatest sociologists of his time and is attributed with major developments in the understanding of symbolic interaction.

His first and most famous book, 'The Presentation of Self in Everyday Life' (Goffman 1959, reprinted 1990) is the part of his work which I consider to be most helpful in understanding the interactions and actions of the gay, male, nurses I have interviewed. Goffman sees performances of self as occurring within social interactions between individuals and in the wider culture of a given social setting (for example the hospital or university). Goffman (1974, P10-11) argues that frames organise social experience and help create 'definitions of the situation [that] are built up in accordance with principles of organization which govern events... and our subjective involvement in them'. It is these experiences that are governed by the rules and norms of society (and in the case of these students, nursing. See Chapters 4, 5 and 6) and we learn to present behaviour in accordance within the frame of interaction (Poloma 1979).

A 'performance' may be defined as all the activity of a given participant on a given occasion, which serves to influence in any way any of the other participants. Taking a particular participant and his performance as a basic point for reference, we may refer to those who contribute other performances as the audience, observers, or co-participants (Goffman 1959, P26-27).

And therein lies the fundamental elements of Goffman's dramaturgy: a stage; the performers and an audience. Underpinning these interactions is the belief that social interactions are constructed events in which individuals attempt to present themselves in the way that they wish to be perceived. Firstly he asserts that for the performance to be believable by the audience, the performer seeks to develop their own belief of the performance; 'there is the popular view that the individual offers his performance and puts on a show for the benefit of other people...one finds that the performer can be fully taken in by his own act' (Goffman 1959, P28).

Within the theory of dramaturgy there are two types of performance, the 'front' performance which is a public performance, and a backstage for private rehearsals. Goffman suggests that there are three different parts to this front performance (Goffman 1959). First, there is the setting which provides the location for human interaction to take place and which is then played out inside, before or upon it. A setting is geographically fixed, for example the clinical placement/hospital (Chapter 5) and the university (Chapter 6). Second, there is the 'personal front' that conveys what Goffman refers to as appearance and manner that are the parts of the performance, which are clearly seen. Appearance is the stimulus which tells us about the performer's social status and their temporary or ritual status at a given time or situation. Manner is the stimulus that tells us what interaction role the performer will potentially play in a given situation (Goffman 1959).

A large number of acts can occur behind a social front performance and different routines can be presented behind the same front (Goffman 1959). This means that there is not always a perfect fit between the character of a performance and the 'socialised guise' (Ward 2013). As I show, the students enact different performances in different professional situations. For example in Chapter 5 the students' performance of their sexuality was different to that in the university (Chapter 6) and in Chapter 7 the students' performance of sexuality is different again in relation to care and patients. The back-stage, which occurs behind the front, is further defined by Goffman as 'a place, related to a given performance, where the impression fostered by the performance is knowingly contradicted as a matter of course' (1959, P114). Away from the front, performances can be adjusted and changed.

The actor employs props and performs in settings (for example in the case of nurses uniforms, nursing documentation, routines and medical equipment), all with the intention of creating a believable role that signifies the actor's intended meaning (P22). This act culminates in a 'dramatic realisation' (P30-34) of a performance in which the staging is favourably received by the audience. Furthermore, the rejection

or acceptance of this presentation will determine the future course of the interaction. For Goffman, people read each other and give feedback to know how their interactions are developing, which Giddens (1986) describes as 'active monitoring' (P3).

The underpinning framework of Goffman's dramaturgy can be reconciled with the performance of nursing, nurses and care. Nursing takes place within a large institutional (in its most general sense) space and nurses 'perform' nursing actions, cleaning bodies, environments, taking observations, forming relationships. It is on this stage that nursing takes place, and on which the gay men I interviewed negotiate and develop their front and back role, learning by their mistakes and developing believable performances that are deployed as part of their sexuality and masculinity.

Goffman has been praised (Lofland 1980) and criticised (Schegloff 1988) for his research. Schegloff (1988), like many of the commentators, found Goffman unsystematic to the point of chaos. Goffman's approach to the three main elements in social science: theory, method, and data, is he suggests, to say the least, not clear. Furthermore, Scheff (2001) suggests that Goffman's works are all individual and that he does not appear to build upon each of his theories/research as he moves from one project to the next. Jackson and Scott (2010) suggest that there is a need to rehabilitate the insights of the interactionist tradition in order to highlight and re-establish its continued relevance to sociology and the analysis of sexuality and gender identity. It was this tradition, they argue, that first developed a sociological theory of sexuality and began to understand gender relations in the 1970's (Gagnon and Simon 1973) challenging biological determinism. Garfinkel's (1967) essay on Agnes, a nineteen-year-old transsexual seeking medical treatment, is an example of how sexual theory developed from interactionism. Interactionism has suffered what Jackson and Scott (2010, P812) call 'theoretical amnesia' among sociologists of gender within recent years. This perspective has been eclipsed by the rise of Foucauldian, post-structuralist and queer theory (Foucault 1976, Butler 1990). While

much of this latter work has been influential in theorizing the ways in which gender, performativity and the subversion of gender norms are connected, Jackson and Scott (2010) argue that much has been lost by forgetting the insights of interactionism. Ward (2013) suggests that what is missing from much post-structuralist work is attention to the discursive practices, embedded in everyday social life and the local social relationships and meanings that shape gender identities.

The performances of individual nurses, nursing students and healthcare professionals generally cannot be seen in isolation. Within the hospital, professional and social expectations may partly construct the individual identity of patients, relatives and nurses. For example the ill patient, the grieving relative and the caring nurse. Hospitals 'rather than containing particular subjects (may) actually and actively create them' (Pile and Thrift 1995, P4). Furthermore, the individuals own agency will form part of the public identity that is performed within the hospital. The construction and performance of nursing and nurses' workplace identities are influenced by the history of the profession, as well as contemporary professional demands and the public nature of wards. Thus, organisational spaces, such as the hospital and the university, are also stages on which identity is constructed and performed (Halford and Leonard 2003). I am interested in how gay students work to create their identities within the container of the hospital by learning and interpreting the professional rules and boundaries of being a nurse and through their own agency.

1.8 Space and Situated Performances

Space is no longer seen as Euclidean, constructed in purely material form (Valentine 2001). Rather, it is now recognised that space is the product of the intricacies and the complexities of relations. As space is the product of relations, including active practices, material and embedded, which have to be carried out, space is always in a process of becoming - it is always being made (Massey 1999). Social spaces can be understood as ordered, with the social order arising from the ways in which participants conduct themselves together (Garfinkel 1967). Furthermore Garfinkel

suggests that the normalisation and order of the social setting can be breached by some performances or identities (most likely those that are less acceptable). A number of theorists have explored the many and varied practices that exist within the broader sphere of the hospital and within nursing itself. Heartfield (2005) explored how social practices around length of hospital stay are translated and how they pattern contemporary hospital nursing practice. Lawler (1991) explored practices in relation to 'bodywork', which can be defined as labour performed on others bodies (and the products from the body), emotional labour and the effects of work on one's own body (Gimlin 2007). Latimer (1997 & 2000) examined the relational practices of nurses and the hospital that formed the organisational life of a medical ward. She shows how the material practices and spatial arranging and re-arranging of people and things in space, enact, and communicate, the symbolic meanings that underpin and perform particular power relations. For example, those between a hierarchy of values, moral forms, categories of work, patient and nurse. Having explored Goffman's notions of performance I now move forward to Rubin and her theory of how sexualities are viewed within western society.

1.9 The Charmed Circle

Rubin's (1984) Charmed Circle (Diagram 1) theorises how value systems in social groups define sexuality as either good/natural (the charmed circle) or as bad/unnatural (the outer limits). Rubin identifies how sexuality is constantly reconstituted by various discourses on sex, be they religious, popular, psychiatric/medical or political. These discourses define the sexual boundaries of human sexual capacity as sanctifiable, safe, healthy, mature, legal and politically correct. Those in the 'charmed circle' are 'the heterosexual, marital, monogamous, reproductive and non-commercial' [P279]. Rubin argues that there are clear benefits, both material and social, associated with being inside this charmed circle:

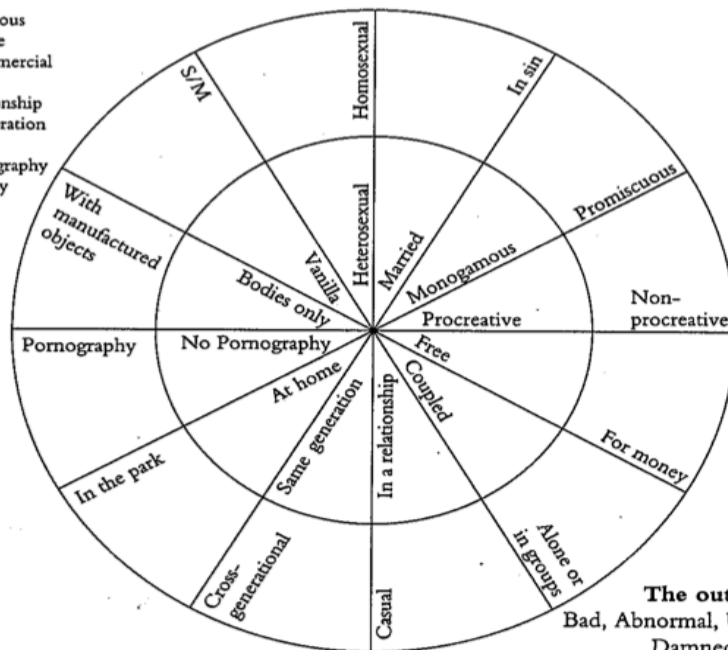
Individuals whose behaviour stands high on this hierarchy [of accepted sexual practices] are rewarded with certified mental health, respectability, legality, social and physical mobility, institutional support, and material benefits. (Rubin 1984, P279)

While Rubin clearly relates her model to discourses on sexuality there is a clear relationship between her model and the notions of performance I have outlined above. Performances have the intention of creating a believable role that signifies the actor's meaning (Goffman 1959) and furthermore performances are constructed in order to maintain social order (Garfinkel 1967). The notions of performance and social ordering can be related to what Rubin describes as being within and outside the charmed circle and how certain behaviours are privileged (ordered) over others.

The charmed circle:

Good, Normal, Natural, Blessed Sexuality

- Heterosexual
- Married
- Monogamous
- Procreative
- Non-commercial
- In pairs
- In a relationship
- Same generation
- In private
- No pornography
- Bodies only
- Vanilla



The outer limits:

Bad, Abnormal, Unnatural, Damned Sexuality

- Homosexual
- Unmarried
- Promiscuous
- Non-procreative
- Commercial
- Alone or in groups
- Casual
- Cross-generational
- In public
- Pornography
- With manufactured objects
- Sadomasochistic

Sexuality that is outside of the circle is deemed bad/unnatural, and those who practice this form of sexuality enjoy only limited social privileges. For example, in relation to mental health, it was only relatively recently that male homosexuality was de-classified as a psychiatric disorder. Also, it was only in 1967 that homosexuality in the UK was decriminalised. The binaries of this “charmed circle” include sex as a couple/in groups, monogamous/promiscuous, same generation/cross-generational, and bodies-only/with manufactured objects. The notion of bad/unnatural can be seen as someone simplistic in contemporary society where the acceptance of sexuality is much more nuanced than ever before.

Three ideological notions underpin the charmed circle. One is the Western notion of sex negativity in which sex is considered to be a dangerous, destructive force. If marriage, reproduction, or love is not involved, almost all sexual behaviour is considered bad. Second, the domino theory of sexual peril, where people feel a need to draw a line between good and bad sex as they perceive good sex as sexual order and bad sex as chaos. There is a fear that if certain aspects of “bad” sex are allowed to transgress this line, unspeakable acts will follow as well. Three, that there is one proper way to do sex, which is normally perceived to be heterosexual.

Critiques of Rubin’s charmed circle include suggestions that it is insensitive to gender and race. For example different races, culture and indeed genders may well have varying attitudes towards issues of sex and marriage. More recently, Sik Ying Ho (2006) argues that alternative forms of heterosexuality disturb the hierarchy between the charmed circle and the outer limits. He suggests that this view of heterosexuality as an institution, identity, practice and experience is problematic at an individual level, and the lived experiences of, for example, marriage and monogamy can disrupt the limits of the circle. Furthermore, Rubin’s model assumes unified sexual identities and fixed positions within the sexual hierarchy, but it has been argued that people can actually adopt multiple ‘subject positions’ in that hierarchy. For example, a person can be simultaneously heterosexually married and

practice gay sex, for example men who have sex with men. A final critique is that Rubin does not acknowledge the ability of an individual, through their own power to utilise coping strategies, to re-create their own charmed circle.

A number of the above critiques have developed following the modernisation of, and significant shifts in, attitudes towards sexuality during the last twenty-seven years. During this period sexuality has undergone a transformation in society, the law and the media. Some practices that were on the outer limits of the circle, such as non-procreative, cross-generational and unmarried sex, and sex with manufactured objects, are now much more acceptable and have become more mainstreamed via the media and changing values. Furthermore, how those practices then translate to the enactment of this set of practices (performance), for example, sexuality has also changed, which can be seen by the increasing visibility of LGBT people in the media and society more generally. However, even though these practices may now be part of the inner circle of acceptability, they may still be at the edge of the charmed circle.

It could also be argued that gay sexuality has become more mainstream, as demonstrated earlier with reference to civil partnerships and the current debates on gay marriage, which has recently been legalised in the UK. So, if gay sexuality is linked to particular practices within the charmed circle, homosexuality as a category moves from the outer limits towards the edge of the charmed circle. For example, homosexuality that is linked with marriage (civil partnership) and monogamy is much more acceptable than homosexuality that is not. Alternatively, the homosexual who is associated with casual, pornographic or public sex remains in the outer limits. I draw upon Rubin's conceptualisations of sexuality and acceptability when exploring the students' experience of being accepted or not in university and clinical placement in a later chapter. The following section describes the chapters and content of this thesis.

1.10 Chapter Signposting

Chapter 2: Nursing, Professionalisation and the Male Nurse

In this chapter I explore the history of nursing from homely care, to occupation and then profession. I then set out the major theories of masculinity and proceed to explore nursing from a gendered perspective. I chart the historical milestones of men within the profession of nursing and then more specifically the role of the male nurse and gendered perspectives on caring. I draw this chapter to a close by discussing the dearth of literature relating to gay male nurses.

Chapter 3: Methodological Considerations - Researching Gay Nurses

Having set out my position on gender, masculinity and sexuality in nursing, this chapter explores and justifies the methodological challenges and the decisions I have made. Specifically, I address the recruitment, data collection and analysis procedures of this study. I then reflect on my difficulties in the recruitment of participants to this research, the hostility I met with and decisions and actions that defend my position as a researcher and demonstrate that my research is underpinned with consideration for ethical principles. I propose that the hostility I met from fellow nurses, academics and institutions emerges from heterosexist attitudes, which border on the homophobic. Finally, I introduce my research participants and explore their choice of nursing as a profession.

Chapter 4: Gay Nurses, Straight Spaces.

In this chapter I explore the ways in which two distinct spaces (clinical practice and the university) are constructed in relation to gender and sexuality. Drawing on the work of human geography, I interrogate these spaces and suggest ways in which heteronormative practices are produced and re-produced. What this chapter has become is the underpinning lens through which I analyse my research data.

Chapter 5: The Experience of Being a Gay Student Nurse: Clinical Placement.

In this chapter I explore the experience of gay nursing students and the negotiation of their sexuality within the space of the students' clinical placement. The negotiation

of sexuality in clinical placement can be problematic and is often not undertaken; some spaces are safer or more comfortable in which to negotiate coming out. Sexuality, rather than being negotiated within clinical placements, is hidden and kept 'private'. This is explored in the context of professional boundaries, placing the patient's needs first and the divorcing of personal and private lives. Here I draw upon strategies for negotiating sexuality and coming out from the literature. Where participants do negotiate their sexuality, culminating in coming out, it can be problematic and can disrupt the environment of care. In contrast, certain clinical spaces make the negotiation of coming out easier and more desirable due to the nature of the work, the environment or clientele.

Chapter 6: The Experience of Being a Gay Student Nurse: University Life

In the previous chapter I explored the ways in which my research participants negotiated their sexuality within the space of their clinical placements. This subsequent chapter can almost be described as a 'companion' chapter as I draw upon similar theoretical concepts (i.e. binary notions of the private/public and the professional/personal) and theories (i.e. Goffman's notion of performance and Rubin's theory of the charmed circle) to explore how they negotiated their sexuality within the space of the university. I argue that for these nursing students a number of factors influence and shape their performance of sexuality in university spaces. Also, although university space is viewed differently from the clinical space of the hospital, I argue that in both environments there exists a tension between the professional and public performance of sexual identity.

Chapter 7: Gayness, Masculinity and the Performance of Nursing

Nursing practices are inherently gendered and feminised. The literature exploring the performance of men as nurses is sparse, but suggests that male nurses use their masculinity to distance themselves from feminine forms of caring, in their performance of nursing. In contrast, I argue that gay men negotiate their performance in a way that mobilises both masculine and feminine attributes. Furthermore, in

negotiating their performances the gay men I interviewed drew upon their personal experience of coming out and being different to inform their approach to nursing.

Chapter 8: Conclusion

In this chapter I draw together the main themes of the thesis, which include the negotiation of masculinity within the differing spaces of the university and clinical placement and the performance of nursing from the perspective of being a man and being gay. I then discuss the key issues that emerge from my research for policy makers, those who recruit student nurses and patients. I conclude by considering the limitations of this research.

1.11 Conclusion

This chapter commenced by sharing an example of how male nurses are portrayed stereotypically within mainstream media by exploring a short narrative from the film *Meet the Fockers*. In this film male nurse Gregg, is chastised by his future father in law for being a male nurse and his masculinity questioned. The negative portrayal of male nurses within the media reinforces stereotypes that are perpetrated in female dominated professions and which bring into question the masculinity and sexuality of male members of those professions. I then proceeded to explore my personal perspective of this research from the position of being a gay man, a male nurse, and an academic.

I then progressed to contextualise men in the context of nursing and nurse training, specifically highlighting the career pathway of nurses from student to nurse consultant and framing nursing as a female dominated profession where men make up 10% of registrants in the UK. I suggested that a number of complex and competing concerns have prevented investigation of masculinity in nursing, in the same way that recruitment of men into nursing has remained static and the profession appears to be ambivalent to this fact and that these concerns are related to the binary of power and gender and the feminised perception of caring. Additionally, have

defended my choice of researching gay male nursing students in the context of evolving attitudes towards gay sexuality and the dearth of LGBT research within nursing.

I then explored the theoretical lens through which I have analysed this research. I argue that women have in the past and continue to be seen as carers. I conclude that women undertake the majority of paid and unpaid caring work in this society. Professionally and informally, as mothers, wives and daughters, as well as care workers in the various professions. I acknowledged that men also care, in lower numbers and often in very specific circumstances, such as a spouse looking after their wife, or a man choosing a career in the caring professions. However, my key argument here is that caring roles are gendered, not through subordination of women by men, but through the constructed identities and roles that men and women enact in different times and spaces, including the private, the public and the professional.

I then moved forward to explore how Goffman's (1959) notions of performance and Rubin's (1984) charmed circle could help me in making sense of my participant's stories. I suggested that the underpinning framework of Goffman's dramaturgy could be reconciled with the performance of nursing and that the space nursing takes place is a sort of stage. It is on this stage where the gay men I interviewed negotiate and develop their front and back role, learning by their mistakes and developing believable performances that are deployed as part of their sexuality and masculinity. I then proceeded to explore how Rubin (1984) sees sexuality as a set of practices that are either privileged within society or not. Here I linked identity, performance and sexuality. Finally, I concluded by signposting to the individual chapters of this thesis to offer a flavour of the forthcoming discussion.

In the following chapter I explore nursing from a historical perspective and then proceed to explore how nursing became a profession and the problematic ways in which nursing is constructed as a feminised space. I then discuss the context of men as a minority within the profession of nursing.

Chapter 2: Nursing, Professionalisation and the Male Nurse

2.1 Introduction

The nursing profession, and attitudes towards it, have been affected and have reflected temporal morality and social attitudes - particularly with regard to gender roles and performance. It was only in 1960 that the first male nurse became a member of the Royal College of Nursing, some forty-five years after the college was founded. As this chapter attests, the profession of nursing continues to be strongly perceived and positioned as a feminised area of work.

In this chapter I explore how the expectations of masculinity and manhood within wider society influence the experience of men working in this typically feminised profession. I seek to illuminate and unpack the impact that such discourses and expectations surrounding gender and gender roles has on male and gay male nurses' performance, and how these experiences are constructed within the feminised workplace. For issues of transparency, it should be noted that this chapter of the thesis has particular personal resonance, because as a male nurse I have shared many of the experiences related by the men whose voices are evident in the literature.

I begin the chapter by exploring the history of nursing since and the movement from homely care to occupation and then profession. However, I am mindful that historical accounts are culturally and socially constructed and cannot be taken as wholly accurate or truthful representations of what actually happened, as cultures and meanings attached to social histories change over time and place. I move forward to discuss the problematic way in which nursing is constructed as a feminised space, before considering issues of masculinity. Subsequently, I explore and define the terrain that represents men and masculinities within the social sciences, examining the major theoretical concepts that have emerged in the sociological study of men. I then introduce the literature on men in contemporary nursing, and give a brief history of men as carers and nurses.

2.2 Nursing: From homely care to occupation

Nursing, as we view it today in terms of being a defined occupation and a profession, began development in the early 19th century. Prior to this it is suggested that, 'nursing' encompassed a wide variety of caring activities that were typically undertaken by family members or (for the wealthy) by servants (Baly 1986). Historians indicate that two major events shaped the concept of nursing as an occupation during this time. First, the sanitary and poor reforms led to workhouse infirmaries for the poor, and later private wards for the wealthy. As medicine increased in complexity the medical profession became frustrated with limitations of home care, and it is suggested that they encouraged the move of illness from the realm of the home to the hospital (Dingwall, Rafferty and Webster 1991). With this move to institutionalised care came formal nursing posts and titles, each ward being run by a nursing Sister and each infirmary overseen by a Matron. As the following excerpt demonstrates, nurses at this time (around the 1850's) were typically recruited from the servants of wealthy gentlemen's households:

It appears to have been the custom at all times for each ward to have the benefit of supervision by a separate sister who, in addition to the care of the sick should have the charge of the ward stores and also be the medium of communication between the patients and the medical staff. It ...was practice to select for this office respectable females who, previous to their appointment had experience of household work, been upper servants in private families or engaged in the capacity of nursing the sick outdoors... (Guy's Hospital Reports (1871) Cited in Dingwall, Rafferty and Webster (1991, P15)).

The skills required by the nursing sister at this point of the profession's evolution therefore entailed household management, organisation and communication. They would also have been responsible for managing the ward nurses, who were usually recruited from the lower social ranks of the population and had unenviable reputations - as represented by Dickens' infamous drunken nurse, Mrs Gamp. Thus,

the caring aspects of nursing as we recognise it today were noticeably absent in the sister's role at this time.

The second major event to shape the concept of nursing as an occupation was the widely recognised influence of Florence Nightingale. Although other figures such as Mary Seacole and Betsi Cadwaladr contributed significantly to nursing reform (Borsay and Hunter 2012), Nightingale remains the most famous. Within historical accounts and modern day interpretations, Nightingale is portrayed as establishing nursing as a respectful profession for women (DeLoughery 1977). The role Mary Seacole and Betsi Cadwaladr played in the Crimean war and the reformation of nursing is often neglected in the re-telling of the story. It is probable that Nightingale's higher social position coupled with access to monetary assistance and people of influence enabled her to position herself at the forefront of nursing's reformation. It has to be noted that the re-telling of nursing history as suggested by Nelson (2001) is often from a very English perspective that emphasises the role of military nurses, such as Nightingale. Later I discuss the effect Nightingale had upon the feminisation of the profession, but here it is sufficient to recognise her impact on the work of nurses and their training within the hospital environment. On her return to the UK, following the Crimean war in 1856, Nightingale, alongside a number of doctors, formed the Nightingale Fund that sought 'to establish a permanent institution for the training, sustenance and protection of nurses and to arrange their proper instruction and employment in hospitals' (Baly 1986, P9). When the fund closed in 1856, it had collected £44,039 (Approximately £3,484,000 in current monetary value).

Nightingale's legacy was also apparent in the St. Thomas's nurse training scheme, which commenced in 1860 and provided lodging and wages for each probationer (Dingwall, Rafferty and Webster 1991). Later the St. Thomas's training scheme became the Florence Nightingale School of Nursing, which is now incorporated into Kings College London and is recognised as one of the UK's leading nursing

academic departments. Although the St. Thomas's training scheme was intended for the 'training' of nurses, it is worth noting that the nursing role was thought to be largely limited to non-medical caring tasks such as feeding and washing, whilst medical students took temperatures and pulses and tested urine (Baly 1986). Dingwall, Rafferty and Webster (1991) theorise that doctors feared that their own mistakes would be identified and therefore they suppressed the nursing role. Thus, nursing and medicine became divided by the work they did and medicine became dominant in defining what nursing work was and was not, for example by claiming clinical tasks such as measuring vital signs as medical work. The next section explores how nursing sought to become a profession.

2.3 Nursing and the Professionalisation Agenda

By the late 1800's nursing roles were established within Infirmaries and Nightingale's training school had become also established. Medical doctors had gained professional status in 1858 when the government of the time formed the General Medical Council and nurses now sought professionalisation as well.

Freidson (1990) suggests that since nursing's emergence as a modern occupation, the profession has been preoccupied with its status in general society and in the institutions that provide health care. He recognises that historically efforts were made to make nursing a socially respectable, full-time occupation that was grounded in the authority of both training and the orders of physicians, but that from the 1900's nursing has had larger ambitions to become a profession. Furthermore he recognises that nursing has increased training and registration requirements and persisted in its search for greater independence from medicine. Nurses and the nursing profession has striven to distance itself from the dominance of medicine and on this matter Freidson (1994) suggests that medical doctors maintain the ability to prevent encroachment on their medical autonomy by maintaining 'discretionary powers' over their daily work. He also suggests that a profession is based upon the power of knowledge and that nursing (and other health professions except medicine) has a

form of intermediate knowledge that is based on the division of healthcare work and that is difficult to define as unique to nursing:

The position of nursing as a profession would be enormously strengthened if it too could claim jurisdiction over a body of knowledge and skill that can be practiced independently of medicine, a body of knowledge and skill whose use is not contingent on the direction provided by medicine. (Freidson 1990, online)

The following discussion briefly explores nursing professionalisation and history suggests that one of the major proponents of the registration movement for nurses was Mrs Bedford Fenwick (former Matron of St. Bartholomew's Hospital until her marriage to Dr Bedford Fenwick) (Dingwall, Rafferty and Webster 1991). Fenwick was also a supporter of the suffragette movement that was seeking the vote for women in the UK and US. It is thought that at this period of time, nursing and feminism first converge as the debate for registration and professional status of nurses commenced. Interestingly, by this time, nursing was an almost exclusively female profession, except for male attendants in asylums who were retained to maintain peace and restrain inmates as and when directed (Arton 1998).

These first ties to the women's movement however, were short lived, as nurses shied away from the suffragette cause (Baly 1986). Two possible reasons for this reticence are the influence of the medical profession, and the 'respectability' the nursing profession had gained. As an example, at this time nurses were still expected to be single and would leave their position once married, as had Mrs Bedford Fenwick when she married Dr Bedford Fenwick (Dingwall, Rafferty and Webster 1991). Both medical dominance of nursing and respectability are, and were, constructed through the dominance of men at the time and their desire to control women's sexuality. In contrast to earlier periods of time, nurses were expected to demonstrate the highest

moral standards. Therefore, nurses and nursing could not be seen to support the women's movement for fear of placing the profession into disrepute.

Further reformation of nursing occurred slowly, and it was not until 1923 that the General Nursing Council (GNC) was formed. This was a critical moment in the development of the profession as medical doctors had been recognised as a profession and regulated since 1858. The GNC was given the task of regulating the profession of nursing some 65 years following the regulation of medicine. One of the strategies adopted to accomplish this was the creation of a register of nurses. This act proved contentious and even became a political issue that was debated in Parliament. It was reported that registration was particularly unpopular with many members of the medical profession and one can hypothesise that these doctors potentially sought to maintain nurses' subservient position.

Andris, Nicholas and Wolf (2006) assert that nursing has been in 'professional limbo' for over 100 years due to its gender specific association and dominance of men, for example medical doctors. They contend that if nurses had not resisted the call to action as part of the early women's movement, then nurses would not have struggled for so long to attain professional status, autonomy and control over their practice. Furthermore, Davies (1995) states that gender continues to be a professional issue that affects the work of nurses and the structures within which they operate, with men dominating the organisation of professional work. The continuing dominance of medicine in the organisation of nursing work can be recognised in the organisation of hospital spaces, for example how wards and departments are grouped using medical categories such as the medical ward and surgical wards. Later developments include the unionisation of nurses through the formation of the Royal College of Nursing (RCN) and the more recent fight for equality in relation to nurses pay and terms of employment - which cumulate in the strike of 1988 (Hart 1994).

Amidst heated discussion in the profession, the GNC formed four supplementary registers covering sick children's nurses, mental nurses, male nurses and fever nurses (Dingwall, Rafferty and Webster, 1991). Many within the profession and the GNC did not support the use of these supplementary registers, preferring instead a generalist approach to the regulation and education of nurses - a debate that continues in nursing to this very day. The birth of the GNC, underpinned by the Nurses' Registration Act (1919), contributed to the formation of the four fields of nursing practice that exist today (i.e. adult, children's, mental health and learning disabilities nursing).

After the formation of the GNC the profession remained relatively stable and although minor changes occurred when nursing moved into the newly formed NHS in 1943 (such as the formation of nursing schools outside of the hospital environment), modernisation of nursing did not take place until the 1980's. During the 1980's the GNC was disbanded and replaced with the United Kingdom Central Council for Nursing and Midwifery (UKCC). High on the new council's agenda was the reform of nursing education, and in 1986 they published Project 2000: A New Preparation for Practice. This document outlined radical changes to nurse education, including the move to higher education and the attainment of diploma level education as the minimum standard for entry to the nursing register. More recently in 2012 the minimum standard for entry to the nursing register became degree level, commensurate with our colleagues in medicine and many allied professions (although it has to be recognised that a degree in medicine takes five years to complete and not the three years it takes to become a nurse). It is worth noting at this point that it has taken over a hundred years for nurses to be educated to degree level, which signifies women's problematic position as professional nurses, whereas medical doctors have studied for medical degrees since before the inception of the GMC.

Further reforms took place in 1998 following the UKCC's Commission for Education report (UKCC 1998). This highlighted the need to focus upon partnership with the NHS in the preparation of nurses, and to develop the clinical skills of nursing students. The Nursing and Midwifery Council (NMC) superseded the UKCC in 2002, and continues to reform the profession, education and practice of nursing. For example, it recently introduced degree-level education as the minimum standard for registration in the UK and dispensed with the Common Foundation Programme, in favour of an integrated curriculum where each field develops both generic and field specific knowledge and skills.

The nursing profession has been, and is, reformed not only by professional bodies such as the UKCC and NMC. The work of the RCN, the Department of Health and the Chief Nursing Officer's recommendations in *Modernising Nursing Careers* (DOH 2006) have all been strongly influential in defining the modern nursing profession with regard to regulation, education and role development.

Nowadays, nursing roles are becoming more patient-focussed, teams increasingly inter-professional and career opportunities clearer. The proliferation of advanced practice courses and roles, training to become nurse prescribers and the emerging role of nurse consultants demonstrate how nursing has, in the course of the last twenty years, become increasingly autonomous. Nursing has striven to differentiate itself from, and free itself from the dominance of the medical profession for some time. Nightingale's achievements in securing the professionalisation of nursing are immense, but the legacy of servitude and dominance by the medical profession remains apparent and Allen (2001) suggests that the professionalisation of nursing has been undermined by the reality of practice, where the care provided by nurses has to be co-ordinated by the needs of complex organisations. Having discussed the emergence of the profession and major changes and challenges, the next section explores the role of men as nurses.

2.4 The Feminised Space of Nursing

Earlier in this thesis I made reference to the problematic way in which nursing is constructed as a 'feminised space'; for example, in the prologue I discussed how 'Beth' was portrayed as being promiscuous. Then, in Chapter 1, I set out the feminised nature of nursing in terms of the percentage of women and men in the profession, and explored the cultural discourse of women as carers. I now explore how the construction of nursing as a feminised space is problematic for women and the profession before addressing why this is also problematic for men and gay men in the subsequent sections of this chapter.

The way nursing is portrayed within Western society is directly linked to the feminised position of the profession. The iconography of nursing can be both positive and negative, as I show below, but in terms of how the profession, and specifically women in the profession, are viewed, these images and stereotypes are deeply problematic. As Delacour (1991) argues:

...even stereotypes regarded as dubious may, after measure of exposure, become internalized and naturalized, they are thereby metamorphosed into categories of the normal, the real, and the healthy and desirable.

(Delacour 1991, P413)

Dominant stereotypes about nursing are numerous and the majority of them relate to nurses as women and bring into question women's sexuality. Muff (1982) identified six nursing stereotypes: 'angel of mercy, handmaiden to the physician, woman in white, sex symbol/idiot, battleaxe and torturer' (P211). I would also add to that list the historical stereotype of Nightingale's lady with the lamp. Dunn (1985) in an examination of tabloid newspapers of the mid-1980's, identified only three stereotypes: 'angel, battleaxe and nymphomaniac' (P2). Although these stereotypes are somewhat out-dated, they are persistent. Kelly, Fealy and Watson (2011) analysed 100 YouTube videos identified using the search terms 'nurse' and 'nursing' and found three main themes emerged in the representation of nurses on this modern

Internet resource: nurse as a skilled knower and doer; nurse as a sexual plaything and nurse as a witless incompetent individual. Hallam (1997) identifies that:

...nursing stereotypes are variations on culturally embedded stereotypes of gendered femininity, situating nursing firmly within the discourse of femininity. (Hallam 1997, P34)

Furthermore, she identifies the popular feminine counterparts to nursing stereotypes as: 'dutiful daughter, man's little helper, embittered spinster and promiscuous whore' (Hallam 1997, P34). There appears to be a disconnection between the reality of contemporary clinical nursing practice and the public image of nursing which is problematic as this stereotypical discourse has the power to constitute reality. The problem is: 'On the basis that discourse has constitutive power, the nurse is a sexual woman and is incompetent' (Kelly, Fealy and Watson 2011: P1811).

There are other discourses of nursing which also link with discourses of gender, one of the most prevalent being nurse education. One of the major changes in nurse education has been the move to higher education and, more recently, the change to degree level education. Gillet (2014) examined how nurse education was constructed in UK newspapers and found that there was a somewhat nostalgic response to the move into higher education, as these newspaper extracts she cites demonstrate:

We were regarded as angels of mercy. We weren't paid lavishly, but our status could not have been higher. Now nurses are educated to university degree level but, as students, spend a limited time in hospital... This means that nurses are not taught to care...(Claire Rayner, *Daily Mail*, 22nd April 2008)

She also quotes *The Times*:

Sir my mother was a nurse during and for a period after the Second World War and always maintained the dictum, instilled by her first matron, that ‘nursing is the art of making people comfortable in bed’. Modern nursing can have as many medical, degree level or other layers it likes added on top, but if this bedrock principle is ever forgotten, ignored or swept aside as being too menial or time-consuming, then hospitals...will be places of unnecessary suffering. (Chris Whitby, Letters to the Editor, *The Times*, 19th November 2009. Cited in: Gillet 2014, P5)

These nostalgic reflections on nursing are not only problematic in the way that they construct two distinct identities — caring nurses and educated nurses (Gillet 2014) — but because they represent a discourse where knowledge and education have little value, because knowledge is based on practices which are seen as feminised. Latimer and Ozga (2012) argue that some forms of knowledge, such of that in nursing, are seen as feminised and therefore achieve a lower status than more masculine forms of knowledge such as science and medicine:

Through processes of comparison, ‘the feminine’ is rendered both ‘less than’ and, frequently, supplementary to, those practices and attributes characterised as masculine. For example, knowledges characterised as subjective and intuitive are made to seem, through comparison, partial, provisional and feminine. (Latimer and Ozga, P6)

This ordering of knowledge is based upon essentialist notions of gender, which assert that both men and women have innate or essential qualities that are attributable to biological reasons rather than social order or social constructions of maleness and femininity (Crompton and Layonette 2005). As I discussed in Chapter 1, the

dominant discourse of women in Western society continues to be based on essentialist ideas of women as mothers, housewives, and carers, and as such, knowledge relating to ‘caring’ is deemed less worthy than the science of men. The problem here, as identified by Davies (1995), is that nursing is ‘ordered to care in a society that does not value caring’ (P38). She goes on to say: ‘Nurses are expected to uphold the values of a female identity in the face of masculinity which is ambivalent about it’ (ibid). These essentialist notions are produced and re-produced in the ways that nursing is performed and written about and how the profession is portrayed in the media. Later in this chapter and in the data chapters of this thesis, I explore how male nurses position themselves in certain ways and enact certain performances that assert their masculinity — and how, by doing so, they produce and re-produce the essentialistic ways in which nursing is constructed as a feminised space.

2.5 Men and Masculinity

The remainder of this chapter explores nursing from the viewpoint of men. I commence this discussion by briefly outlining contemporary thinking in relation to masculinity, followed by more explicit explorations of men in the profession of nursing.

The concept of masculinity has been written about extensively, and the last two decades have seen an exponential increase in literature on men’s studies and defining what it is to be male. Connell (1993) suggests that this interest emerged from the growth of feminist research in the 1960’s, which questioned and problematised purely biological explanations and accounts of gender and sex roles. This work asserted that while the genetic, hormonal and physical differences between men and women cannot be ignored, they cannot account for the traits, roles and expectations that for centuries have emerged as differences between men and women.

Conceptualisations and understandings of what it is to be a man are associated with traits that are understood as masculine. These traits are typically positioned in relation to their binary partners, female and feminine. Thus, men are powerful and women are weak, men are aggressive and women are gentle etc. Petersen (2003) explains:

Definitions of masculinity often entail little more than the compilation of lists of what are seen to be characteristic masculine qualities or attributes...masculinity is often referred to as though it had a definable and distinctive essence. The specific historical and social constructions of masculinity cannot be dissociated from constructions of femininity...it is difficult to speak of masculinity without implying a binary notion of gender. (Petersen 2003, P58)

However, masculinity cannot be defined simply or completely as the opposite of, or the rejection of, femininity. What makes men masculine cannot be based wholly on gender and sex roles, as the definition of being male and masculine is clearly embedded in societal norms and values. Therefore, what we expect of being a man and of men, is socially constructed rather than a biological given. Kimmel, (1997) recognises that masculinity is 'invariably invisible in shaping social relations, masculinity assumes the banality of the un-stated norm' (P181). Thus, masculinity could be seen as natural, expected and dominant; so much so that it is only recognised when un-masculine (maybe 'un-natural') traits and behaviours are seen. An example of how un-masculine traits can 'illuminate' masculinity is the stereotypical image of gay men as effeminate that highlight the importance of masculinity.

Connell (1995) rejects the notion of a universal conceptualisation of masculinity, recognising that definitions of manhood change between cultures and within history, social class settings, ethnic communities and differing environments. Connell therefore cites the plural term masculinities to describe the plethora of alternatives associated with 'being a man'.

In the 1970's and early 1980's, masculinity in the literature was primarily defined in terms of social constructs such as sex roles (Connell 2005). Emphasis was placed on societal role expectations, role stereotypes, and role models for males. Unlike the biological and evolutionary theories of masculinity, these social theories allowed and acknowledged the inclusion of social influences upon the development and meaning of masculinity. However, Connell maintains that such biological and social sex-role theories provide an inadequate framework for understanding masculinity because they do not address the emotional complexities of gender. He argues that the personal expression and meaning of masculinity cannot be isolated from institutional contexts (such as the state, workplace or labour market, family), and that the concept of masculinity is relational, situational and transformative. The concept of masculinity changes over time, and the changes in turn reshape the context in which the concept originally arose. Thus, Connell asserts that masculinity is a dynamic concept and it is constantly changing in relation to social structures and influences.

This ever-changing and dynamic concept of masculinity is referred to in the literature as hegemonic masculinity (Connell 1993). Three concepts underpin hegemonic masculinity: that masculinity is the dominant form of gender; that there is a natural, 'normative' ideal of masculinity; and that this form of masculinity subordinates others (for example, homosexuality). In western society hegemonic masculinity is associated with whiteness, heterosexuality, marriage, authority and sexual prowess (Giddens 2009). Connell emphasised that hegemonic masculinity was not a fixed character type, always and everywhere the same, but that it was the 'culturally exalted form of masculinity' (Carrigan, Connell and Lee 1985, P592). Connell

(1995) also emphasised that even though a very small number of men actually embody hegemonic masculinity, all men still benefit from the 'patriarchal dividend' (P41).

Connell (1995) also developed the notion of complicit masculinity, which refers to men who benefit from patriarchal oppression, but do not enact hegemonic masculinity:

A great many men who draw the patriarchal dividend also respect their wives and mothers, are never violent towards women, do their accustomed share of the housework, bring home the family wage, and can easily convince themselves that feminists must be bra-burning extremists. (Connell, 1995, P80).

While men who fall into this category do not receive the same benefits and privileges as those who inhabit hegemonic masculinity more securely, they do still support it, are controlled by it, and the practices which constitute it are used to judge the conduct of other men.

Men who occupy hegemonic masculinity assert a position of dominance by obtaining the approval of other males and females. Martino (1999) argues that boys learn to establish their masculinity in opposition to femininity and feminine behaviours and that those feminine behaviours are 'markers' of homosexuality in men:

...it appears that many boys learn to establish their masculinity in opposition to femininity (Connell 1994). In other words, they define their masculinity within a set of cultural and social practices which involve the rejection and denigration of what they consider to be feminine attributes or behaviours that often serve as markers of

homosexuality on the policing of ascendant forms of masculinity.

(Martino 1999, P244)

Furthermore, Martino suggests that being a certain kind of boy (his research took place in schools) requires the acquisition and demonstration of particular practices. He cites the example of boys who adopt a pro-sport position in school to assert their masculinity and how this form of hegemonic heterosexual masculinity is positioned in opposition to femininity and homosexuality. At the same time Martino suggests that achieving hegemonic masculinity may involve 'othering' (P253) boys who do not participate in sport through homophobic verbal abuse. Due to the binary notions of masculinity and femininity the positioning of hegemonic heterosexual masculinity that Martino identifies further reinforces and compounds the position of women and the essentialising notions of womanhood and nurses that I discussed earlier in section 2.4, which are produced and re-produced in gender identities. Haywood and Mac an Ghail (2013) acknowledge that the concept of hegemonic masculinity moves the analysis of masculinities from a singular notion of masculinity to multiple masculinities, which questions the similarity of male identities and the distribution of men's power. Furthermore they suggest that:

...the concept of multiple masculinities has enabled an understanding of male identities that are both historically produced and locally configured through the articulation, policing and regulation of normative meanings.

(Haywood and Mac an Ghail 2013, P114)

Critics of Connell's multiple masculinities have argued that the concept tends to promote and re-produce static categories that are difficult to apply without re-producing simplistic accounts of masculinity (Beynon 2002, Anderson 2009). Further criticisms include, who, if anyone, actually embodies hegemonic masculinity? (Martin, 1998). Due to these criticisms Connell and Messerschmidt (2005) modified their concept of multiple masculinities. They argued that in any

given setting a form of masculinity exists which is associated with authority and power and therefore that hegemonic masculinity can be identified at the local, national and global level through differing 'configurations of practice' (Connell and Messerschmidt 2005, P847). Because hegemonic masculinity has often been attributed to behaviour that subordinates other men and women, the term has become connected with the worst excesses of masculinity for example 'laddish' behaviour (Ward 2013).

More recently hegemonic masculinity has been challenged by the emergence of new forms of masculinity. One example of this are the men in Anderson's (2009) ethnographic study of white, middle-class university students in the United States. This research suggested a decline in overt homophobia and more open forms of homosocial relations, which challenge hegemonic masculinity. Furthermore, in relation to hegemonic masculinity, Anderson argues that this 'archaic archetype of masculinity' (P4) is now on the decline and that this is in part due to wider social changes in sexual practices, for example sex before marriage, higher divorce rates, same sex marriages/civil partnerships. Building on this work McCormack (2012) investigated masculinity in three UK school sixth forms where he found that the male participants were much more comfortable with physical contact between each other and that there were reduced levels of homophobia, describing a number of friendships between heterosexual and gay students. McCormack utilises Anderson's (2009) theory of inclusive masculinity to theorise his findings, suggesting that if homophobia is reduced, then the dynamics through which hegemonic masculinity dominates other forms of masculinity are also reduced. McCormack (2012) also found that boys in the school did not publicly invoke misogyny when discussing girls, claiming that 'girls appear to have greater freedom from sexualized harassment than other research suggests' (P92), although he did acknowledge that he was not present during the boys private discussions about girls. Anderson and McCormack's research is useful in recognising changes in homophobic attitudes amongst young men, however, it is important to remember the privileged positions the men they

interviewed hold as white, educated, middle-class men and how this may enable them to display 'softer' forms of masculinity (Ward 2013). This research also has to be considered alongside other research that reveals high rates of homophobia in UK schools (Stonewall 2012). Having explored modern definitions and theories of masculinity the next section discusses the history of men in nursing.

2.6 Men Becoming Nurses

The beginning of this chapter addressed the historical course of nursing and the struggle for professionalisation over the past 100 years. That discussion quite deliberately did not address male nurses and the role they played as the history and contribution of men in nursing is quite different to those pioneering women such as Nightingale.

History suggests that men have been at the forefront of caring work for centuries, and it was only within the 19th century that the feminisation of nursing occurred (Brown et al. 2000). This resulted in men no longer being seen as performing caring activities such as nursing. Since the feminisation of nursing, I suggest, the history of men in nursing has been contested, understated and written from the viewpoint of a feminised profession, with much of the focus being on the work of female nurses. Miers (2000) also suggests that male nurses have occupied a difficult position:

Male nurses were probably, for the first half of the twentieth century, considerably disadvantaged by the dominance of women. (Miers 2000, P91)

Table 1 summarises the key events in the history of men in nursing. Hippocratic writings describe how male slaves performed therapeutic activities and were trained by doctors to undertake these activities in the baths of Greece, although interestingly caring in the home at this time continued to be the role of women (Wright and Hearn 1993, cited in Brown et al. 2000). Monks within religious orders also undertook

nursing care for centuries before the development of organised medicine (Brown et al. 2000).

Table 1: The History of Men in Nursing		
Date	Event	Significance of Event
1095	Creation of religious orders	Men are the main providers of nursing care
1200	Knights of St Johns	Men are the main providers of nursing care
1500's	Dissolution of monasteries	Female carers emerged. Little mention of men.
1800's	The Victorian era	Men and women worked in segregation in workhouse infirmaries and asylums
Late 1800's	The Victorian era	Little importance attached to nursing. Men involved in nursing are seen as doing women's work
1907	Army and Navy Male Nurses Association. Royal Army Medical Corps	800 male nurses
1919	Nurses Act	Male nurses only recorded on part 2 of the register
1943 and 1949	Nurses Registration Act	Male nurses allowed admission to the general part of the register
1960	Royal College of Nursing (RCN)	Men accepted as members
1975	Sex Discrimination Act	Men allowed admission to midwifery
1983	American Nurses Association	The number of men in the US nursing system is 4%
2003-2014	Nursing and Midwifery Council analysis of the register	The number of male nurses on the UK nursing register remains static at around 10%

Source: Ryan (2010, P52)

Men as carers and nurses were inextricably linked to conflict and war, offering a further example of how men limited their caring to 'public sector' activities, leaving women to care in the home. The Romans were one of the first cultures to practice battlefield medicine in tent hospitals (Evans 2004), which were staffed predominantly by males. More recently, the Second World War saw a large number of men within the forces taking on the role of medical technician, with many of these men training as nurses when leaving the armed forces (Evans 2004, Mackintosh

1997). However, nursing within and outside of conflict became and continues to be a female dominated activity, and has been since the reformation of nursing by Florence Nightingale during the Crimean War.

Before Florence Nightingale, untrained male orderlies conducted nursing care in wartime. Nightingale is believed to have challenged this, believing that to 'be a good nurse was to be a good woman' and that the 'hard and horny hands' of men were not fitted to touching, bathing and dressing injured limbs (Thewelitt 1987, cited in Brown et al. 2000). Evans (2004) locates the feminisation of nursing by Nightingale into the general context of changes in attitudes towards masculinity and femininity during the 19th century. At this time tenets of masculinity were moving away from sensitivity, closeness and emotion, as demonstrated by writing at the time being negative towards male friendship (Evans 2004). During this historical period the world was becoming increasingly industrialised, further reinforcing masculinity and stereotypical gender roles, for example men as 'bread winners' and women as 'home-makers'. Nightingale's belief that women made good nurses mirrored the developing gender roles of this time, reinforcing the notion of women being inherently gentle and caring. Furthermore, Nightingale's recruitment of middle class 'ladies' to the profession, who followed the directions of medical doctors, meant that ideas of women's' rights and the beliefs of the suffrage movement failed to influence nursing. The position of women and specifically nurses at this time was indicative of the patriarchal power of men and their dominant position. Nurses have not been recruited specifically from the ranks of the middle classes for a long time now and many nurses are undertaking advanced, autonomous roles, however in Chapter 4 I explore men and medicine continue to dominant the healthcare arena.

The gendered nature of the profession can also be traced back to the initial registration of nurses. The need to register male nurses specifically, as part of the GNC supplementary register, was due to male orderlies working in asylums. Only men worked in these spaces at the time of the Nurses Registration Act 1919, and such gendered recruitment is still apparent with many men drawn to mental health

nursing. In his ethnography of male mental health nurses, Holyoake (2001) reported that mental healthcare environments proved attractive to his subjects because such spaces enabled them to draw upon and utilise their masculinity, power and strength – with, for example, the physical control and restraint of patients. Indeed, men currently account for only one in ten registered nurses, with a third of all male nurses being in mental health (Tweddell 2008)⁷.

In contemporary healthcare recent⁸ UK figures report that there are 676,547 Registered nurses, 10.60% are male and 89.29 are female (NMC 2008). Although men are a minority within the nursing profession, they have more rapid career progression, hold higher-level posts (for example, working in management, education or specialist areas of practice) and are paid more on average than their female counterparts (nurse consultants are paid in the region of £39,000-£67,000) (Evans 1997). What is significant here is the influence of patriarchal power within a female dominated profession, which enables men who are a minority group in nursing to occupy more positions of leadership and earn more money than female nurses. I explore the power of men in feminised professions later in relation to Kanter's (1977) seminal work.

Men are thought to enter the profession for a number of reasons, including caring, power and empowerment, and practical motivation (i.e. salary and job security), which is possibly linked to the need to provide for a family (Boughn 2001). Also, salary enhanced career development and opportunities, and related to this nurse education, taking place in higher education (Whittock and Leonard 2003).

⁷ Within children's there are far fewer men than in mental health nursing. A possible explanation for this finding concerns the difficulties that men face in relation to accusations of abuse, especially sexual abuse. Men in the field of children's nursing often feel vulnerable, especially in relation to personal care. I have worked with male nurses who have requested a chaperone when undertaking nursing procedures with children, so as to avoid untrue allegations of abuse, accompany them.

⁸ This is the most recent statistical analysis of the register the NMC have published. Equality and Diversity data is available from the NMC and includes information related to gender, however this is self-reported information and only 43% of all Registrants responded.

2.7 Are you man enough...To be a nurse.

Issues of gender, masculinity, politics and sexuality converge when considering the role of the male nurse in contemporary healthcare. In the past five years there has been an increased interest in masculinities research exploring the motivations and experiences of men in feminised professions (Simpson 2004). Specifically in nursing, this interest has been invigorated by the estimated shortfall of nursing students: in 2001 Bough discussed the 'long-anticipated' nursing shortage, and in 2003, Whittock noted 'a continuing shortage of qualified nursing staff'. The Department of Health commenced an initiative to recruit 20,000 more nurses by 2004. With this estimated shortfall, increasing the recruitment of both men and women into the profession of nursing has been of paramount importance, although gender diversity rarely features as an issue and in the UK there is no strategic advertising to encourage men to join the profession.

The deficiency of gender diversity in nursing is largely not discussed in the literature and little is done to address the recruitment of men into UK nursing. Sullivan (2000) sees gender to be as important as racial and ethnic diversity, but also acknowledges the profession's contentment with the current lack of men recruited to be nurses:

The lack of sexual diversity in nursing is rarely discussed. We wait for men to apply for admission to nursing schools and when they stay away, we figuratively shrug our shoulders at their lack of interest. (Sullivan 2000, P253)

Contemporary attitudes towards men within nursing can be stereotyped as identified by Holyoake (2002) in his ethnographic study of male mental health nurses, where he found that male nurses often reinforced their masculinity by ensuring they were 'straight acting', thus, reinforcing and asserting their heterosexuality.

The concept of hegemonic masculinity is useful in understanding the perceived feminisation of men who enter nursing. Connell's concept of hegemonic masculinity, the dominant man who is recognised by all as masculine, 'a man's man' that all men strive to be, is incongruent to the attributes that are associated with nursing, for example caring, touch and empathy. Within the concept of hegemonic masculinity a man who is overtly masculine cannot be seen as caring since this contradicts the rules that for example, 'real' men do not display sensitivity. Therefore, when a man enters nursing he is associated with feminised traits that are normally ascribed to women.

Within the US male nurses have attempted to 're-claim' their masculinity and the image below is a representation of this.



'Nursing takes strength, courage and compassion—qualities all "real men" possess. And this heavy-duty tee, designed just for men, lets everyone know you're proud to be a nurse. It features the popular contrast sleeve look—with colored piping separation—and our custom-made "Real Men Are Nurses" logo.' (Narrative from the US advert for this T-shirt⁹.)

The description of the T-shirt asserts that: 'Nursing takes strength, courage and compassion—qualities all "real men" possess'. 'Real men' being seen as hegemonic in this context and being described using words associated with hegemonic

⁹ Source: <http://shop.advanceweb.com/real-men-are-nurses-t-shirt.html>: Accessed: November 2010

masculinity such as ‘strength’ and ‘courage’. The wording of the advert promotes hegemonic masculinity in the strongest terms, but the image and the T-shirt itself achieves this too. The model wearing the T-shirt is reminiscent of an American ‘Jock’ who would stereotypically be young, masculine, a football player and heterosexual. Additionally, the style of the T-shirt is similar to American football shirts and the style of the lettering is also reminiscent of fonts and styles used on American football shirts. While the inscription on the T-shirt asserts the masculinity of the male nurse who wears it by proclaiming that he is a real man, subliminally the T-shirt is designed to invoke an image of masculinity as well by drawing upon the imagery of sport.

Unlike the men portrayed in the three pictures I discuss in this chapter, a man who becomes a nurse is positioned as being un-masculine (Harding 2007) and typically assumed to possess effeminate traits that are clearly discernible in the professional practice of caring - especially as such work continues to be heavily tied to the maternal role and child rearing. Men in feminised professions become stereotyped and Burton and Misener (2006) identify four negative stereotypes that are regularly used to explain the motivation for a man to enter the nursing profession, each of which is dependent upon notions of hegemonic masculinity, male nurses were represented as: the physician ‘wannabe’, being gay/effeminate, the misfit and finally the womaniser.

The stereotype of ‘wannabe doctor’ presumes that a male nurse must have aspired to work in medicine but was not intellectually capable of becoming a doctor. This assumption reinforces the subservient position (noted above) that nursing holds as a profession compared to the intellectual vigour of medicine.

I explore the gay stereotype in some depth later in this chapter. However, as has already been mentioned, there is the pervasive assumption that male nurses must be effeminate as it is women who are ‘natural’ carers – a stereotype that I challenge later

in this chapter. Stereotypically, effeminacy in men is linked to homosexuality and male nurses are assumed to be gay.

The category of misfit offers an explanation for those who do not fit the previous categories, it being the only explanation why a man would want to undertake what is essentially women's work.

The final category is somewhat contradictory when viewed in relation to hegemonic masculinity. The womaniser could be seen as the epitome of masculinity, demonstrating a man's prized ability to dominate and attract women. However, in the context of nursing the womaniser would be viewed as a misfit as well since such behaviour is not compatible with the caring profession. For example, both nursing staff and female patients may view a male nurse who is a womaniser as a potential threat.

In addition to defining these classic-nursing stereotypes, Burton and Misener (2006) identify examples in popular culture where they are perpetuated. Most of these cultural examples are from the US – e.g. in the film 'Meet the Parents' which I used to open this chapter, Ben Stiller plays a male nurse and has to overcome the stereotypical gendered assumptions of his new in-laws. However, similar examples of male nurses and the stereotypes that they are used to portray are also evident in UK media.

One example is the character Charlie Fairhead, the long-suffering charge nurse in the BBC programme 'Casualty', which is the longest-running medical drama series in the world. Charlie has been in the series since it began in 1986, and is currently an advanced practitioner in the Accident and Emergency Department. However, like the portrayal of many male nurses in the media, his life is difficult, plagued by poorly formed relationships, a divorce, an affair, depression, brushes with death and an argument with a patient which saw his character leave the series for some time. The

way in which Charlie's character has developed in the series can be related to two of Burton and Misener's (2006) stereotypical categories: First, the 'wannabe doctor' as Charlie is portrayed as a nurse who is in a senior role and pushes the boundaries of nursing and medical roles by making medical decisions. However, this portrayal could be seen as both positive and negative; developing nursing roles could be positive, although negatively a woman may not have been allowed to push boundary roles like Charlie. Second, the 'womaniser', as Charlie has had relationships with a number of the female nurses he works with. Such is the lot of the male nurse on television, stereotyped and negatively dramatized.

Considerable efforts have been made in the US to encourage men to enter the profession, especially as there is a considerable nurse shortage there. To encourage men into the profession some of these adverts attempt to overcome the image of male nurses being effeminate or gay as the slogan 'Are you man enough to be a nurse?' demonstrates in the image below¹⁰.

ARE YOU MAN ENOUGH...

...TO BE A NURSE?

If you want a career that demands intelligence, courage, and skill, and offers unlimited opportunity, consider nursing. For information about careers in nursing, and educational and financial resources in Oregon, go to www.oregoncenterfornursing.org

OCN NURSING

Sang Kim RN
Cardiac Telemetry Nurse
Snowboarder

Terry Misener RN, PhD
Dean, School of Nursing
Retired LTC
U.S. Army

Yuri Chavez RN, CNA
Nurse Anesthetist
2:14 LA Marathon

Robert Anderson RN
Post-Anesthesia Recovery Nurse
Decorated Vietnam Combat Medic & Retired Major, U.S. Army

Don Muscigrosso RN
Poison Specialist Nurse
Harley Rider

Walter Moore, Jr RN
Intensive Care Unit Nurse
U.S. Navy Seal
Team One

Bill Madaleno CN
Student Nurse
2nd Degree Black Belt Karate

E. Ray Arvola RN
Cardiology Nurse
Hugly Right Prip

Jason Scott Carreck RN
Student Nurse
Basketball Power Forward

¹⁰ Source: <http://www.oregoncenterfornursing.org/index.php?mode=postersandmore>

Harding (2007) suggests that the stereotype of men who are nurses are also gay is widely accepted and this advertising campaign is an attempt to remedy this situation and to recruit men into a feminised profession. The slogan 'Are you man enough to be a nurse?' suggests that you need to be a 'real' man to be a nurse, as also suggested in Image 3 which says 'Real men are nurses', the notion of a real man relating to hegemonic masculinity and societal expectations of masculine traits. The bottom of the poster is more explicit about the masculine traits they are promoting in the men they are trying to recruit: 'If you want a career that demands intelligence, courage, and skill, and offers unlimited opportunity, consider nursing.' The words intelligence, courage and skill are associated with hegemonic forms of masculinity and other non-feminised professions such as the military, especially courage.

The image on the poster is a composition of nine men and someone once commented to me: 'They look like the Village People!', an impression which would undermine the intentions of the poster (the promotion of masculinity) as the Village People were a pop group in the 1970's with some iconic gay characters in it. Half of the men in the image are in their everyday, non-working clothes and half of them are dressed for their work as a nurse. Those in everyday clothes are dressed for specific activities, for example one is holding a large skateboard, another a rugby ball and one dressed to look like a heavy metal music fan. While this is a diverse group of people, the activities they are undertaking portray them as typically (hegemonically) masculine – 'real men'. The men who are dressed as nurses could also be thought to be doctors and are the personification of Burton and Misener's (2006) 'wannabe doctor' stereotype, with two of them having stethoscopes draped around their necks (the stethoscope being a traditionally medical adornment) and one wearing a white doctors coat. These advertisements appear to be aimed at recruiting heterosexual men to become nurses as they display images of hegemonic masculinity. The 'Are you man enough...' poster was so popular that the Oregon Centre for Nursing designed a second poster that can be seen below: 'Caring knows no boundaries...Be a nurse'. While this poster has both male and female nurses present, the male nurses are again wearing stethoscopes draped around their necks and one is wearing a white coat,

reinforcing the wannabe doctor stereotype. In this image ‘soft’ masculinity is also represented as the only child in the image, a baby, is being held by one of the male nurses. It is interesting to note that these posters are so popular that the web site contains an order form where they can be purchased for \$25 each.



Being a man in a feminised profession is not completely negative; moving away from stereotypes of feminisation and sexuality, men in these professions can find themselves privileged over their female colleagues. An effect known as the ‘glass elevator’ which is present in nursing and a number of other female dominated professions, but which include men in their workforce, for example, air stewards, primary school teachers and librarians. Although research in relation to gender segregation and the division of labour in these workforces is now prevalent, investigation of the career aspirations and achievements of men in these professions remains limited. The experience of women working in male-dominated professions has been explored for some time, the seminal piece of work being Kanter’s (1977) ‘Men and Women of the Corporation’ which examined high-ranking executive women working in the male-dominated world of corporate business. Kanter asserted that women were viewed as tokens, highly visible, socially isolated both within and outside the corporate environment, and adversely stereotyped. Ultimately, women

working in male environments may find it hard to blend in, work effectively with their colleagues or within the organisation, and face barriers to promotion. Often women in these situations fulfil the stereotypical behaviour that is expected - for example, the 'Rottweiler' businesswoman who works within a powerful, dominant, paradigm that mirrors the masculine traits and approach of her male co-workers.

Conversely, the experiences of men working within feminised professions are different. Rather than having to work hard to be accepted within the organisation and by their colleagues, they fair better than similarly situated women (Heikes 1991). Men and women in gender segregated professions become tokenistic. While women tokens are disadvantaged by their high visibility, men tokens find that their visibility acts as a conduit for more productive work engagement with both colleagues and the organisation, leading to greater opportunities. Williams (1995) described this as the glass elevator effect, finding that men do not experience the isolation, visibility and blocked access to social networks that women do. Although men are in the minority, they instead are facilitated to 'opportunity and advancement'. The processes that are in place to achieve these are identified by Williams as the culture and everyday interactions that are dominated by their masculinity, the behaviours, attitudes and beliefs that men bring to the profession of nursing and which women nurses view and react to in a gendered manner.

Williams also argues that although men tend to achieve higher-level positions in feminised professions, they are often forced to progress their careers to underpin their masculine standing and I suggest, their heterosexuality. Masculine positions are assumed to be not only high ranking, high earning positions of power, but also certain spheres of nursing practice which include mental health nursing, intensive care and accident and emergency are viewed as more masculine than others, such as child health, maternity and health visiting these clearly being 'women's work' due to the very feminised caring occurring in these situations which can clearly be related to maternal care.

A number of drivers create the glass elevator and keep men moving upwards in the profession. Wingfield (2009) identifies the relationships men develop when working with women as a key issue. Male workers are often welcomed to the workforce, possibly because feminised professionals are often poorly paid, and attracting more men may enhance the status of a feminised workplace. Rather than the cold reception women in men's workplaces receive, men form gendered bonds with their male and female colleagues and interestingly she cites that male nurses may form better relationships with male doctors, further intensifying their esteem. Within the realms of these gendered bonds is an element of socialising, not only in the workplace, but also outside. This is an interesting phenomenon and one that also occurs in other professions such as teaching (Simpson 2004). It is possible that the feminised culture of these workplaces is more inclusive of difference and that the absence of patriarchal power in the workforce creates a better working environment of cooperation.

Furthermore, she examines the issue of men's suitability for women's work, the gendered approach to this being that men do not possess the feminine attributes of nurses, with male nurses frequently encountering patients, friends and family who see them as doing a woman's job. Williams (1995) asserts that this view of men not being able to undertake women's work underpins their movements to more 'masculine' nursing positions, with men aspiring to assert their masculinity and the profession needing to retain the position of caring within female nurses' work with some exclusivity. One further consideration to this process are male nurses who are simply not seen to be good at their job, and who are seen to be promoted away from clinical activities. Wingfield (2009) describes how masculinity works to advantage within nursing:

Masculinity is often associated with competence and mastery, and this implicit definition stays with men even when they work in feminised fields. Thus, part of the perception that men do not belong in these jobs

is rooted in the sense that, as men, they are more capable and accomplished than women and thus being in jobs, which reflect this. Consequently, men nurses are mistaken for doctors and are granted more authority and responsibility than their women counterparts, reflecting the idea that as men they are inherently more competent. (Wingfield 2009, P11)

The final factor, which promotes the glass elevator, is men's need to establish a distance from femininity in the workplace. Men who work in feminised professions develop strategies to disassociate themselves from femininity and retain the privilege of their masculinity. The process of distancing themselves from femininity also reasserts their heterosexuality, which often is questioned and stereotyped by colleagues and friends. Consequently, men in nursing gravitate towards masculine clinical and non-clinical positions where their hegemonic masculinity, which emphasises toughness, strength, aggressiveness, heterosexuality and the assumption that femininity is subordinate to masculinity, can be displayed. Male nurses often aim for higher paid and more technological positions in order to reinforce the 'social value' placed on their masculinity (Wingfield 2009). The way in which some male nurses re-assert their masculinity simultaneously re-produces the essentialist way in which female nurses are viewed, reinforcing stereotyped gender differences. This is problematic for both male and female nurses as this process of asserting masculine gender differences then exaggerates the feminine gender differences that the male nurse is attempting to distance himself from.

Within the UK, the disproportionate promotion of men to high-ranking positions in nursing is not merely hearsay. Tweddell (2008) reports that men are more likely than women nurses to earn higher wages and although men account for only 10% of the profession, they occupy 17% of nurse consultant posts and 18% of nurse manager posts. Tweddell goes on to establish there are 1,303 male nurse managers compared with 5,707 female managers, asserting that if the number of men in this role was

proportional to the numbers in the workforce there would only be 657 male nurse managers. Furthermore, this finding leaves almost 305, 000 female nurses who are not proportionally represented.

If we look across the profession at very visible, high level positions, many of these have been held by men, for example the United Kingdom Central Council (the predecessor to the Nursing and Midwifery Council) was headed by Sir Jonathan Ashbridge and Dr Peter Carter currently holds the position of President of the Royal College of Nursing. Incidentally, both organisations are acclaimed to be the largest professional organisations for nursing in the world and Sir Jonathan Ashbridge was the first male nurse to receive a Knighthood in 2006. The Council of Deans of Health (Nursing School Deans and Heads of School) has 88 members, 28 of which are men (31%). Thus, there are a clearly disproportionate number of men within clinical practice, nursing management and education. Having discussed how gender can influence the career choices of men in both positive and negative ways the next section explores perceptions of men as carers.

2.8 Where's that pretty blonde nurse?

“Nursing, historically, has been a white female’s job [so] being a Black male [nurse] it’s a weird position to be in. . . . I’ve, several times, gone into a room and a male patient, a white male patient has, you know, they’ll say, “Where’s the pretty nurse? Where’s the pretty nurse? Where’s the blonde nurse?”. . . . “You don’t have one. I’m the nurse.”

Interview extract from: Wingfield (2009, P18)

The title of this section and the extract above demonstrate how nurses are sexually objectified within clinical practice and more broadly in Western society. This extract expresses not only a sexualised view of female nurses, but also a view of nurses based on gender essentialism, where, in this case, blond hair and female beauty are

made synonymous with nursing. Furthermore, if female nurses are objectified and sexualised, this becomes problematic for both the nurse and the patient in the conduct of nursing care.

In this section I first explore notions of caring in the context of nursing in order to then explore caring in the context of being a male nurse. Nursing is viewed as a 'caring' profession and although caring is at the heart of our work (Leininger 1991) views within nursing of quite what the concept is or means are diverse. Each nurse articulates this term differently into his or her personal philosophies and workplace activities. Therefore, caring is a complex notion that can be wrongly assumed by nurses to have a shared meaning.

In their review of nursing literature, Morse et al. (1991) identified five key perspectives on caring that were portrayed in the work of 35 authors. The first perspective is caring as a human trait. This implies that caring is an innate action and behaviours that demonstrate the concept are influenced by socio-cultural experiences. The notion of caring as a human trait links directly to notions of gender essentialism and women possessing caring traits, that are usually feminised. Second, caring as an affect, describes caring as a feeling of emotional involvement, motivated by mutual goals that can make the individual vulnerable or open to criticism due to being seen as altruistic. The third perspective is caring as the moral imperative. Here, caring is described, as a fundamental value that can never be quite attained, but is the foundation for nursing. The fourth perspective perceives caring as being demonstrated through the inter-personal relationship between clients and nurses. The final perspective is the demonstration of caring through therapeutic intervention, such as patient advocacy, active listening or more globally all the actions of the nurse. Thus, just what 'caring' means as a concept within nursing is contested. I agree with Davies (1995) that caring is a notion which is undervalued due to being feminised in a patriarchal society which is ambivalent towards its worth.

Chad (2006) in his appraisal of caring, contests the apparent esteem attributed to the concept and alongside others asks: 'Does the expressively caring but unskilled nurse provide caring; and does the skilled but emotionally cold nurse provide caring?' (P124). He argues that simply having a caring ethos is not enough to meet nursing's moral and social contract in contemporary times when highly technological interventions are required. In this statement he is recognising that caring in modern healthcare is a complex endeavour that has to be based on knowledge and experience and not merely a caring attitude. However, one has to consider that if a caring attitude is not valued in comparison to knowledge and experience, is this due to the patriarchal view of what is valuable as asserted by Davies (1995). A further consideration, raised by Latimer (2000) is how nurses deliver quality care in a context that is: 'dominated by medical objectives and reinforced by the politics of the waiting list. Quality is defined by the demands of 'management by objectives' (P122). Clearly, care is an issue that is challenging to define and at times identify as nurses undertake their daily work.

As apparent in the five perspectives that Morse et al. (1991) identified, many of the constructs underpinning ideas of caring are feminised, for example being a human trait, emotional involvement. Consequently, these descriptions of caring may not be clearly articulated by male nurses. For example, caring as a human trait related in the first place to women and mothers, men are frequently unable to participate in the full care of female clients, and as Wingfield (2008) identified (heterosexual) male nurses tend to reject accepted and feminised expressions of caring for fear of stigmatising their sexuality. So while caring is certainly a gendered issue, the focus is often upon women as carers and nurses, and little acknowledgement made of masculine constructs and workplace exhibitions of caring. Chad (2006) agrees with this assessment of caring and discusses how when the concept is examined through the lens of gender it is historically and pervasively associated with women and femininity, which is problematic as these assessments of the concept are based on essentialist notions of gender. This is demonstrated by caring being defined most

often with affective and emotive characteristics, for example touch and empathy, which he refers to as 'Madonna'-like.

In his discussion of the traditional gendered perspectives of caring, Chad identifies the gendered division of labour that exists within western societies as a great influence over how gender is perceived in nursing. Women work in the home, provide sustenance and care for the home and children, while men work outside the home to provide much-needed financial resources. Chad poses an important question in relation to what constitutes caring and whether providing financial resources is caring:

It is not clear why general efforts to provide for and protect the family have not been identified as caring, especially since nursing, providing for clients and protecting them from injury or health complications are essential...a question that comes to mind is whether the man who toils all day to exhaustion in order to feed the house and his family is any less caring than the woman who toils all day to exhaustion in order to comfort and provide personal care to the children of the same family.

(Chad 2006, P127)

One explanation of how caring is constituted is the balance of power. Within the binaries of male and female co-exists the binary of power and weakness. Men, through their masculinity, have traditionally been seen to dominate women and the household. Chad identifies this powerful position as being incompatible with caring, and thus re-inscribes the general assumption that caring is the domain of women only, which is based on ideas of gender essentialism. In relation to nursing, it is thought that Nightingale found the power men exerted through medicine intolerable, and this led her to excise men from nursing (Brown, Nolan and Crawford 2000). By removing men from nursing Nightingale distanced the profession from the power of men in order to constitute the profession based upon her somewhat gender

essentialist notions of nurturance, gentleness and empathy which Brown, Nolan and Crawford (2000) suggest Nightingale asserted as the traits of women. MacDougall (1997) identifies that feminism challenged the traditional boundaries of caring. However, while women struggled for equality the feminist views on caring were often divergent, some women seeing caring as a burden which further emancipated women and some re-embracing caring as something which society has for too long devalued, as I discussed earlier in this chapter.

Conceptualising caring in relation to male nurses is not possible within the traditional literature and discussions within nursing thus far, as often men are not included in such studies or results are not examined from the perspective of gender. Furthermore, the conceptualisation of male nurses as caring is also problematic, as this could feminise the male nurse and further the stereotype of homosexuality. While research examining the perceptions of clients being cared for by male nurses is limited, there is some evidence that patients expect nurses to be women and make assumptions about the men that care for them (Ekstrom 1999). For example, patients assume that men are doctors, as some patients expect what a participant in Wingfield's (2008) study recounts as: 'The pretty blonde nurse'. The expectation that men are medical doctors and women are nurses is persistent, even when as many (or more) women are entering the medical profession as men. That such assumptions are so enduring attests to the power of masculinity and patriarchal society.

One way of conceptualising caring by male nurses is to consider it in relation to Connell's (1993) notion of 'multiple masculinities'. Connell's (1993) theories of masculinity offer the possibility of multiple masculinities, where although the performance of masculinity is governed by the expectations and regulations of hegemonic masculinity, it is nevertheless variable and contextual. Streubert's (1994) study of male nursing students goes some way to illuminate how multiple styles of caring and masculinity can be engaged in. One student in this study noted it is essential to develop an intuition about the client's response to maleness, and how this

is a challenge posed by the societal expectations of men and the nursing context of physical and emotional intimacy that requires careful negotiation. Paterson et al. (1996) interviewed 20 male nursing students and identified the category of 'caring as male'. Here, junior male students noted that women were socialised to care, freely showing emotions and touching clients. Several of the male students expressed concern that they could not negotiate these feminine caring skills. By the time the students reached senior level they reported development of an amalgamation of what they considered feminine and masculine styles of caring - they had established some connection with their patients, but were clearly not as 'touchy-feely' as their female counterparts and more of a caring friendship. The description of caring by the male students as 'touchy-feely' is problematic in two ways: First, it re-produces gender essentialised notions of touch and care being feminised. Second, the phrase is used in a comparative way, whereby the male nurse friendship is better than touch, a position which is enabled by the power of the *male* student and his masculine status. One student said he:

Was amazed at the relationship he [another male nurse] had with his patients. He was loud at times. He told jokes. He teased them a lot. But they loved him. And you could tell he cared about them deeply. I think some of the female nurses on the unit thought he was too casual and not caring enough. I think they were wrong. (Paterson et al. 1996, P32)

Within Paterson's work there are multiple examples of how male nurses construct 'masculine caring', and how they differentiate it from the caring female nurses provide. It appears that masculine forms of caring are demonstrated through the formation of client-centred relationships that operate at a less formal level than female ones. Perhaps to compensate for the lack of physical contact in the caring relationship, and also to emulate the masculine nature of relationship formation outside of nursing, male nurses tend to joke and have fun with their patients. Thus, it is suggested that male nurses form 'masculine' relationships in order to demonstrate

caring, while at the same time ensuring their behaviour is not deemed inappropriate by other colleagues or their patients.

Being a male nurse may make one vulnerable to accusations of misconduct. In the UK the number of male nurses undergoing Fitness to Practice investigations and receiving sanctions from the Nursing and Midwifery Council is disproportionate to the number of men on the nursing register, and has been for some time. For example in the period 2011-2012 the NMC received 3,190 referrals where gender was identified, of these 2,479 (78%) were female registrants and 711 (22%) male registrants (NMC 2012), while male registrants represent only 10% of the register. One reason for this could be that the performance of masculine caring may ultimately leave the nurse vulnerable to accusations, especially in the area of forming inappropriate relationships with clients. Masculine forms of caring may also explain why men gravitate to certain areas of nursing (Intensive Care Unit (ICU), Accident & Emergency (A&E), Mental Health), as these areas may be more accepting of this less formal and at times 'jovial' approach to nursing work. Additionally in areas such as ICU and A&E patient relationships are limited or transient, which may suit masculine forms of caring better than for example long stay care of the elderly wards. Within mental health nursing men may be able to directly demonstrate their masculinity through the use of control and restraint of violent patients.

Masculine forms of caring can be as problematic. Embodied within caring is the concept of touch, and it is here that caring and masculinity becomes most contested for touch is the most intimate form of caring. Male nurses are often limited in relation to the activities they undertake with female patients and clients by local chaperoning policies and their own fear of accusation. For example, intimate care and examinations are often not conducted without a chaperone, if at all, for the protection of both the male nurse and what is largely believed to be the protection of the patient. O'Lynne (2004) surveyed 111 graduating male nursing students and reported that 49% of men had received no guidance on touch in relation to their clinical

practice. He stated that this omission leaves male nurses vulnerable to accusations of inappropriate behaviour as touch within Euro-American culture is severely limited for men and that violations of these roles place men in a suspect position. Indeed, 45% of the men surveyed in O'Lynne's study feared false accusations of sexual inappropriateness.

Each year the General Medical Council and the Nursing and Midwifery Council deal with a number of misconduct cases in which male healthcare practitioners are accused of inappropriate behaviour towards female clients. This notion of men as abusers of their privileged position and the limitation of their practice with female patients is problematic for male nurses who are attempting to fulfil their roles in a professional and caring manner. In the UK one male student nurse found his role so limited in relation to his ability to care for female patients that he left the profession and commenced proceedings against the hospital he was based at, accusing them of sexual discrimination (Womack 2006). The Equal Opportunities Commission supported his claim. He successfully challenged an employment tribunal decision, which found that it was acceptable for the trust to have a different chaperoning policy for male nurses than for female nurses when intimate procedures were given to patients. As part of his evidence he asserted that male nurses should be expected to provide care whilst being guided by the same rules as female nurses, and that male nurses should be offered the same respect in relation to their ability to adhere to the professional standard of the Code.

However, notions of caring which are constructed on stereotyped assumptions of how male and female nurses conduct themselves are problematic. While the research I have explored in the above discussion offers some insight into the experience of being a male nurse, many of the studies are limited by the ways in which they seek to investigate caring as from the beginning they are looking for difference between male and female nurses, which reinforces traditional stereotypes. By asking the question do male nurses care differently from female nurses, the traditional

stereotypes of femininity and masculinity are engaged. This is an area of nursing that requires further examination so that both male and female nurses can be educated and informed about their caring practices. The following section closes this chapter and sets the scene for the remainder of the thesis by exploring the limited literature concerning being a gay nurse.

2.9 Being a Gay Nurse

When I first wrote this literature review six years ago I searched a number of academic databases and of course Google and Google Scholar, attempting to find literature concerned with being a gay nurse and what I found was that there is little academic writing exploring the lived experience of gay nurses. I have continued to periodically search the literature and little has changed. Coming to the end of writing up my research I have once again searched the academic databases and Google/Google Scholar and in the end, as I found little new information, I passed an hour or so reading online articles, comments and blogs, many of which had similar discussions to the one below:

Source: Allnurses.com. (Accessed: November 2013.)

Greygooseuria posted:

This is a discussion on Gay male nurse stereotype? So, a question has arisen in my mind since I have been in CNA class waiting for nursing school to start.

There are only 2 guys in my class of 25, and the other guy is married and I'm gay. After doing clinicals in the hospital, I have yet to see another gay male CNA or nurse.

Where does this stereotype come from? I am not seeing it at all.

Responses:

Padawnleaner posted:

Maybe you just need to take your gaydar in for calibration.



Gonzo1 posted:

Don't know where it comes from but I have been a nurse for 5 years and only a very small percentage of male nurses are gay that I know of. People love to talk and I think this perception has been blown way out of proportion because some people seem to find entertainment in this situation.

Spideys mom posted:

I think the stereotype comes from people's perception that nursing is a career for females and why on earth would a male want to do it. "He must be gay".

I imagine women truck drivers have to contend with the same stereotyping.

Steph

This single post received 170 separate responses and two things struck me. First, how alone this nursing student sounds, he appears to be reaching out for support from his peers. Second, how stereotypes can be so enduring; men have been nurses now for many years and there are some male nurses in public positions and portrayed in mainstream television and film. Yet, the stereotype of male nurses being effeminate and gay persists. While searching the literature I have found some interesting research about men and male nurses which I have cited and explored above. Almost all of the literature relating to lesbians and gay men in the context of nurses (rather than patients) explore the attitudes of heterosexual nurses or nursing students towards lesbian and gay patients (Röndahl, Innala and Carlsson 2004, Cant 2005) or the attitudes of heterosexual medical students (Arnold et al. 2004, Wallick et al. 1995).

My searching did reveal one piece of research that explores the working lives of lesbians and gay men: Röndahl, Innala and Carlsson (2007) *To Hide or Not to Hide, That is the Question! Lesbians and Gay Men Describe Experiences from Nursing Work Environment*. This research explored the working lives of 10 gay men and 11 lesbians working in nursing in Sweden using an interview method. Fourteen participants were registered nurses and the remainder were equivalent to UK nursing assistants with further education level qualifications. The main findings were:

1. Participants thought that the nursing environment reflected the attitudes of general society in relation to attitudes towards lesbians and gay men.
2. Some participants felt that acceptance of their sexuality was not a workplace issue that should be pressed and that acceptance was often about other issues such as nursing competence or personality.

3. In general, the informants considered themselves open about their sexual orientation at work. This openness was closely connected to positive or less positive work environment experiences. The benefits of openness included friendship with workmates, taking part in discussions about private lives, etc.
4. Most informants spoke positively about their psychosocial work environment. They felt they were accepted and respected by their workmates. Many of the informants never thought of themselves as “different” or experienced themselves as outsiders. Many of them felt the risks of coming out at work were less than the risks of concealment and subsequently being found out. Although participants constantly assessed the risks associated with coming out.
5. Regardless of whether informants were open or concealed about their sexual orientation at work, they talked about the constant fear they carried. For example fear of social exclusion or special treatment.
6. Some participants shared issues of harassment in the workplace, which included being socially segregated, and examples of homophobia¹¹.
7. Most of the participants regarded the invisibility of lesbians and gay men a great threat, which could lead to unconscious as well as conscious discrimination.

The findings of this research are similar to other studies examining coming out in the workplace more generally (Griffith and Hebl 2002, Ward and Winstanley 2005). Although Røndahl, Innala and Carlsson (2007) explore nurses coming out, their investigation did not to explore nursing and the experience of being a gay nurse. For example influence of nursing and professional conduct is absent, as is the issue of disclosing ones sexuality to patients and their relatives.

¹¹ The word homophobia was constructed by the heterosexual psychologist George Weinberg in the late 1960s. He used homophobia to label heterosexuals’ dread of being in close quarters with homosexuals as well as homosexuals’ internalised oppression. The word first appeared in print in 1969. Source: https://www.stonewall.org.uk/at_home/sexual_orientation_faqs/2697.asp. Accessed: March 2014.

Additionally, I have found glimpses of narrative that have quite incidentally been from gay male nurses in a study with a non-gay focus. Wingfield's (2009) study of male nurses in the US is one such example and while Wingfield sought to explore ethnicity as a factor in male nurses' experiences of professional experience, one participant did identify his gayness:

“I've been called awful things - you faggot this, you faggot that. I tell people there are only three F's in life and if you're not doing one of them it doesn't matter what you think of me. They say, 'Three F's?' and I say yes. If you aren't feeding me, financing me, or fucking me, then it's none of your business what my fagot ass is up to”. (Wingfield 2009, P23)

This experience, suggests that this gay male nurse may encounter difficulties in the workplace because of their sexuality, and that these difficulties may relate to developing good professional and social networks with colleagues. The dearth of literature examining the professional lives of gay male nurses opens up a space for my research to take place.

2.10 Conclusion

I commenced this chapter by exploring the historical events that led to nursing becoming the profession that it is today. I investigate how the formation of institutional care and the influence of Florence Nightingale formed the basis on which nurse education and the nursing profession developed from, with the first UK school of nursing forming in 1860. I have however argued that the history of nursing is re-told from an English perspective, which concentrates upon the military and Nightingale, which denies the many other histories of nursing including that of religious orders and I suggest men.

I then explore the development of nursing as a profession and the how the formation of the General Nursing Council (GNC) in 1923 was a critical moment in the development of the profession. Furthermore, I argue that as medical doctors had been recognised as a profession and regulated since 1858, this was the first step towards seeking equality with our medical colleagues. Medical doctors have dominated the nursing since Nightingale's time and there had been opposition to the formation of nursing as a profession as doctors felt threatened.

I moved the discussion forward to explore the problematic way in which nursing is constructed as a feminised profession before exploring the position of the male nurse. Subsequently I explored men in nursing and argued that male nurses have been disadvantaged for the first half of the nineteenth century by the dominance of women, as demonstrated by the lack of recognition of male nurses by bodies such as the RCN until 1960. Furthermore, I found that men were involved in nursing the sick for some time before the nineteenth century and I argue that in part Nightingale's professionalisation agenda contributed to men being excluded from nursing except in the role of male orderly.

In the concluding sections of this chapter I explore how caring has traditionally been seen as a feminised trait and how nursing is seen as a feminised profession. I argue that male nurses are negatively stereotyped, including being seen as gay. I argue that the way men are viewed in nursing can be negative and problematic in the way we are expected to perform professional nursing. I conclude by drawing together my thoughts on being a gay nurse, exploring the lack of literature exploring the experience of being a gay nurse and by attempting to explode this myth using modern social media discourses.

The following chapter explores and justifies the methodological challenges and the decisions I have made.

Chapter 3: Methodological Considerations - Researching Gay Nurses

“I just really don’t think there are enough gay male (student) nurses to make this research viable or even worthwhile...”¹² (A response to my research recruitment advert in the Nursing Times student nurse forum).

3.1 Introduction

In the previous chapter I have explored the way in which men have participated in the practices of nursing, for example within asylums, for many years and how it is only within relatively recent history that men have been embraced within the profession. I also discussed the way nursing is gendered and how masculinity, gender and sexualities are intrinsically linked within the professional context of nursing. With this in mind I will explore the process of constructing my research, the underpinning values that have influenced my approach, and the extraneous factors I have encountered, for example the experience of external ethical approval. Specifically this chapter describes the difficulties I have encountered in relation to recruiting gay men to participate in this research (as alluded to within the opening quotation of this chapter), the ethical issues I have considered, the process of interviewing and the process of data analysis.

Like many PhD students I wrote the first draft of this chapter near to the beginning of this journey and since that time my methodological considerations and this chapter have evolved as I have evolved as a researcher. This chapter charts the course of this research, my own development and some of the constraints of undertaking a PhD as a part-time student. The first draft read somewhat like a social sciences manual of research methods, in that I had read the relevant texts, planned my activities for recruitment and interviewing of participants and written this all down rather neatly and logically. What was missing from that initial ‘manual’ for my research approach

¹² This is a response to my research recruitment advert in the Nursing Times student nurse online forum. At the time I did not realise how difficult recruitment to this study would be.

I now realise was me, my reflexivity, my engagement with participants and their stories and an ability to critically evaluate my data.

Revisiting this chapter and my initial plans for the collection of data made me realise quite what a messy journey this has been from the perspectives of being a PhD student, a researcher, an academic and life more generally. Difficulties with recruiting participants, as I discuss in some detail later, meant amongst other things, a change from a proposed longitudinal study to grasping at any opportunity to recruit participants and conduct an interview. As an academic, periods of progress with this thesis, coupled with many periods of high workload have been difficult to manage. From a personal perspective this journey has been intersected with the issues that everyone faces in life, the loss of grandmothers, companions and pets. Being a nurse I thought that coping with loss would be easy to understand, manage and cope with, however the loss of people dear to me, my elderly cocker spaniel, my rescued St Bernard Molly took their toll. So, this version of my research methods draws upon my experience as an academic, a novice researcher and life in general. Moreover, this chapter focuses on the experience of conducting research as a post-graduate student, a nurse and as a gay man, rather than the mere planning of research.

3.2 Reflexivity and Researching Gay Nurses

In the prologue to this thesis I explored the personal experiences as a gay man and a gay nurse that have led me to undertake this research concerned with gay nursing students. Now I will explore my personal experience of undertaking this research and how this has influenced a number of the methodological decisions that I discuss within this chapter.

My own experience of being a gay nurse has been positive throughout my 24-year career. With this experience in mind, coupled with more accepting attitudes towards sexuality in society more broadly, I assumed I would not have any problems recruiting participants to my study. As a confident gay man who is open about his

sexuality socially and in my career as a clinical nurse and now as a nurse educator, I have now found my positive experiences are not universal within nursing.

Furthermore it is now clear that at times I have been somewhat naïve in my approach to this research both from a personal and a professional perspective. In Chapter 1 I explored how being gay in the United Kingdom (UK) has become more acceptable over the last three decades, demonstrated by recent changes to marriage and civil partnership laws. As my later discussion demonstrates I could not have been more mistaken and recruitment of research participants became one major obstacle in completing this research. I had assumed that gay nursing students would want to talk about their experiences and that as each university's intake of student nurses is around 150-200 students I would have no problems recruiting.

A survey conducted by the NMC in 2011 (NMC 2011), long after my recruitment to this research was completed, confirmed that my assumptions about the number of gay men entering nursing were seriously skewed as they identified that 9% of nurse registrants are male and that only 3% of registrants (both male and female) identify as lesbian, gay or bisexual. In Wales this drops to 2.7%. Although these statistics cannot be totally relied upon as not all NMC registrants responded (possibly as the survey was undertaken by the nursing regulator themselves) it does offer an indication of the general picture. Furthermore, I assumed that the gay students who did participate in this research would be engaging and potentially as confident as I am. However, as I discuss later in the chapter, this was not always the case. Some participants were extremely engaging and others appeared to either lack confidence in discussing their sexuality or have little to say at all. What I had not anticipated is the very personal and private nature of the questions that I was asking at that time and it was only when analysing the data some time after this that I really recognised the deeply embedded sense of 'the private' that participants not only talked about, but also demonstrated through their body language and in some cases the difficulty they had articulating their experience.

When commencing this research I did not foresee how other nurses and academics would react to me undertaking what they see as 'gay' research and I did not realise that being accepted as a gay nurse/academic came with limits, some of which I have crossed in the course of this project. What I mean is how I am viewed by some people has changed from Dave who has a male partner to Dave who IS 'gay' or DOES 'gay', due to the focus of this research. Additionally, I have engaged in wider issues of sexuality by, for example, leading the equality and diversity teaching in the school of nursing I work at and arranging for academics I have met at the School of Social Sciences Sexuality and Gender research group to give talks in my own school. For example, an academic from another department spoke to my colleagues and students about intersex. Later, in Chapter 6 I have explored Epstein and Johnson's (1998) notion of the good gay and the bad gay in the context of the university and I suggest that while I have not been labelled as a bad gay, I have been labelled as a 'gay' gay, someone whose life is dominated by their sexuality, which I suggest is a marked change from before I started researching gay male nursing students and transforming the curriculum.

The apparent lack of understanding about this research is at times quite clearly articulated by other nurses and academics in the way they talk about my research. This extract from my research diary shows how other academics have not understood my research or intentions:

If one more person asks me why I am researching gay men or suggest that it is unethical for me to interview gay men I will go mad. They say things like: 'won't your interviews be really biased as you are gay' or 'wouldn't it be better for a straight person to do the interviews'. I think what they really mean is be careful how you are viewed interviewing gay men, people might think you are being sexually predatory!
(Research diary. March 2009)

Finally, people often assume that my research is concerned with revealing homophobia, which given the lack of research about gay nurses and the proliferation of survey style research by the Royal College of Nursing (RCN) and Stonewall, which often appears to explore negative experience of gay lives, should not be a surprise. However, while I cannot state that the experiences of the students I interviewed are overwhelmingly positive, my analysis of their experience in Chapters 4, 5 and 6 are not concerned with homophobia, although there are major elements of heterosexism.

The fact that homophobia, as a specific issue, is not present in my analysis of these students' experiences, reflects the current liberalisation of attitudes towards LGBT issues and people more generally. However the predominant discourse associated with the literature regarding sexuality and nursing students' centres around notions of homophobia, discrimination and attitudes towards lesbian and gay people (Anderson 1981, Clift 1988, Page and Yee 1986).

3.3 Research Design and Rationale

3.3.1 The Choice of a Qualitative Location and Student Nurses

The notion of methodology and how this intersects with research methods is part of the confusing terrain of any research. So at this point it is important that I distinguish what I believe to be methodology and what are research methods before progressing to explore the underpinning location of this work within a qualitative paradigm.

Clough and Nutbrown (2002) propose that methodology is not contained within just one chapter of a thesis but irradiates throughout. Also, that the methodology describes and explores the methodological concepts that underpin the research activity and decisions of the researcher. Furthermore, they identify a critical relationship between key aspects of the 'methodology': research design as planning, building research questions and an approach to fieldwork and developing strategies for data analysis. Here I intend to explore the choice of a qualitative research design, before later describing the methods of data collection and analysis.

Any set of research questions in the social sciences could be explored using a quantitative or qualitative approach. However, the approach taken must not only be able to answer the questions posed, but also clearly link to the researcher's interests and ontological perspectives. Holdaway (2000) writes:

...methods of research and theory are related. First, all methods of research imply a particular view of the human being. They imply a particular philosophical anthropology.... (Holdaway 2000, P157)

What Holdaway describes here is a pivotal consideration when developing research questions and methods. What he recognises is the ontological perspective of the researcher and how this interacts and shapes not only the research process, but how research participants are viewed, and how their stories are considered and analysed. Within this complex interaction the relationship of the researcher's personal lens and their epistemological viewpoint becomes a focus for the researcher and their view of 'the human being' (P157).

To understand the experience of gay male student nurses a rich and contextual range of data collection methods, underpinned by a qualitative philosophical viewpoint, is essential. Without this approach my research would lack depth and meaning. For example, conducting a survey of gay students in large numbers may be interesting and offer some insights into their experience, but ultimately little understanding of the social processes that contribute to and shape that experience will be visible. The meaning of being a gay student and a nurse may well be lost. My aim was not to produce a large-scale study, which enables findings to be generalised in the terms described by Huberman and Miles (2002). What I have achieved is an in-depth examination of the experience that is rich and explores the 'humanness' of being gay and a nursing student. Holdaway (2000) summarises this:

Methods of research used by social scientists must be designed to document adequately the richness and diversity of meanings people attribute to phenomena. They must allow us to document the ways in which meanings are constructed, negotiated within particular social contexts and become regarded as taken for granted. (Holdaway 2000, P166)

Having completed the process of interviews and data analysis and having written the forthcoming data chapters I paused and reflected on my initial aim of gathering ‘in-depth’ data that explored the life experiences of these gay students. As I discuss later, the interviews I conducted were difficult to recruit to and at times difficult to really get some participants to engage in a deep way. My sample, though small, offers significant insights into the lives of gay nursing students and to some of the issues that gay nurses must negotiate more generally.

During the course of this research I have been asked why I have chosen gay nursing students? Some people have suggested interviewing male heterosexual nurses to draw comparisons with gay nurses or to interview lesbians as well as gay men. The introductory chapter to this thesis has dealt with my choice of researching gay nurses from both a personal and a professional perspective. However, what I do need to justify at this point is my choice of student nurses as opposed to registered nurses.

I focussed my research of gay male nurses on students as they are at the beginning of their careers and as such they have not been as exposed to the traditional practices and attitudes that have become embedded within the nursing profession. Previous research, such as seminal study of medical students, *The Boys in White* (Becker et al. 1961) have examined the social processes of becoming a healthcare professional. Although Becker et al.’s study has limitations within contemporary life (for example the study did not include any women) it does offer an understanding of how, in this case, medical students became medical doctors and some of the social processes

involved in their socialization within medicine. In the context of nursing, Melia's (1987) seminal study of nursing students' occupational socialization showed how nursing students experienced two versions of nursing: one in the classroom and one in clinical practice. What these studies show, which is of importance to my study, is that the experience of becoming a doctor or a nurse is about *how* the student is socialised. Of course, as nursing students progress through their three years of nursing education, they will themselves be exposed to the embedded practices that influence nursing and care environments. However, I see student nurses in terms of being a novice, described by Benner (1982) as someone with no experience of the situation in which they are expected to perform and who are taught general rules to perform tasks. The problem with rules is that they are context free; therefore Benner suggests that these rules are applied in an inflexible and limited way. As I outline in Chapter 1 I am interested in the performance and negotiation of gay sexuality within the context of the student's clinical practice and their university lives. I have previously discussed Goffman's (1959) notions of performance and in Chapters 6, 7 and 8 I draw upon Goffman and notions of performance to analyse my participants' experience.

While I am drawing upon Benner's (1982) notions of the novice to frame the way that student nurses may negotiate their role as students using rule led approaches, this does not address the socialisation of student nurses into their professional roles and as I discussed in Chapter 1, the 'social' space of the clinical placement. While the physical environment orders hospital spaces alongside the traditional constructions of medicine (medical, surgical, maternity etc.), hospitals are also constructed upon social relations. The status of the student nurse is not unproblematic as they are novices within the space of the clinical placement and this makes them vulnerable. They are neither a nursing auxiliary (a permanent, unqualified member of the clinical team) nor a registered nurse and as such the student occupies a space that is in a threshold between these established clinical roles. Indeed, Melia's (1984) seminal

research exploring the occupational socialisation of student nurses establishes the difficulties this threshold creates:

The students were very much made aware of the fact that if their time on a particular ward was to be trouble free, they would not have to make waves. The ward sisters, the students knew, have at their disposal a potential sanction in the form of the student's ward report. In a different way, the auxiliaries occupy a powerful position in the wards by virtue of their stability as a workforce and their consequent familiarity with the wards. (Melia 1984, P143)

Although Melia's research took place some time ago, I suggest that this vulnerability of the student nurses still exists and that the student is indeed responsible to both unqualified and qualified members of the clinical team. Her research was conducted at a time when student nurses were still paid to be employees of the NHS and were expected to become part of the workforce. From personal experience I can recall the elevated and powerful status of the nursing auxiliary in my first job as a registered nurse. I spent my first week as a newly qualified staff nurse on the intensive care unit working with the nursing auxiliary who was seen as the 'expert' (in the sense of Benner) at cleaning and remaking the complex intensive care bed spaces which had to be furnished with all kinds of life preserving medical equipment. Nowadays, student nurses are supernumerary, meaning that they are not included as part of the workforce, but are seen as having the role of learner. Even with this change in the status of the student nurse, they are not guaranteed to work with their registered nurse mentor all of the time. A more recent study (Allen and Smith 2009) found that the shift to student nurses being supernumerary has created a new set of problems connected to the division of labour. Allen and Smith suggest that student nurses observe unqualified staff performing bedside care whilst registered nurses are concerned with more technical tasks, leading the student to reject bedside care. However, this leaves the student nurse in a problematic position because they have to

demonstrate their ability to both perform and supervise bedside care in order for their mentor to declare them as competent.

The socialisation of the student nurse into the profession of nursing is further complicated by the way in which nurse education and nursing work are compartmentalised. Later in the thesis I explore university life and clinical placements in separate chapters and this is not just because these are different physical or even social spaces; they are spaces where the students have to 'fit in' in order to pass academic and clinical assessments. Melia (1984) describes how nursing is 'segmented', on one side education and the other service. These segments are described as compartmentalised versions of nursing, both of which have competing agendas. Education is concerned with 'professional' nursing, one that is credible, convincing, evidence-based. While nurses working at the coalface are concerned with getting nursing work done. She found that 'fitting in' was a large concern for students and that they would engage in activities, which actively promoted the potential to fit in. For example one student describes how they would not seek to impose the perfect and professional version of nursing espoused in education in the environment of the ward, where the main concern was getting the job done. In this context an ordering of students into the space of the clinical placement occurs, where the student negotiates their status and position and accepts their vulnerability. Furthermore, the transient nature of the student nurse, moving between differing clinical placements throughout the course, compounds the student's vulnerability and they need to become adept at negotiating fitting in quickly in order to work effectively in the clinical environment. Melia (1984) suggests that the student nurse has to negotiate the realms of education and service and present a mode of behaviour, which satisfies the expectations of these competing parts of nursing. More recently, Curtis et al. (2012) showed how student nurses found that in relation to compassionate practice there was a dissonance between the teaching of the university and the reality of practice which left the students feeling vulnerable as they cannot balance the differing expectations (university versus practice) of their occupational socialisation.

So, the socialisation of student nurses is an important part of their nurse education and what I am interested in is how students employ different modes of behaviour to negotiate both education and clinical practice. What I present in the forthcoming data chapters is an account of how the men I interviewed negotiate their gender, sexuality, conduct and nursing work as gay male student nurses, in the context of education and clinical placements.

3.3.2 Methods of Data Collection

Miles and Huberman (2002) identify that in order to explore how social interaction, meanings and negotiations are achieved, it is pivotal to choose data collection methods that will facilitate the research process. Within this journey a number of data collection methods have been tried, the enduring one being the in-depth qualitative interview, which I will explore in some depth. My original intention was to design a longitudinal study, repeating qualitative interviews one year apart. Alongside this I was going to augment the quality of the data by asking participants to contribute to a group and individual blog.

However, difficulties in recruiting participants and the poor contribution to blogs by the two gay students I had recruited meant that a different approach was needed. The constraints of time for completion of a PhD, coupled with an interruption of studies for health reasons and poor participant recruitment meant that a longitudinal design was no longer sustainable within the time frame. Therefore I decided that single in-depth qualitative interviews were the way to complete this research within the required timeframe and so I commenced a second wave of recruitment, which I detail in the next section.

At the time I decided that undertaking single, in-depth qualitative interviews would be the method of collecting research data, I needed to complete my data collection quickly, in order to complete this research within the time constraints of a part-time PhD. The pressure to complete my data collection and commence writing up this

thesis somewhat limited my ability to consider other forms of data collection and therefore I did not consider collecting data in the university setting using ethnographic or other approaches. On reflection, observing the day to day teaching of nursing and seeing how lecturers and students engage or did not engage with issues of diversity in healthcare could have revealed a wealth of data. Additionally, I could have sought out nursing lecturers to interview about their understanding and teaching of diversity and LGBT issues and I acknowledge this as a limitation in the data that I have collected regarding university life. Furthermore, observation of university lectures and students from other professions and the university more generally would have enabled me to consider how variations in culture and professional practice may inform the different constructions and performances of identity in the space of the university. However, in the circumstances I was faced with, consideration of these additional data collection methods did not occur until after I had completed my interviews and the writing-up of this thesis had progressed. I realised at this point that the participants I interviewed had talked much more about their clinical experience than their university experience. By the time I had realised this, it was too late to seek further amendments to my ethical approval and to commence another period of data collection and the in-depth interview remained as my substantive method of data collection.

The qualitative interview has long been a tradition in social sciences research with examples and debates dating back to the Chicago School (Linder 2006). However, it is in the last twenty years that narrative has become an essential tool in social sciences research. Benney and Hughes (1956), cited in (Elliot 2005) stated that 'Sociology has become the science of the interview..' (P137). But the use of narratives cannot be justified by their historical use alone. Narratives can be understood to organise a sequence of events so that they can be analysed and the significance of each event comprehended through viewing the whole. Hinchman and Hinchman (1997) and Elliot (2005) summarise that key features of narrative are: they are chronological; they are meaningful; they are inherently social. Furthermore,

Elliot (2005) identifies five themes that research using narrative have in common: 1. An interest in people's lived experiences and an appreciation of the temporal nature of that experience. 2. A desire to empower research participants and allow them to contribute to determining what are the salient themes in that area of research. 3. An interest in process and change over time. 4. An interest in the self and interpretations of the self and 5. An awareness that the researcher him – or herself is also narrator (Elliot 2005, P6).

From this list of commonalities in narrative research I can identify four facets that link clearly to my own ontological and epistemological understandings. For example, it centres on the research participant and their experience, asks for interpretations from within the narrative and recognition of my own influence upon the research process as both insider (gay nurse) and outsider (lecturer), which is explored later in this chapter. Later in this chapter I examine the status of my data and specifically its significance as a form of story.

3.3.3 Recruitment of Participants

The recruitment of participants for this research has been problematic, as I have previously discussed. Recruitment occurred in two distinct phases and while in-depth interviews are the focus throughout, the strategies for the collection of data and type of data had to be amended. Firstly I will deal with my strategies and actions from April 2007-April 2008 and subsequently October 2008 onwards. When planning a strategy to recruit research participants, I had to balance four main considerations: - a sampling method appropriate to qualitative research; my research questions; reaching potential participants and my personal commitments restricting travel across the whole UK, coupled with no external funding.

A number of methodological issues required attention. The notion of vulnerability in relation to gay men as research participants became apparent at an early stage, not least due to the requirements of gaining ethical permission. And, as detailed in my

previous discussion, student nurses are also vulnerable in the way that they seem to be outsiders within the university and clinical practice who struggle to 'fit in'. While the view of ethics committees was to assume gay men are vulnerable, I had difficulties in defining 'all' gay men as being vulnerable. I do not consider being gay as automatically making one vulnerable in contemporary society and I had problems with this blanket approach. Gay men can be 'out', have supportive families, partners and employers. The recent Equality Act (2011) afforded protection in law and the Civil Partnership Act (2004) recognised same sex partnerships. Indeed rather than being vulnerable, I would expect that participants would be relatively self-assured, independent people who were preparing to enter the nursing profession. They would have the ability to consider the implications of their actions, possessing autonomy and competence. They may have some vulnerability due to their sexuality or they may be vulnerable in a way not connected to their sexuality - all research participants can present with vulnerabilities. What I had not considered at that time was their vulnerability due to being a student and the sense of powerlessness that I found in some of their interviews. The basis of ethical research that I outline later (informed consent and confidentiality) should be able to safeguard the interests of adult, competent, research participants and, where the basic ethical conduct of a study is not able to achieve this it is the role of the researcher to recognise it and act appropriately. However, as I discuss in some detail when exploring the interviews themselves, the gay student nurses I recruited were all vulnerable in different ways and negotiating the interviews was not always an easy process.

Addressing vulnerability became an issue not only in relation to gaining ethical permission. What transpired was the difficulty in reaching gay male nursing students, I simply thought adverts in local universities, would enable recruitment of participants. Although within qualitative research the concept of large numbers of people participating in research is unrealistic, it was clear that I would not obtain a sample that would achieve data saturation, which Sandelowski (1995) identifies as an important aspect of determining sample size in qualitative research. Realising that

posters alone were not going to recruit participants I developed a three-tier approach thinking that using multiple recruitment points and methods may produce a more diverse sample, as experienced by Biernacki and Waldorf (1981).

The first tier of the recruitment process was through placement of posters (as detailed in Appendix 1.) at four local universities as they are easily accessible from my workplace for interviews to be arranged. I contacted Heads of School by letter requesting permission to access their students. The introductory letter explained the aims of the study, the recruitment process and a copy of ethical approval from the academic ethics committee. It quickly became apparent that I had been naïve and that this simple process was not going to suffice - in three of the four institutions I approached, full ethics committee approval from that institution was required in addition to the approval I had already obtained from the School of Social Sciences. This process of applying for ethical approval in the three schools was time consuming with each institution requiring their own forms be completed and each with different queries to address. It was also my intention to visit these universities during September and March when new students commenced and to talk to new students about my research using a short presentation. In reality, the bureaucratic issues I encountered gaining access to individual institutions and the time it took rendered this impossible. Therefore in each institution I displayed posters outlining the aims of the research and listing a research web site which contained further information, as well as an email address so that potential research participants could make contact with me. The design of the poster was simple and I used an image of Rainbow Flag¹³ to clearly identify the poster as of interest to LGBT students. A total of four participants from four institutions were recruited through this method.

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The world's best-known version of the rainbow flag, sometimes called 'the freedom flag', was popularized as a symbol of lesbian, gay, bisexual and transgender (LGBT) pride and diversity by San Francisco artist Gilbert Baker in 1978. The different colors symbolize diversity in the gay community, and the flag is used predominantly at gay pride events and in gay villages worldwide in various forms including banners, clothing and jewelry.



The second tier of recruitment was a targeted advertising campaign in the nursing press. The strategy of advertising in the healthcare press was implemented successfully by Cant (2005) in his research exploring the experiences of gay men coming out in healthcare settings. His advertising campaign recruited thirty-eight service users and twelve service managers. The advertisements I placed directed participants to my research web site and were placed in the RCN Student Bulletin, the RCN student online discussion forum and the Nursing Times online student community forum. I also contacted the RCN student advisor and Equality and Diversity advisor who emailed my research poster and request for participants to their respective forums. No participants were recruited through this method and the reception I received on web based forums was steeped in misunderstanding and an overtly heterosexist view of my research as demonstrated by this interaction extracted from a forum advert I placed on the Nursing Times Student Discussion:

Me: Hi everyone. Bumping this up as I still need to recruit to my study and have had only a few responses. Good luck to those of you who seem to have just started your courses. Dave

Chestnuts Response: Well Dave that should tell you something. Maybe you need to look for a different topic. I would say on our course gay males accounted for 1% not much to go on.

SJC's Response: Obviously the stereotypical view of the male nurse being gay is a myth!! I think you have your answer now.

Chestnuts Response: I just really don't think there are enough gay male (student) nurses to make this research viable or even worthwhile...sorry I just think there are so few they are seen as individual in their own right. I do not believe you can prove any kind of 'cohort' attitudes etc.I really don't think there is a worthwhile study here...

While SJC and Chestnut are not making homophobic comments and Chestnut is clearly respecting gay men as individuals, my interpretation of these comments identifies two main themes. The first is that gay men are not visible in large numbers in nursing courses. While I recognise that this expectation is a stereotype, both these responses do not take any time to consider why gay students may not be visible, although I concede that the NMC (2011) research I cited earlier does identify only 3% of registrants identify as gay. Over the last twenty years research has shown that being openly gay in health and social care can be problematic (Cant 2005 and Page 1986) and more recently Stonewall's (2007) survey confirmed that some of these difficulties still exist. Not being able to recognise that society (and health-care) may be more difficult to negotiate if you are not heterosexual demonstrates the heterosexist views of these students in that they are unable to recognise the effects of heteronormativity in education or nursing.

The second theme that emerges from this interaction is the notion that research only truly matters and has any purpose if it can make a difference to a large number of people. The students in this conversation suggest that gay nursing students cannot be seen within a 'cohort' and therefore their experience is inconsequential and unmeasurable. Surely the opposite should be true, if we are to offer dignity and equality to marginalised groups, it is the hidden members of these groups we must focus upon. Furthermore, investigating the experience of marginalised/stigmatized groups can in fact illuminate the experience of the majority.

These attitudes towards my research are not surprising – as I explored early in this chapter, I have encountered them from far more experienced nurses and academics. In relation to qualitative research the lack of knowledge and understanding is unsurprising. In my experience undergraduate nursing research education continues to be steeped in a positivist paradigm, which does not reflect much of the contemporary research in nursing.

The third tier of participant recruitment consisted of snowballing techniques, which Lee (1993) states are often employed when researching sensitive topics, or where a group is hidden, illusive, deviant or rare. In this case gay men may be reticent to reveal themselves, as peers on their course may not know about their sexuality. Snowballing traditionally involves the use of gatekeepers who have access to the group. Originally I considered approaching lecturers in each school, asking them to give information about my research to gay students they taught or supervised. However, approaching individual students about my research was specifically prohibited in the responses from two institutional ethics committees and therefore not employed. Therefore, snowballing was employed by asking research participants to pass details of my research to anyone appropriate that they knew. This worked in few instances, for example I was contacted by a radiography student, who then referred me to his ex-boyfriend who was a nursing student, however the potential participant failed to engage in an interview despite making contact via email.

The second phase of recruitment began in October 2008 when I returned to my PhD studies following an interruption of studies for ill health. By this time I had recruited and interviewed four participants and made contact with two others. In order to recruit further participants a new strategy had to be implemented. First I approached the SOCSI Ethics Committee for permission to recompense participants fifteen pounds of expenses for their time. Mendick et al. (2008) successfully used small payments to recruit students in their investigation of students' attitudes towards mathematics. Permission was granted and I consequently placed advertisements in both the gay press (Gay Times) and nursing press (Nursing Standard and Nursing Times) asking for participants interested in an initial telephone interview to contact me by email or telephone. From a short telephone interview I would be able to assess if a face-to-face interview could be arranged. As it was now likely those participants would present from the whole of the UK a small amount of funding was obtained from the SONMS staff development fund to enable travel. By mid 2009 I had recruited eight participants in total (whom I introduce in Chapter 4) and although I

continued to advertise in local universities for some time after this no further potential candidates came forward.

The participants I recruited came from a number of different universities (I have changed the names and made the locations vague to ensure the confidentiality of the students I interviewed):

Three participants were studying at Hogwarts University, which is the university I work in as a lecturer and which presented some issues in relation to power and positionality, which I discuss later. Hogwarts University is a research university located in a large Welsh city. The university is consistently recognised as providing high quality research-based university education in Wales. Hogwarts University is ranked number 136 of the world's top universities (and 35 in the UK).

Two participants were studying at The University of Gryffindor. The University of Gryffindor is a university based in a Welsh town. The university is a former polytechnic and the most recent rankings show that the University of Gryffindor is rated the top "new" university in Wales, and one of the top five Welsh universities, by the Sunday Times. In November 2012, the University of Gryffindor was awarded the Times Higher Education award for "Outstanding Support for Students".

One student was studying at Slytherin University. A former polytechnic, Slytherin University is a university based in a large city in Scotland and has 17,000 students. In the *Guardian Good University Guide 2011* the university was ranked 66th in the UK.

One student was studying at Ravenclaw University. A former polytechnic, Ravenclaw University is one of the largest universities in this part of England, with a total student population of around 31,500. This university had three major campuses

based in towns around the area. In the *Guardian Good University Guide 2011* the university was ranked 107th in the UK.

One student was studying at The University of Hufflepuff. A former polytechnic, the University of Hufflepuff is the largest university in this part of England with over 30,000 students studying there. In the 2008 research assessment exercise 37% of research in this university was ranked as world leading or internationally excellent. In the *Guardian Good University Guide 2011* the university was ranked 62nd in the UK.

3.3.4 Conducting the Interviews

Recruiting from a hidden population of gay students not only required a multi-level approach to recruitment, but also a sensitive and reassuring approach to negotiating contact and arrangements for interviews. Rossman and Rallis (2003) refer to this as the process of introduction and invitation followed by, recruitment and initial contact in the research field. This is normally preceded by negotiation of expectations and relationships. Idealistically I thought this would be a simple process of providing the information leaflet (Appendix 2.) about the study via email (the method of first contact) and negotiating a safe place to meet for the interview. The reality of this was that introductions, negotiations and the process of building trusting relationships happened via email over a period of time from first contact. For some participants this process was undertaken in two emails, although with one participant fifteen emails were exchanged over a period of a month before the interview took place. Therefore I had information about some of the participants before the interview took place; for example, relationship status, stage of their educational programme, concerns they may have regarding confidentiality. This additional data was recorded and added to other observations such as field notes.

All of the interviews took place in university classrooms; six took place in one of the two nursing campuses where I work. This included the three students who lived in South Wales and the two students from England (one was from South Wales and was visiting his partner and one was visiting South Wales as an RCN student representative at a meeting). The student from Scotland was also interviewed in South Wales as he was attending a student RCN event). The two students from another local university were interviewed at their home university on their request. I had already made good contacts with the administrative staff at this university who had placed my posters on noticeboards for me and therefore I approached them to book a classroom for the interviews. Although negotiating interviews took some time, being able to conduct interviews in a geographical location that suited the student in terms of travel, but also feeling 'safe' was important. Therefore some of the students were content to meet me at their home university and some wanted to travel to my place of work to ensure their anonymity. The shortest interview was one hour-long and the longest two hours. The majority of the interviews were approximately 1.5 hours long.

At the beginning of each interview I introduced myself and I talked about the focus of my research. I asked each participant to sign a consent form (although I did not know if they were even using their real names). I also discussed the audio recording of the interview and how I would ensure confidentiality of their identities and I gave them written information about the study. On the reverse of the written information were the details of local and national LGBT support and counselling services which I would draw the participant's attention to at the end of the interview during the debriefing. The interviews were recorded using a digital voice recorder and the subsequent files were stored on a password-protected section of my university network drive.

The interviews were structured around my three questions, which relate to the research questions I presented in Chapter 1: life before university; choice of nursing as a career; and experience in the university/clinical practice environments.

Throughout the interviews the notion of performance (I talk about Goffman in Chapter 1) and the negotiation of sexuality as a nurse were upmost in my thinking. Maxwell (2005) contends that interview questions do not have to be deduced from the research questions and he asserts that such notions stem from a positivist standpoint. While the interviews were semi-structured, I did not have a list of definitive questions to be answered and as Maxwell (2005) suggested, I guided interviewees through the interview process using loosely configured, open-ended questions, such as 'Could you tell me a little about your clinical placements'. The beginning of the interview explained the nature and background to my research so that participants had a clear idea of the areas I was interested in.

There are a number of issues to consider when undertaking interviews for qualitative research that may impact upon the quality, depth and trustworthiness of the data obtained. These include the potential impact of the environment upon the data, comfort (psychological and physical), rapport and guiding, not controlling the interview (Smith 1995). With these considerations in mind a large amount of negotiation took place regarding the venue and environment where interviews took place, ensuring safety and comfort for the participant and myself. Concerns, which were identified from the research participants, included being seen as a research participant, being a student at the same university that I worked in and being overheard during the interview.

The conduct of the interview can also affect the quality of the data and a good rapport between the interviewer and participant is essential and often depends upon the skills of the interviewer. Walliman (2005) encourages the use of non-verbal gestures within the interview such as smiles and nods to encourage participants when talking and show a humanistic and sensitive approach to the interview. It was

important to put the interviewee at ease by building a good rapport quickly; this was achieved through general chat at the beginning of the interview, but also through preceding emails discussing their participation. Wicks and Whiteford (2003) suggest that if researchers show a genuine interest in the story being told, then the storyteller is more likely to be open and honest.

At the conclusion of the interview I de-briefed the participant by asking if they had any questions and I drew their attention to the written sources of advice and help for LGBT people that I had given them. The purpose of this was for the participant to access professional services following the interview if they wanted to discuss the issues raised further. For example, they may want to seek support with coming out as gay to other students, clinical colleagues or to their family.

3.3.5 Other Perspectives

I have emphasised that the main source of data underpinning this research are the qualitative interviews I have undertaken, however in Chapter 4 I intend to draw upon my personal experience as a form of data. Specifically, I will examine and analyse my experience of accompanying my mother-in-law to acute hospital settings when she was suffering from intractable vomiting, which we eventually found, after three hospital admissions, was due to a hiatus hernia. During this time I experienced healthcare and more specifically acute medical wards from the perspectives of being a visitor, a gay man and a nurse. I was able to observe the conduct of the nurses caring for my mother-in-law and more generally around the ward and I was able to observe reactions to what could be viewed as our unconventional family. By unconventional, I mean that Craig my partner, his mother and I reside in the same household. Furthermore, at the same time I read an article co-authored by Professor Trudy Rudge, who I had previously met at the Cardiff School of Social Sciences which was entitled: 'Black nurse in white space? Rethinking the in/visibility of race within the Australian nursing workplace' (Mapedzahama et al. 2012). These two experiences became pivotal moments in my critical approach to this research and

how I view hospitals, wards, nurses and the conduct and practice of nursing. Indeed, one of my chapters now uses the notion of space in the title and space has become central to analyses of my participants' experience. I present an interrogation of these notions in the subsequent chapter.

3.4 Data Analysis and Status

The first version of this chapter contained a lengthy and detailed account of how I was going to approach and analyse the data I obtained from the interviews. Much of that has now been deleted and I will only offer a short procedural overview of how I loosely adhered to the conventions of 'content analysis'. Following this I will explore my difficulties in finding an appropriate analytical lens through which to view my participants' data and my subsequent decisions in this matter.

Content analysis is: 'The systematic reading of texts, images and symbolic matter, not necessary from an authors or users perspective...(Krippendorff 2004, P4).

Content analysis has a long tradition in both quantitative and qualitative research and the systematic process of reading, coding and interpreting can be applied within both paradigms. Krippendorff (2004) recognises that it is essential to focus attention upon epistemological 'elaborations' during the process of analysis, adding that the contribution of theorists and analysts to the field should not be explored.

Initially I undertook what Hsieh and Shannon (2005) identify as conventional content analysis, where coding categories are derived directly and inductively from the raw data. So following each interview I fully transcribed the conversation, but as I was not using an analysis based on linguistics I did not make notes of inflections, pauses and the like. As the interviews were conducted over an extended period of time, I started reading, re-reading and coding after the second interview was complete, as by this time I realised the recruitment of participants was not going to be a rapid process. The process of coding, however piecemeal did enable me to identify broad themes that accumulated in number as I included further interviews.

However, what I lacked for a quite some time was the ability to engage with my data in an analytical manner, I kept on going back and forth between various descriptive ideas without being able to focus on 'the social' processes involved and without being able to clearly link any of the participants' diverse experiences. The pivotal moments I described above added some clarity to my thinking, but it took me some time to work out exactly what these experiences meant and how they influenced my view of the data. Alongside this I re-read my supervisor's work (Professor Latimer) based on Goffman (1959) and his notions of performance (Latimer 2000). With a new found lens, which incorporated notions of performance, negotiation, conduct and how society privileges certain kinds of sex over others, I re-read my data, but this time without trying to systematically code and follow the 'rules' of content analysis. This time I read my data thinking of hospitals as social spaces rather than bricks and mortar and nurses as actors in a complex web of interlocked relationships, governed by the conduct of nursing.

I see the interviews in this research as accounts and stories that the gay male students I interviewed have chosen to share with me. Parker and Wiltshire (2003) suggest that a story is something told to the researcher and that by accepting that the interview is a story the researcher needs to accept that this has consequences:

A story is necessarily contingent: it is produced in the matrix between two persons, on a particular occasion. A person's 'story' (their account, their testimony) may well vary when they tell it to another person, or on another occasion. (Parker and Wiltshire 2003, P100)

On the matter of the 'truth' of the accounts that I explore in the forthcoming chapters, I have to accept that the gay students telling their stories may amend or embellish these. They may decide to add or subtract certain elements of the story they told me for a number of reasons. First, it is only natural to tell a story from a personal perspective and to do so in favour of one's own account. Second, the

participants are recounting a story that takes place in the context of professional standards and so any behaviour on the part of the storyteller, which does not adhere to ideas of professional conduct, may be edited. However, this is certainly not the case for one student who talked quite openly about his sexual relationship with the medical registrar on his ward placement. Third, as I talk about in detail in the next section, the students are recounting their story to a nurse, who is also a lecturer, in a position of power, which again may cause the storyteller to tell a more 'favourable' story. During the course of all the interviews I conducted (as detailed above) the discussions occurred in a relaxed manner, were believable and the students were able to explain their stories in further detail when pressed.

3.5 Personal Orientation and Status

The notion of positionality, which Rhoads (1997) describes as the social position of the knower in terms of class, race, gender and sexual orientation, among others, is a complex phenomenon. He goes on to say that positionality is epistemological in nature and related to how knowledge is produced and how the knower comes to an understanding of the knowledge. Therefore, it is no longer an issue of belonging or not belonging to the group being researched, but also how the social status, knowledge and experience of the researcher influences interaction in the research process. Positionality as discussed by Merriam et al. (2001) has been influenced by critical and feminist theory and has been re-constructed, aiding us to understand issues of positionality, power, knowledge construction and representation in qualitative research. For example my understanding of power and inequities within social life, representation of the 'truth' and recognition of positionality in relation to class, culture, race and sexuality have been influenced by critical and feminist theory.

The insider/outsider status of the researcher is not as simple as gaining easy access to research participants, through sharing cultural or professional boundaries. As an openly gay man, it is probable that potential participants will view me as non-

threatening, an insider, which will aid in recruiting a sample, as in Cant's (2005) and Platzer and James' (1997) experience as openly gay researchers. While the use of the rainbow flag on my posters signified that this was gay research, it did not inform participants that I am a gay man. Being an insider may also encourage participants during the interview process to be more open about their experiences and during the opening of the interviews I disclosed my sexuality. However, this shared cultural understanding cannot be assumed, as these issues may not be this clear. Merriam et al. (2001) describes the experience of Johnson-Bailey researching black women and how as a black woman she assumed she shared an identity with her participants. She found that while she was viewed by the research participants as sharing some parts of their identity, in relation to growing up in a poor background the participants assumed the researcher would not share their experiences.

Within this complex process power relationships are also fundamental. I could be viewed as being in a position of power, I am an experienced nurse and teacher, I have 'become' a nurse, while the students I want to interview are still striving towards 'becoming' a nurse. I may be seen as an outsider within my research in two contexts, one as a qualified nurse and secondly as a university lecturer. Both of these roles could be seen as threatening by research participants, for example they may assume I will react negatively or as a patriarch to any examples of poor nursing practice they relate to me or they may assume that certain experiences they have are too shocking to share with me or that I may view them negatively due to their actions. There is little that can be done to ameliorate this situation, except to discuss any fears the participants may have, reinforce my non-judgemental perspective and reassure them on issues of confidentiality. One participant (Jake) clearly stated (in a positive way) that the interview was not what he thought: 'you're not what I expected...you know for a lecturer, I didn't expect to be telling you all this stuff...'. Within this complex process power relationships are also fundamental. I could be viewed as being in a position of power, I am an experienced nurse and teacher, I have 'become' a nurse, while the students I want to interview are still striving towards 'becoming'.

For one of the participants, Mark, the issues of positionality were immense, due in part to his own position of not being out as a nursing student, this necessitating from his point of view the strongest assurances of confidentiality. This was further compounded as I worked in the institution Mark studied at. These issues became evident when we met on campus to undertake the research interview. We met in public as pre-arranged and I had booked a room for the interview five minutes walk across the campus. Mark said that he would follow me and proceeded to walk behind me. When we arrived at the room I invited Mark to sit down, he noticed he could be seen through a window and asked to rearrange the seating, which we did. This experience demonstrated to me the potential sensitivities participants may experience and that I need to be cognisant of. For example, if I saw Mark or the other two participants from my own institution with their friends I would always wait for them to acknowledge me first, for fear of outing them or their participation in my research to their friends.

Wider issues of positionality for my study and myself relate to issues of reflexivity. While many see reflexivity in social sciences research as an under-developed area of research practice and at times a theoretical and philosophical ‘problem’ (Mauthner and Doucet 2003), reflexivity is a part of research practice that will help me to understand my interactions within the social spaces occupied by the research participants. Indeed, in the subsequent chapter I recognise my experiences and reflexivity as data. Hammersley and Atkinson (1983) state: “There is no way in which we can escape the social world in order to study it. Put simply, a relationship always exists between the researcher and those being researched”. For example within my interviews participants through interacting with me reflexively change the telling of their stories.

We can see how reflexivity is required when reading Justin’s account of making a bed with another nurse and how he sees this as an opportunity for socialising,

although at this point he does not recognise whether his interaction is appropriate or not:

I wasn't out to patients, but you know in a six bed bay erm.. and you're you're doing a bed that the patient has just gone and your wiping it down clean and erm they have this policy that if you are making a bed, I don't know if it's a written policy or more of a cultural thing that its best to bring someone with you and do it with you

Oh right, it's better for your back

(laughs) and erm and er this staff nurse, she's a staff nurse that really loves gay men I think (laughs) and we're talking about this male celebrity and that male celebrity (laughs) and er you could just see her face (a patient's) just cringing and subsequently when I go over to help she like gives me a funny look and oops

So she never really said anything to you?

No not really no, she did say something to sister but even sister didn't get back to me...it was one of the senior staff who said....try no to.....try not to erm....expose your personal preferences to patients...(Justin)

This is a complex interaction between student nurse and the staff nurse. Justin being a junior student (first ward) fails to recognise the context of the situation, in relation to acting out for someone who he perceives as 'loving gay men'. While he is quite naturally attempting to be friendly with his colleague, he fails to see the effect this may have on his professional relationship with the patients in the bay. He also appears to exclude the patients from the conversation. It is almost as though they do not exist for him, which enables this interaction to occur. What Justin has not yet come to recognise is his position as a student nurse and carer. He needs to understand his role in communicating with patients while undertaking other tasks and that he can 'be himself' in these interactions. For example the patients may have liked to talk about film stars or the latest scandal in Bella! Or generally have a gossip to pass the time. By engaging with his patients as well as his colleagues, Justin may have been able to avert this individual patients negative attitude towards him.

At the time of the interview and on reading this data subsequently I am faced with a myriad of thoughts and feelings. Justin's account reminds me of being young and maybe camping it up a little and engenders some fondness for my own time as a student, but conversely as an experienced nurse I understand that his behaviour could be interpreted as unprofessional and may affect the future care he gives to this particular patient, especially as she now feels uncomfortable. It also makes me consider the question of learning professional and personal boundaries, which Justin may not yet negotiated or understood. How do we learn these and is this process different if you are gay? It is clear that my social location, memories and experiences all play a specific part in understanding Justin's experience and could at the time of the interview affect my response to his story.

One issue arose that I was not prepared for — my disappointment in the data that I collected. My disappointment was not related to the amount of data collected or the number of participants that I had recruited. My disappointment stemmed from the stories the participants were telling me about being a gay nursing student some 25 years after I had also been a gay student. What I had hoped to find in my participants stories were examples of young queer nursing students attempting to queer the boundaries of the profession. I was expecting that the gay men I interviewed would be pressing the boundaries of the performance of nursing and professional work through the open expression of their gay sexuality. As I explore in later chapters, what I actually found was that the negotiation of sexuality for many of the gay men that I interviewed started from a stance of non-disclosure. Often, even when students had been working in a clinical placement for some time, they were extremely reticent to be open about their sexuality with colleagues, mentors or patients. This may not appear to be problematic as of course coming out as gay is a personal decision; however research suggests that when LGB people are able to be open about their sexuality at work they are much happier (Croteau et al. 2008). In the analysis and re-telling of these stories in Chapters 5, 6 and 7 I have had to be mindful of my own

hopes, expectations and experiences to ensure that the stories I re-tell here continue to be true to the way the students who told them represented themselves.

Reflecting on the data during the analysis phase and during the writing of the data chapters helped me to think carefully about why the students I had interviewed found it difficult to negotiate their sexuality (especially so in clinical practice) and why nursing as a profession continues to find the public performance of sexuality problematic. The forthcoming data chapters explore some of these issues and open up space for further debate. However, the construction and performance of gender and sexuality has a wider professional context than just nursing which led me to consider the evolution of other professions, for example medicine, physiotherapy and teaching.

Medicine has in the past been regarded as holding homophobic values (Wilkerson 1994); however there indications of this declining. One indication of developing liberalised attitudes to sexuality in medicine is The British Medical Association publication - *A celebration of lesbian, gay, bisexual and transgender doctors' contribution to the NHS: A collection of members' experiences* (BMA 2009). This documents the experiences LGBT doctors, which are surprisingly positive, (considering the findings of other organisations such as Stonewall (2007) which recount more negative experiences), with many of the LGBT doctors in this 2009 document sharing positive experiences of coming out at work. The profession of physiotherapy acknowledges the problems of negotiating sexuality. Mahony (2012) explored the experiences of LGBT physiotherapists and reveals a wide range of experiences from acceptance to bullying. In teaching a similar pattern of variable levels of LGBT acceptance is revealed by Gray's (2013) study examining the coming out experiences of teachers. This research showed that coming out in schools continues to be difficult due to the continuing dominance of heteronormative discourses. However, in the case of schools more positive findings are found in

McCormack's (2012) study of three high schools revealed a decline in homophobic actions by school students and an increasing level of acceptance of LGB peers.

It appears that nursing is not alone in being unable to create a space where performances of gay sexuality by professionals are not problematic. However, in the UK, public opinion on gay rights has moved forward and have become much more liberal (Weeks 2008, Clements and Field's 2014). There is a disparity between increasingly liberalised public attitudes towards sexuality and the attitudes within the professions I have discussed above, which makes coming out in those professions problematic to some degree. While negative attitudes towards LGBT people appear to be declining in the professions of medicine, physiotherapy and nursing and there is an emergence of positive experiences from LGBT professionals, coming out remains problematic for some. I suggest that like nursing (as I explored in Chapter 3) the agenda of professionalisation, which comes with obligations to uphold standards and morality, has constrained the development of spaces in these professions where the performance of sexualities is not problematic.

The changing divisions of gender within the professions further complicate the constructions and performances of gender and sexuality. Alongside the emergence of more liberalised views towards sexuality within UK society and to some extent within the professions, there has been a significant change in the gender division of some professions. For example, the number of women in medicine have increased significantly with women representing 47% of general practitioners and 32% of community and hospital consultants (Baker and Cracknell 2014). Furthermore, it is suggested that women will become the majority of doctors in the NHS in England between 2017 and 2022 if current trends continue (Royal College of Physicians 2009). Additionally, women now represent 30% of secondary school head teachers and 36% of senior civil servants (Baker and Cracknell 2014). However, it has to be recognised that these figures do not meet the threshold of 51%, which is the current

proportion of women in the UK at the current time and some professions remain stoically male dominated, for example engineering, where only 6% of women are represented. It has been recognised for some time that women were not well represented in the sciences and other areas of work and organisations such as Athena Swann have been founded to tackle gender inequalities in higher education. However, there is far less of a focus on those subjects and professions where men are not represented, with Swain (2014) suggesting that to redress the situation another 20000 men would need to be recruited into nursing courses, 7000 in education and 10000 in psychology.

It appears that my disappointment in not finding student nurses who were challenging the boundaries of nursing and making inroads in creating a space in which sexuality could be more easily negotiated and performed may not be wholly attributable to or confined within nursing. Exploring other professions and the representation of both women and men in the professions shows that the professions are in a state of flux and re-development, where the more liberal attitudes of society are influencing attitudes to sexuality and where the traditional gender balance is being challenged. With these changes, the gendered power dynamics are likely to alter and the dominance of men in the professions and traditional roles, which are often gendered, may well be challenged. The challenge for both men and women in the professions will be not to both de-traditionalise (changing gender divisions) and re-traditionalise (women taking on essentialised caring roles in their new professions), which Adkins (2000) recognised some time ago. The current state of flux within the professions in relation to gender and sexuality may be a transformative period in which, as Simpson (2011) suggests, individuals can shape their identities as they make sense of 'divergent, emergent and ever-changing roles and practices' (P378) as they re-assess and challenge traditional notions of gender and I suggest sexuality.

3.6 Ethical Considerations

Ethical issues are an important component of all research and are concerned with the idea of ‘doing no harm’ (Walliman 2005). The guidelines produced by the British Educational Research Association (BERA 2004) have been used to underpin the ethical conduct of my study. This includes documentation of informed consent, clearly written information for research participants and making clear the right of participants to withdraw. The guidelines also contain a section related to children and vulnerable adults, however this relates mainly to the capacity to understand information and consent, which do not directly relate to the vulnerabilities I have attributed to my research participants.

Silverman (2005) discusses the potential for ethical issues to arise in qualitative research due to engagement with the public and private lives of individuals, alongside the potential for new ethical issues to arise as a study progresses.

Silverman (2005) suggests it is useful to consider the boundaries of your research and the potential ethical questions that may arise.

Gay men do not conform to the BERA (2004) definition of a vulnerable group per se, but when conducting research with gay men it is essential to recognise that for some the process of coming out and negotiating their sexuality can be a traumatic time. While all of the participants in my research may not be seen as vulnerable and as I discussed earlier in this chapter, I was reticent to ‘classify’ gay men as vulnerable, some of the participants were vulnerable. For example not being out about ones sexuality is a clear vulnerability. James and Platzer (1999) discuss these issues and assert that some lesbians and gay men find themselves in vulnerable situations due to societal attitudes and the potential for oppression. It was not the case, but further inequalities and vulnerabilities, such as disability or race, could have intersected with sexuality to make these issues more complex.

One major concern for myself within the interview process was responding to distress. James and Platzer (1999) offer a very personal account of their experience

of listening to women recount their experience of sexual and physical abuse by healthcare workers. The discussion recognises how this can be harmful to both researcher and participant and that emotion can be viewed as an ethical issue. However, they do warn that without adequate supervision, both academic and therapeutic, the nurse researcher may find themselves propelled into a counselling situation. In reality, the interviews proceeded without incident. In fact the majority of the participants were quite relaxed and made the occasional joke.

All aspects of research deserve the same level of scrutiny and the application of ethical principles may be differential. Hammersley (2006) states:

Even where we agree a certain ethical principles applies, we are still likely to make differential judgements about what it implies in a particular case, this varies according to whom was involved, what would amount to full information/what could reasonably be taken as consent, likelihood of harm that could result... (Hammersley 2006, P4)

I have previously outlined the difficulties I faced in terms of obtaining ethical permission to recruit to my study in multiple universities. I now want to focus on the experience of this. The response I received from the three ethics committees was different in each case. For example, one stated that I should not approach individual students (although this was not suggested in my proposal), one modified the poster I was to use and one sought clarification of issues around storage of personal data. Potentially, in the formal process of acquiring ethical permission, it could be that the decision making process fundamentally will have a heterosexist perspective. When making decisions about research pertaining to lesbians and gay men it is unlikely the committee will really have a clear idea of the issues affecting the potential vulnerability of the research participants and may fundamentally under or over-estimate the potential risk of harm. Approval was eventually gained in all three sites from the local ethics committees. Following approval, posters were first placed in

two research sites, a staggered approach being taken so that if I was inundated with interviews (needless to say this was an unsubstantiated concern) then potential participants would not have to wait too long.

Some time following the distribution of posters I received an email from a Professor in one school I had gained ethical approval in. The email stated that my research posters had been removed from the university notice boards as I did not have permission from the schools ethics committee and that I should discuss my actions with my research supervisor. This email was also copied to the head of post-graduate research in the school I work in, which could have been deeply embarrassing if had not already discussed my research with her.

Needless to say I did have explicit, written permission from the ethics committee concerned and it transpired that the professor had not been at the meeting and had received concerns from two members of staff about my research posters, questioning their validity. While I accept that mistakes can happen, what really concerned me about this experience was the clearly demonstrated over-reaction, which was not congruent with the possibility that I had not received adequate ethical permission. For example what was the worst-case scenario likely to be? That a competent adult gay man would contact me? I suggest that the reactions I encountered within this establishment were latent homophobia, fuelled by the stereotypical assumptions that Christensen (2005) identifies as often misdirected at gay men, for example that we are all promiscuous and therefore anything we do has to be motivated by sex. It could also be interpreted as the professor taking a principle-based approach to protecting the students in her university, described by Hewitt (2007) as being an appropriate way of judging the moral actions of a researcher. For me personally, this experience further demonstrated to me that research about gay sexuality is treated with suspicion and misunderstanding.

3.7 The Participants

In the penultimate section of this chapter I introduce the eight gay male nursing students that I interviewed and examine their reasons for choosing a career as a nurse.

Justin is one of two students at the University of Gryffindor in South Wales and he was undertaking a degree in children's nursing. He is 25 years old and he previously worked as a teaching assistant in a primary school. He describes himself as 'camp' and he actively sought to work in a female dominated profession because he feels more accepted by women, something he talks about in relation to his work in primary schools. His career choice was 'either train to be a teacher or a nurse' and he was not totally sure about why he chose nursing. I met Justin during the first year of his course and after his first clinical placement, which took place in an adult medical ward (at this time the first year of nursing degrees was generic, called the Common Foundation Programme).

Jake also attended the University of Gryffindor and as it happened was in the same year as Justin. He had previously moved away from home to an English university when he was 18 years old to study law. While he was undertaking his law degree he supplemented his student grant by working as a nursing auxiliary and this, coupled with the fact that his parents were nurses, made him decide to come home to Wales and start a degree in nursing. He is now 22 years old. His father is a senior mental health nurse and his mother a community nurse. His brother is also gay and he is open about his sexuality with friends and family. I met Jake in the first year of his degree and after his first clinical placement in an adult ward.

Trey studied at Hogwarts University in South Wales and he was undertaking a degree in mental health nursing. He was 26 years old when I met him and he was in the second year of his course. He had previously has girlfriends while at school but in the 6th form he came out to one of his friends. He had not disclosed his sexuality to his parents or family. He had previously completed a degree in drama and after doing

this he worked as a carer for two young people with autism. His experience of having a brother with autism and his time as a carer influenced Trey's choice to pursue nursing as a career.

Mike also studied at Hogwarts University in South Wales and he was undertaking a degree in adult nursing. He was 39 years old and had previously been married. He had three children and was not currently open about his sexuality with many people. His previous work experience included working in shops until he became a carer in his 30's. He was in the third year of his degree.

Dylan also studied at Hogwarts University in South Wales and he was undertaking a degree in adult nursing. He was 40 years old and came out in his 30's. He had previously had girlfriends and he was not open about his sexuality at university at the point I met him, although he was considering telling a few close friends. He has a male partner, but as he is not out at university he tends not to socialise with people from his course. He was in the second year of his degree and had previously worked as a nursing auxiliary.

Ivan studied at Slytherin University in Scotland and he was undertaking a degree in adult nursing. He was in the third year of his degree and very near to registering as a nurse when I met him. He was 23 years old and had come out before entering higher education. He planned to work in the private sector and was applying for jobs in nursing homes as he enjoyed caring for older people. His mother has been a nurse for some years when he was growing up.

Joshua studied at Ravenclaw University in the East of England and he was in the second year of his degree in adult nursing. He came out as gay at school and was in a relationship from this time until he was 17, when sadly his partner was killed in a road traffic accident. Following compulsory education Joshua started an apprenticeship programme at a major bank and quickly worked his way to become

branch manager. He said he 'fell into' nursing after realising he could not spend his life working at the bank. He was 25 years old, appears confident and is out to his family, friends and university peers.

Jonah studied at Hufflepuff University in the West of England and he was at the end of his degree and he had just gained employment on the ward that he was currently in placement on. He was 28 years old and his mother was a nurse lecturer. His brother was a physiotherapist and his father a builder. He had come out in the second year of his nursing course to his family, friends and some university peers.

When I conducted the interviews I thought that men would have a great deal to say about why they had chosen a non-traditional career in a feminised profession. Interestingly, the responses to this question were not particularly illuminating. But what did become apparent was that five of the men I interviewed had previously worked in caring roles, mostly as nursing auxiliaries. One of the men had worked as a classroom assistant in a primary school, which I would suggest has links with nursing/caring/nurturing. Of the eight men, three of them had family members who were in the health professions, which included three mothers, one father and a brother. All of the participants had previous work experience outside of nursing, which included three of them having undertaken other university courses, working in shops and one in a primary school. Simpson (2004) examined the career choices of forty men in non-traditional occupations that included librarians, primary school teachers, nurses and cabin crew. She found that men in each occupation could be categorised into 'seekers' (men who actively choose a female occupation), 'finders' (men who find the occupation in the general process of making career decisions) and 'settlers' (men whose occupation involved at least one career change). She found that cabin crew tended to be 'seekers', librarians 'finders' and nurses and primary school teachers 'settlers'. My participants also fitted into Simpson's (2004) category of settlers as they had all had previous occupations or careers.

Finally, I need to draw attention to the age ranges of my participants, as none of them were 'traditional' university students. All of them could be classed as mature students as they were over the age of 21 years at the commencement of their courses. The youngest participant was 22, with six of the eight being in their 20's. The oldest participants were 39 and 40 years old. Taking into consideration the demographics of undergraduate students undertaking nursing programmes, this is very similar, with the numbers of 30+ entrants being similar to both the under 20's and 20-24 year old entrants, only those aged 24-29 are not represented equally.

3.8 Conclusion

This chapter has explored the process of undertaking this research and the decisions that I have made during an 8-year journey. Furthermore, I have discussed how my personal experiences and development have influenced recruitment, interviewing and subsequent analysis of data and how I came to see my data through a very specific lens. My aim here has been to present a full account of this study's methodological development and the complex research process. I have explored in some depth the process of recruitment to this study and the challenges that I encountered. I have detailed the study design, data collection, data analysis and status and the ethical issues I have considered.

I have then introduced the participants in my research and explored their career choice to become men in nursing. The following chapter further explores my view of hospitals as straight spaces and how they are constructed and how these spaces are regulated and organised by processes, practices, discourses and routines that nurses actively participate in and reproduce.

Chapter 4: Gay Nurses, Straight Spaces

4.1 Introduction

In this chapter I explore the ways in which two distinct spaces are constructed in relation to gender and sexuality. First the clinical space, which for my participants centred upon acute hospital wards, and second the educational space of the university. Drawing on human geography, I interrogate these spaces and suggest ways in which heteronormative practices are produced and re-produced. This chapter has taken many forms and was originally based on a reflective account I wrote concerning my experience of being the relative of a patient in an acute hospital ward. I then intended this chapter to explore my participants' experiences of life in hospital wards and universities; however, I now do this in a later chapter. What this chapter has become is the underpinning lens through which I analyse my research data. Within this chapter I argue that the expression of sexuality is disclosed or not disclosed depending upon the heteronormative practices within these specific clinical and university spaces and additionally, the professional discourses that seek to regulate nursing practice. As argued by Taulke-Johnson (2009), gay students need to be highly sensitive and skilled social actors in performing their identities as gay students within the university, and additionally I suggest as nurses within clinical spaces.

This chapter is sub-divided into five main sections:

1. An exploration of how hospital spaces are constructed, here I argue that these spaces are not merely vessels in which the ill are contained and cared for by healthcare professionals, but spaces, which are regulated and organised by processes, practices, discourses and routines that nurses actively participate in and re-produce.
2. An interrogation of how hospital spaces are constructed, where I explore how the organisation of hospitals and wards and the practices of nurses are gendered and (de)-sexualised.

3. Using the context of the hospital bed space, I argue that hospital spaces are constructed around the enactment of heteronormative practices that are accepted and re-produced by patients, relatives and healthcare professionals.
4. An exploration of how university spaces are constructed as heteronormative, but may be viewed by students as a permissive space which enables independent exploration of their sexuality away from home and family.
5. In the final section I explore the notion of private lives and professional performances in relation to the disclosure of sexual orientation in the workplace and more specifically in the space of the acute hospital ward.

The two spaces I explore in this chapter are fundamental to the structure of undergraduate nursing programmes within the UK. The Nursing and Midwifery Council (NMC) as the regulator of nurses within the UK, sets the standards that universities offering nursing programmes must adhere to. Currently the notion of apprenticeship learning, that takes place throughout the whole programme, continues to be strong, with 50% of the three year nursing programmes, taking place within clinical placement areas. Whilst undertaking placement activities the student nurse is supervised by a nurse mentor and is assessed on their clinical performance. This assessment not only seeks to measure competence at clinical interventions, but also evaluates professional behaviour and attitudes. The remaining 50% of the programme is based upon learning theoretical concepts within the traditional space of the university, which offers both informal social (such as coffee bars, the students union) and formal learning spaces (such as seminars, lectures and tutorials).

The analysis I present in this chapter is based upon the work of human geography (Valentine 2001) and social architecture, as well as Goffman (1959) and notions of performance. I conceptualise space within the hospital and university environment as linked to identity; that is, people make spaces but the constitution of space also shapes the people who inhabit it. This is achieved by both constraining them, not just in a physical sense, but also in relation to their behaviour and relations with others

and by offering opportunities for the construction of identity within certain performances, such as the professional performance of the nurse (Keith and Pile 1993, Lefebvre 1991). I explore how, on close examination, the organisational structures, enacted in processes and practices (discursive as well as practical), routines and repetitions, and accounts, of the hospital construct a space that is gendered, de-sexualised and straight.

4.2 Hospital Space, Gender and (De)-sexualisation

Space is not merely a 'frame' or 'container' for lived experience, but is rather a 'tool of thought and action' (Lefebvre 1991, P26), through which individuals may or may not 'give expression to themselves' (Lefebvre 1991, P33). In relation to the space of the hospital, the physical structure is carefully planned by architects who plan the movement of patients, relatives and healthcare professionals through the geography of the space. The hospital is divided and sub-divided into wards, specialist services such as intensive care or accident and emergency and corridors through which people are guided to their destination. Along the corridors, people are ordered and divided. Patients are housed in wards, often categorised using the medical model (for example medical and surgical wards) and relatives are welcomed to social spaces such as the cafeteria.

The built environment of the hospital is further inscribed with medical paraphernalia such as bed curtains, oxygen points, emergency alarms, monitors and the walls painted a neutral blue or oatmeal. The specific layout of the hospital and the inscription of the space as 'medical' will have an impact upon the way in which people inhabit and use these spaces. For example, patients will expect to be cared for and nurses will be seen as the care providers. However, the specific ways in which individuals inhabit and use these spaces, 'giving expression to themselves', will not be defined through the materiality of the space.

Within the hospital, professional and social expectations may partly construct the individual identity of patients, relatives and nurses. For example the ill patient, the grieving relative and the caring nurse. Hospitals 'rather than containing particular subjects (may) actually and actively create them' (Pile and Thrift 1995, P4).

Furthermore, the individual's own agency will form part of the public identity that is performed within the hospital. The construction and performance of nursing and nurses' workplace identities are influenced by the history of the profession, as well as contemporary professional demands and the public nature of wards. Thus, organisational spaces, such as the hospital and the university, are also stages on which identity is constructed and performed (Halford and Leonard 2003). I am interested in how gay students work to create their identities within the space of the hospital by learning and interpreting the professional rules and boundaries of being a nurse and through their own agency.

The practices of the hospital, nurses, other healthcare professionals are interwoven at a social, relational and material level. These practices are not totally dependent on the physical space that structurally organises the hospital, but on the relations of those who work within those spaces. Later, I offer examples of how hospital spaces are constructed at a social, relational and material level as heteronormative.

Heteronormativity as a concept is dependent upon the binaries of gender, so firstly I will explore how the hospital is divided into categories of gender.

The hospital is organised around a number of categories that constitute the physical structure of the hospital and attempt to classify patients so that they 'fit' within the physicality of the space. These include: medical categories, the way that medical doctors diagnose, interpret and organise illness (Conrad 2007): administrative categories, which are concerned with throughput of patients, length of stay and case-mix (Heartfield 2002) and within modern hospitals, patient and staff facilities such as coffee shops, banks and bed-side television units, all of which have proliferated

within the hospital environment. Within this discussion I explore the influence of the medical model upon the physicality and organisation of the hospital.

My analysis of these spaces, how they are carved up, not just physically, but through the practices of those that inhabit them is based upon Foucault's (1976) notions of 'dividing practices'. Within medicine these practices are frequent, illness is distinguished from health, sanity from insanity. Through the process of division from others or through division within themselves subjects become objects. Illness divides a person from the healthy population and turns the person into an object for attention – one who is sick (Street 1992). The division of spaces that enact systems of distinction are apparent in the hospital. For example Latimer (2000) shows the divisions between the elderly and the young, general medicine and elderly medicine. Within her study she found that through the division of clinical spaces, some patients were privileged over others (the young over the elderly) and some clinical spaces were privileged over others based on the acuity of the patient's illness (a bay nearest the nurses station being reserved for the most acutely unwell patients). The following section examines the dividing practices of the hospital in relation to gender and sexuality.

The medical model may not appear to be as powerful as it once was (Baeza 2005), but the mark it has made upon the organisation of the hospital environment is a persistent reminder of medical dominance. Historically hospitals have been geographically arranged by medical specialities (including medicine, surgery, maternity) and sub-divided departments dealing with medical investigations or processes (for example the pharmacy or x-ray department). At first glance it would be easy to think that organising the hospital in this way is practical and credible and it may well be. Hospital doctors work across the hospital in a nomadic way to fulfil their role, visiting the emergency department, clinic and their wards, so organising wards around medical specialities may be convenient (Halford and Leonard 2003). However, the medical organisation of the hospital goes deeper than the physical

organisation of the wards and is a representation of how hospitals developed and the roles of patients and nurses have been configured in relation to medicine.

Examining the organisation of the hospital further, it becomes clear that at least two other divisions are present – gender and sexuality. First, within the delineation of the wards and hospital work, anything that is exclusively female, for example gynaecology and maternity wards, are separated out into specialities. As a male nurse I have little idea about the range of gynaecological disorders women present with, as male nursing students did not work on these wards when I was training. I wondered if twenty-five years later this had changed. A brief email to the university placements department confirmed that ‘sending male students to gynaecology placements was avoided, although there is no strict policy’. Midwifery appears to have a different set of practices in relation to men, although male midwives are rare, they do exist. Conversely, there are no men registered as nurse colposcopists¹⁴, while male gynaecologists regularly undertake this procedure. Furthermore, in the past, hospital spaces were divided exclusively by gender. When I trained as a nurse I worked on a male medical ward, an old style Nightingale ward with two rows of beds – the female medical ward was across the corridor and I was never asked to go to this ward to assist with care if they were short staffed or to borrow equipment. In contrast female nurses routinely worked on male medical wards.

While male nurses do not routinely work in areas associated exclusively with women’s health such as gynaecology and colposcopy, male medical doctors historically have and continue to do so. One may assume that this situation between men, but in different professions, may be historical in origin as at one time all medical doctors were male (the first female medical doctor in the UK was registered in 1859). However, male domination of the medical profession is not merely

¹⁴ A colposcopy is a procedure where the lining of the cervix (the neck of the womb) is closely examined. It is carried out by a colposcopist (a specially trained doctor or nurse) who uses a magnifying instrument called a colposcope to check the cells that line the cervix for abnormalities. Registered nurses can undertake the same training as medical practitioners to become registered colposcopists.

historical and is based upon notions of social norms of the early 19th century, where women were not educated and were either housewives, employed in menial jobs, for example as housemaids, or were wealthy enough to be ladies of leisure. This division of gender and gendered work set in place the basis of the professional and social dividing practices that enable male medical doctors to 'cure' the female body. Male medical doctors continue to be privileged by historical social values, which to some degree continue to be prevalent today. These include the medical doctor's privileged position in society, earning them trust and respect (although in recent years this has been eroded by public outrage at the actions of doctors such as Harold Shipman), their educational achievement, which is endorsed by completion of an eight-year programme and their focus upon the curing of disease. Additionally, they are privileged by their masculinity, in what until relatively recently has been a male dominated profession.

Making sense of why this professional gender relation exists is problematic, not least because research suggests that female patients experience increased levels of stress, when male nurses physically and/or intimately touch their genital and breast areas (Chur-Hansen 2002). Similar research in relation to female patients stress when undergoing an intimate examination or procedure with a male doctor (who would normally be chaperoned) does not exist. The fact that this area of medical practice has not been examined is in itself significant. It shows that male doctors undertaking procedures not normally undertaken by male nurses is accepted and taken for granted. But why is this the case?

Clearly there is something different in the way the male nurse is positioned professionally and within society when compared to their medical colleagues, which prohibits intimate female care. One of the major differences in the position of doctors and nurses is class, with doctors being seen as belonging to a higher social class than nurses. Therefore the nurse, of any gender, is already inferior to the doctor. The male nurse could also be seen as professionally inferior to the male doctor, for example he

has undertaken a shorter course than the doctor and until recently this would most probably not have been at degree level. The professional status of the male nurse is inferior to the medical doctor, in that, belonging to a female dominated profession he is labelled as being less masculine and possibly being gay (Simpson 2004). Additionally, nursing, whether undertaken by male or female nurses is concerned with bodywork (Lawler 1991), as opposed to the medical concerns of curative medicine. Added to this, medicine's curative focus could be seen as more objectively distanced, both emotionally and physically than the work of nurses. For example, the colposcopy is an investigation, which is intimate and invasive, but is undertaken to obtain a clear medical diagnosis and is performed in 30 minutes or less. The patient is unlikely to have met the male doctor undertaking this procedure before, or only briefly at a previous consultation. So, the emotional relationship with the male doctor has clear boundaries and is enshrined in social norms of masculinity and medical dominance. Latimer (2000) described the concerns of doctors during consultant ward round as being the medical diagnosis and classification of the patient, whereas nurses were concerned with the social meeting, where the needs of patients as opposed to diagnosis and treatment were discussed. For the doctors this was an enacted division of labour between the doctors and the nurses. For nurses more generally and male nurses specifically, bodywork is an emotional experience for the nurse (Inoue, Chapman and Wynaden 2006) and for female patients (Chur-Hansen 2002). This level of intimacy further complexifies the professional gender relation that is apparent between male nurses and male medical doctors.

Modernisation of hospitals led to the end of Nightingale wards and re-organisation of wards into distinct bays of six to eight patients, sometimes a mixture of genders. Today, the UK government have banned the use of mixed sex clinical areas (for example mixed sex bays) and they have the power to fine NHS organisations that continue to use these (Department of Health 2011). Although mixed sex clinical environments were thought to be 'modern', reflecting contemporary attitudes to gender and sexuality, which have become less fixed and more permissive, over the

past twenty years patient advocate groups have always maintained their opposition to this practice. Furthermore in some areas, such as mental health, concerns for the safety of women patients have been voiced (Mezey, Hassell and Bartlett 2005).

The second division, sexuality, is a secondary influence upon the way that hospital spaces are organised, issues of sexuality and sex are either hidden or de-sexualised within the hospital space. Here I offer two examples of how de-sexualisation of patients and their conditions is achieved within the hospital space. Firstly, a specific example is the medical speciality of gynaecology; this relates not only to reproductive organs, but also sexuality and sex and is hidden away from public gaze in the way that it is a distinctly separate speciality of general surgery and physically separate from general surgical wards.

A second example of how hospital space sequesters sexuality is the Sexually Transmitted Disease (STD) clinic, or 'the clinic', which is often either in the depths of the hospital basement or away from the main hospital site – hidden from public view. Pryce (2004) describes the problem of the clinic and the position of the clinic within the hierarchy of the hospital:

GUM clinics were in the least visible areas of the hospital, were given 'neutral' names to avoid embarrassment, and represented both clients and staff as morally contaminated, socially stigmatised or professionally suspect. (Pryce 2004, P259)

Problems 'down there' of all kinds appear to be unseen in some way, in an attempt to de-sexualise them; by hiding them we can almost deny their existence unless we need to utilise their services. Through denying, hiding and segregating services related in any way to sexuality in an effort to de-sexualise them, the opposite is achieved. Excitation, intrigue, repulsion and shame are all associated with the sexual when sex is not heterosexual. Goffman (1958) describes how we do some things

backstage (for example hygiene, elimination, sexuality) and some front stage. Sex, heterosexual, or otherwise is backstage, to be conducted in private spaces. In similar ways clinical spaces associated with the sexual, for example care of the genitals or the uterus, is backstage, private. Segregated from other departments, the specific practices of those who work in these departments are hidden from view and as I discussed earlier, specifically hidden in some cases from male nurses.

These notions of backstage spaces, where sex and sexuality can be performed without public knowledge are connected to ‘the problem’ of homosexuality. Since the 16th century homosexual acts have been seen as deviant and were illegal in the UK from 1533 (The Buggery Act), although this covered all forms of buggery, homosexual or heterosexual, until 1967 (Donan and Magowan 2009). However, it does have to be acknowledged that the category of homosexual in the way we understand it today did not emerge until the nineteenth century. Homosexuality is not inherently deviant, but it becomes so as a result of a purposive social process that initiates and reinforces sexual norms based on heterosexuality (Clinard and Meier 2010). Because in the past and to some extent in the present being homosexual or gay is constructed as deviant, closeting occurs - the hiding of ones homosexuality. This leads to ‘secret’, ‘profane’ spaces being created in which sex has heightened excitement.

Some gay men take part in transgressive practices, which blur the boundaries of front and backstage, public and private. Cottaging, where men meet in public toilets and other public spaces for sex, is an example of where the private becomes public. If caught engaging in these practices, prosecution publicly punishes the men involved. Gay men cruising for sex are recreating spaces through their sexuality and it is partly the silence and secrecy around these practices that lead to the sense of trespass as they reverse the normative use of public toilets, car parks or parks for private acts (Donan and Magowan 2009). This notion of trespass is also present in the clinical area – to enter the gynaecology ward or STD clinic could feel like trespassing the

privacy required by those being treated there. In Chapter 7, I explore how for one gay student nurse, the only place in time and space that he felt truly comfortable disclosing his sexuality to a patient was in the STD clinic. He was treating a young gay man, who was cruising late at night and having un-protected sex. For the gay student and the gay patient, there was a shared understanding of this secret, exciting and transgressive behaviour, which the student had not shared before within this professional context.

Foucault (1976) suggested that historically there was a need to: ‘take sex into account’, within society, to discuss it and categorise it in moral and medical terms:

with increasing intensity and authority, bringing into the objective light of science, a multitude of distinctive sexual species. The pervert, child masturbator, homosexual, hysteric, prostitute, primitive and nymphomaniac, all emerged as distinctly classified sexual species.
(Foucault 1976, P25)

The homosexual emerged around the 18th century as a distinctly classified sexual species, whose secret was revealed by what Foucault (1976) called the ‘penetrating gaze of science’ (P25). Furthermore, the rich of the time constructed the ideology of the family, based on the morality of the time and homosexuality was seen as the greatest threat to heterosexual reproduction. The medical classification of homosexuality further constructed and added weight to the notion of homosexual deviance within society.

Similar discourses operate in modern society in relation to ‘sexual’ classifications of disease, for example the potential for stigma and shame in relation to contracting sexually transmitted infections (Cunningham et al. 2002) and the stereotypes that exist in relation to sexual infections and those that attend ‘the clinic’ as ‘dirty’ and ‘promiscuous’ (Scoular, Duncan and Hart 2001). Within this matrix of hospital

organisation, the needs of the patient for privacy in relation to their illness, which is categorised as ‘sexual’ and is certainly intimate, should be taken into account. Social stereotypes and stigma can be dominant discourses in relation to reproductive, women’s and sexual health, necessitating the need for privacy, compassion and confidentiality.

The physical construction of the hospital and the subsequent organisation of hospital spaces, patients and staff into separate specialities, which are gendered and de-sexualised, construct some of the embedded practices of labour within the hospital. An example of this in nursing, and especially interesting to me, as a male nurse, is the issue of chaperoning –; the practice of accompanying a nurse when they are conducting intimate procedures with a patient of the opposite sex, for example a female nurse and male patient or male nurse and female patient.

Historically this issue has affected the practice of male nurses undertaking the care of female patients, while it has been widely recognised that it is acceptable (although not without embarrassment, especially for the nurse at times) for female patients to care for male patients (Waters 2006). The hospital in the past dealt with this through gender segregation and when this was no longer an option, through chaperoning. Evans (2004) suggests that the sexual nature of men’s bodies, size, muscle mass and strength contribute to the gender division of nursing labour and that the sexual body stifles the provision of care by male nurses to female patients. By introducing a chaperone the woman is protected from the seemingly predatory instincts of the man and the situation is de-sexualised. The practice of chaperoning was brought into question in the UK when Andrew Moyhing, a former student nurse won a landmark sex discrimination case in 2008. The judge found the chaperoning policy that had been applied in this case was unlawful and based on ‘lazy stereotyping about the risks to patients and assumptions that all men are sexual predators’ (Carvel 2006).

However, it is seen as acceptable that female nurses care for male patients (Waters 2006) and there is a view that male patients are more accepting of female nurses than female patients are of male nurses. Chur-Hansen (2002) demonstrated that in intimate situations female patients had statistically significant stronger preference for a same-sex nurse, whereas male patients tended to have little preference. Following the Moyhing case the latest recommendations for nurses caring for opposite sex patients is to elicit the wishes of the patient explicitly – a sensible and pragmatic move. However, social practices, the social construction of nursing as feminine and the sexualised nature of men's bodies within the male/female binary will continue to create anxiety in the provision of bodywork by male nurses.

4.3 Straight Space, Bed Spaces and Belonging

The bed space is a place of multiple meanings and interpretations (White 2007). In its material form it is made different from other spaces by the imposition of the hospital bed, now a modern motorised device that patients and nurses can control to ensure the correct height and a comfortable position. Additionally, there is a patient's locker, the angle-poise lamp on the wall next to oxygen and suction equipment and the area is encased with a curtain rail and curtains which can be pulled around the bed to further define the space and offer imagined privacy. In the specialist area of intensive care ventilators, infusion-pumps and monitoring equipment medicalise the space even further, until it is almost possible to forget the patient in the bed. In Latimer's (2000) study of nursing on a medical ward, the bed was representative of 'many resources: a space available to place someone in, the hospital's facilities, expertise, nurses, drinks, machines, cleaning, research, drugs, shelter, food, work' (P44). She shows how the bed space is a complex location of organisational politics, bodywork and identity work.

Beyond the materiality of the space, over time, there are multiple events and meanings that will become symbolic and help to constitute the social identities of those who enter the space. For a patient it may be adoption of the sick role¹⁵, or a comforting and warm post-operative bed, or a place to die. For nurses and medical staff it may be a place to inspect the body and perform invasive procedures or a place to care for the body in intimate ways, the 'dirty work' of nursing (Lawler 1991). It may also be a place to engage in a display of medical drama during resuscitation, doctors and nurses demonstrating their ultimate power to reanimate the body to life. Ultimately the bed space may become a temporary mortuary while the body is prepared for dispatch from the ward and relatives grieve. For all these people the bed space will have a profound symbolic meaning, it will shape their identity and their social interaction with and within the space of the bed. Additionally, the identity of the patient, family and healthcare workers in the space of the bed will also shape the meaning of that space, which I demonstrate in the autobiographical account below.

As a gay male nurse, I also see alternative readings of this space. For me the space is heteronormative. Heteronormativity is pervasive in its action, so subtle that it can best be noticed by its omission (Fernando 2008). Heteronormativity is the term used to describe the powerful heterosexual structure and normative principle that is learned early in life. The term refers to the assumption that heterosexuality is a general norm, that is, heterosexuality is the only sexuality of individuals and society (Röndahl 2011). As a consequence of heteronormativity, everyone is assumed to be heterosexual unless it is suspected or declared otherwise. This means that lesbians and gay men may choose to hide or remain invisible due to a fear of negative attitudes and repercussions (Yep 2005). Heteronormativity is everywhere, already present in individuals, social institutions, cultural practices and knowledge systems (Yep 2005). Heteronormativity in healthcare is enacted in the ways LGBT people assume to be straight and therefore not offered healthcare advice which is

¹⁵ The model of the sick role, which Talcott Parsons designed in the 1950s, was the first theoretical concept that explicitly concerned medical sociology. In contrast to the biomedical model, which pictures illness as a mechanical malfunction or a microbiological invasion, Parsons described the sick role as a temporary, medically sanctioned form of deviant behaviour. Source: <http://www.ucel.ac.uk/shield/parsons/Default.html>

appropriate (Hunt and Fish 2008). Specifically in the space of the bed, heteronormativity is enacted by the material fabric of nursing, such as documentation asking for details of relationships which have invariably not been updated to include civil partnerships (although as I review this chapter gay marriage in the UK has become legal and therefore the once out-dated question in nursing documentation has become relevant to LGBT people). Additionally, the space of the bed is heteronormative due to the way people act and the heteronormative assumptions they make, which I illuminate later in the chapter.

Binnie (1997) suggests, 'space is not naturally authentically "straight" but rather actively produced and (hetero)sexualized' (P223). Heteronormativity is so naturalised, embedded and taken for granted that many heterosexual people cannot recognise how it is constructed and reproduced. Heterosexuality as a dominant discourse is 'consciously and unconsciously accepted and reproduced in modern society' (Yep 2005: P395). In relation to this research even my closet colleagues have asked 'why would you need to research gay nurses?', a question steeped in heteronormative meanings.

In Chapter 1 I briefly discussed how my own experience of having a close relative in hospital has helped in shaping the lens through which I view the space of the hospital and in the following autobiographical account I illuminate how the simple practices of the hospital construct the space of the bedside as heteronormative in geographical, material and cultural ways. The use of autobiographical narratives within the social sciences is an accepted methodology, for example autoethnography (Ellis and Burger 2002). However, within nursing research the use of autobiographical narratives has been somewhat limited (Foster et al. 2006), although there are some examples to support its use: White (2003) is one example of a nurse to publish her autoethnography as a research method, where she recounts her experiences of non-malignant back pain and explains her journey towards choosing autoethnography as the foundation on which to explore the experiences of others who experienced

chronic back pain. Additionally, Muncey (2005) shared her experiences of teenage pregnancy within an auto-ethnography of her life where she argues that representation of individual self-identity is an authentic form of research. While I acknowledge that there are limitations in the use of autobiographical narrative and that autoethnography has been subject to various criticisms, including claims of narcissism, self-absorption, exaggeration, and self-indulgence (Foster et al. 2006), I think that the following short extract from my research diary is legitimate to enable the reader an understanding of my experience.

We arrive at the Emergency Department and go to the reception desk to be booked in; we have a letter from the GP, which we hand over, and we are sent to a waiting room – a sigh of relief from all of us – it is empty. No need to make small talk or struggle to find somewhere to sit and by this point Craig’s mother is looking pretty ghastly. The woman in charge of the reception desk said very little and appeared uninterested, so our first real introductions were with the staff nurse who called us over to a bed space for Craig’s mother to be examined.

The process of introductions with the nurse is one that was repeated with almost every member of staff we met – other nurses, the junior doctor, the registrar, and the consultant. While the nurse was polite and professional in her manner towards us, you could see she was trying to work out our family relationships and how to react to us. She asked us who we both were, ‘son and son’s partner’ were part of our introductory dialogue. This moment felt a little tense; you can never gauge people’s reactions and this first interaction with the nurse felt clumsy and awkward for us all. Interactions within the hospital are the same as in social situations in relation to ‘coming out’, but feel intensified by the lack of choice to be there. Carole is enrolled in the hospital by the completion of nursing and medical records, including the question of ‘Are you married?’.

This feeling of hyper-visibility occurs at key focal points of the hospital journey, walking around the corridors, meeting hospital staff, and sitting in a waiting room.

The junior doctor arrives and we are asked to go to the waiting room while Craig's mother is examined. Our earlier experience of this space was easy. It had been empty, we had sat where we wanted and while it had felt like being in a goldfish bowl as people walked by and looked in, it had felt safe. Entering the waiting room a second time, another group of people had arrived and were awaiting assessment—a young woman who was clearly in some pain, a young man who appeared to be her partner and an older woman who transpired to be her mother. They sat along one side of the room and we decided to sit on the opposite side. There were a number of empty seats and plenty of room, so we did not have to worry about who we sat next to; there is something uncomfortable about sitting next to other men in close spaces like this and I felt relieved I did not have to.

Craig's mother was admitted to the gastroenterology ward, a modern space divided into a number of bays, some male and some female. We spent the week visiting every evening, at the set visiting time. Everyone arrived, grabbed a chair and sat in the bed space of their relative, six bed spaces and again a small physical space. It was clear that the women patients had been talking and socialising during the day and each one introduced their relatives to one another. Within the confines of the space and with the jumble of people who just happened to be there with their families, we stood out as the gay couple on the ward. One of the patients, who was dying from cancer and connected to the oxygen supply, took to calling us 'the boys' in the same way the nurse in the emergency department had. Once again, over a short period of time we had moved from the unusual to the usual and from hyper-visible to being accepted.

Within this account of my mother-in-law's hospital admission there are key points where the heteronormative expectations of healthcare professionals and the general public (relatives and visitors) come into play: the meet and greet, where they are

confused and their expectations are disrupted. Heteronormativity is present in material forms too, the forms filling of marital status and social history, with the un-said question of who are these two men? Your sons? Additionally, the geography of the hospital and the organisation of the ward were underpinned by the cultural expectations of 'family' visiting time and physical closeness of the waiting room, leading to inevitable and sometimes uncomfortable introductions.

As a nurse, the bed spaces I dealt with as both an adult and a children's nurse were heteronormative in the embedded practices they reproduced. Bed spaces occupied by adults are immediately formed in heterosexual meaning, we ask the patient who their family are, and it is assumed they have a husband/wife/partner/children, that they are parents or grandparents. When this is not the case, the status quo of heterosexual normality is disrupted.

I have spent some time exploring the hospital space and how it is constructed as de-sexualised and heteronormative. Before moving forward to explore the negotiation of hospital spaces, I explore the space of the university.

4.4 University Space

Having explored the sociology of space in general terms and specifically in relation to the organisation and practices of the hospital, I explore the specific space of the university and key issues for gay students highlighted within the literature.

For many students going to university demonstrates their final step towards adulthood and independence, with many moving away from their parents and friends and forming new social networks. For many young university students this is an exciting time of self-discovery and identity formation and sexual exploration. For many lesbian and gay students the move to university is also a time when exploration of their developing sexuality is able to take place, away from the potential prejudices of family and school acquaintances (Taulke-Johnson 2009). For some time the

literature has centred upon the exploration of homophobia and other negative discourses within the university campus as demonstrated by a range of studies, for example Waldo (1998) and their exploration of campus victimisation in relation to lesbian and gay students, Rhodes (1997) who explored risk taking behaviour in relation to gay university students and Eisenberg and Wechsler (2003) who examined substance-use behaviours in lesbian, gay and bisexual university students.

More recently, discourses of university spaces and gay students have changed and are now more positive in their findings. Weeks (1998) suggest that there are new social forms, which are more permissive than ever before. For example in many places it is now commonplace for previously marginalised people to define themselves in relation to personal and collective identities by their sexual orientation. Thirty years ago, this process of coming out would have been much more difficult. Valentine, Wood and Plummer's (2009) study of 4000 LGBT students and staff demonstrates a shift in the view of society towards being more permissive than ever. This is demonstrated by the experience of lesbian and gay university students, reporting relatively low levels of homophobia. Additionally, Newman (2007) found that between 1985 and 2001 attitudes of university students towards lesbian and gay students became increasingly permissive and most recently Taulke-Johnson (2010) offers an alternative narrative of university gay student life where they were able to explore and engage with their sexual orientation, skilfully negotiate boundaries and restrictions regarding the display and performance of their homosexuality, where coming out led to acceptance rather than harassment and victimisation. However, within his thesis Taulke-Johnson (2009) acknowledges that the stories of his students were at times contradictory, for example one student stating that university was a safe place to be and express his sexuality, while some specific spaces, such as the Students Union bar were seen as masculine and straight and potentially threatening.

The university campus continues to be hetero-sexualised (Waldo 1998) and the same practices that regulate the lives of gay men in contemporary society are active within the university campus. The space of the university is also gendered and students sometimes express stereotypical and sexist/misogynist discourses (Francis, Burke and Read 2013). However, Taulke-Johnson (2009) found that many of his research participants positioned university space as less restrictive in the policing and regulation of non-heterosexual discourses than non-university spaces.

There is no contemporary research exploring the campus experiences of gay nursing students. Indeed lesbian and gay nurses are somewhat invisible within academic and professional nursing discourses, while work around lesbian and gay patients' experience of healthcare has increased over the last twenty years. However there is some embryonic research exploring heteronormativity in healthcare curricular. Røndahl's (2011) study found that the students who participated (3 nursing students and 3 medical students) described Lesbian, Gay, Bisexual, Transgender (LGBT) people as an invisible minority in all circumstances and that it was not easy to discuss and promote the LGBT issues since the student risked coming out involuntarily. The students felt that teachers and administrators were too passive when it came to LGBT issues and the students themselves felt excluded. Additionally, students felt that heteronormativity was the dominant discourse in both the nursing and the medical education programs.

4.5 Professional Performances

Lesbian and gay people and specifically in the case of this research, gay male nursing students, mobilise differing strategies for the performative management and expression of their sexuality. In this section I explore how issues of coming out, sexuality and professional identity are central to the gay nurses working in healthcare settings.

The dilemma of 'coming out', the issue of disclosure or non-disclosure of sexual orientation at work (Croteau et al. 2008), is a major consideration in the management of one's sexuality. Coming-out can be understood as a recurrent process through which individuals, who self-identify as lesbian or gay, 'perform' their invisible sexual identity and adopt a non-heterosexual identity position in the workplace (Van Lear 2011).

Lesbian and gay people manage the expression of their sexuality using a number of strategies and there is a continuum of performative positions between being 'in the closet' and being 'totally out'. Often referred to as 'coming out of the closet', this spatial metaphor could also be used within the clinical area of the ward, for example coming out of the cleaning cupboard. Within the ward area there are what Goffman (1959) refers to as front stage areas, where nurses are actively seen to engage in their nursing duties. Within the front stage nurses are expected to conform to the cultural norms and regulations of 'being a nurse'. The backstage can be viewed as where nurses take breaks, gossip and relax. This space is less formal and here the nurse does not have to conform as rigidly to the social norms and expectations of nursing. This space is most probably the staff room, but could also be the canteen, the treatment room or the bathroom.

The position a person adopts in relation to their degree of disclosure around their sexuality may change depending upon the social and professional sphere of the interaction. Griffin (1992) in her study of lesbian and gay educators describes four different strategies for managing disclosure of sexuality: passing, covering, being implicitly out and being explicitly out.

A passing strategy involves the attempt to resist a gay identity position and to be seen as heterosexual. Individuals adopting this strategy will for example lie about their sexuality or not correct co-workers when they perceive them as heterosexual. When adopting a covering strategy, individuals will also avoid a lesbian or gay

subject position, without actively embracing a heterosexual identity. So, rather than insinuating they are heterosexual, such individuals censor information that would reveal they are gay. An example of this would be talking about 'their partner', rather than about a boy or girlfriend. A third strategy involves being implicitly out, in which individuals talk openly about their life and relationships, without explicitly embracing the label of lesbian or gay. In other words, this strategy does not involve attempts to be seen as gay or not be seen as gay and does not involve clear and explicit attempts to claim such a position. Finally, an individual can be explicitly out and actively position himself or herself as lesbian or gay (Van Laer 2011, Croteau et al. 2008, Griffin 1992).

Within the ward the position nurses take in relation to the level and type of disclosure of their sexuality may vary between the front stage of the ward, where patients are present and the backstage with colleagues and other nurses. What nurses have to negotiate are the contradictory agendas of being a professional nurse and/or being out of the closet. As one participant said: 'What do you say when a patient asks "Are you gay dear?"'.

Elliason et al. (2011) undertook an online survey of 261 lesbian, gay, transgender and nurses questioning their sexuality in the United States (US). They asserted that lesbian, gay, bisexual, transgender, and questioning (those questioning their sexuality) nurses constitute one of the largest subgroups within the profession of nursing, yet there is very little empirical research in the nursing literature and virtually no attention to issues of discrimination and exclusion in the workplace by nursing education or professional nursing organisations. Their survey found that 57% of respondents were out to colleagues, however the majority of respondents reported that their workplaces did little to encourage a gay friendly environment. The significance of this research in the UK is limited due to a different organisation of care environments, which depends in the main upon the NHS. Within the NHS and professional organisations such as the Royal College of Nursing there have been

initiatives to promote lesbian and gay equality, however there have been no formal evaluations of these.

4.6 Conclusion

In this chapter I have explored and laid out my analysis of two difference spaces that gay nursing students will experience as part of their nursing courses: the hospital and specifically the ward and the university. I have interrogated these spaces in relation to gender, sex and sexuality and shown how these spaces are constructed as gendered, (de)-sexualised and heteronormative.

I have argued that space within the hospital and university environment is linked to identity and how constitution of space shapes the people who inhabit it. And how this is achieved by both constraining them in relation to their behaviour and relations with others and by offering opportunities for the construction of identity within certain performances, such as the nurse. I identified that the hospital is organised around a number of categories that constitute the physical structure of the hospital and that patients are classified so that they 'fit' within the physicality of the space. The practices of the hospital, nurses, other healthcare professionals are interwoven at a social, relational and material level. However, I argue that the space of the hospital is de-sexualised and that ailments of a sexual nature are hidden both physically and metaphorically. I also argued that the hospital, transgressive sexual practices, homosexuality and the gendered and de-sexualised nature of nursing care are all linked in the way that they are socially constructed.

I then turned to the very specific space of the hospital bed and explored how I see alternative readings of this space, which are heteronormative. I illuminated this alternative reading of the bedside by drawing upon my own experience and by offering my autobiographical experience of being on the other side of care, the experience of being a hospital visitor. I explored how at each and every turn myself, my partner negotiated our gay sexuality in the space of the hospital.

With regard to university space I have demonstrated that the university campus continues to be hetero-sexualised and that the same practices that regulate the lives of gay men in contemporary society are active within the university campus. Although, some students viewed university space as less restrictive in the policing and regulation of non-heterosexual discourses than non-university spaces. I highlighted that there is no contemporary research exploring the university experiences of lesbian or gay nursing students, although interest in LGBT healthcare issues has increased in the last two decades.

To conclude this chapter I discussed the strategies that lesbian and gay people use to manage the dilemma of coming out. These included four specific strategies: passing; covering; being implicitly out and being explicitly out. I explored one of very few surveys examining the experience of LGBT nurses which found that while 57% of respondents were out to colleagues the majority of respondents reported that their workplaces did little to encourage a gay friendly environment. I suggested that what gay nurses have to negotiate are the contradictory agendas of being a professional nurse and/or being out of the closet. Finally, introduced a question that is repeatedly alluded to in my interview data: ‘What do you say when a patient asks “Are you gay dear?”’ which is particularly pertinent to the next chapter where I explore my participants’ experiences of being a gay nursing student in their clinical placement.

Chapter 5: The Experience of Being a Gay Student Nurse: Clinical Placement

5.1 Introduction

In this chapter I explore the ways in which my research participants negotiated their sexuality and identities as gay nurses within the clinical space of the ward. The clinical placement for these participants centred upon acute hospital wards within the fields of adult, children and mental health nursing. I argue that the expression of sexuality is disclosed or not disclosed depending upon the heteronormative practices within these spaces and additionally, the professional discourses that seek to regulate nursing practice. For these students the development and performance of their nursing identity further complexifies their negotiation of their sexual identity within the context of the workplace, whether this is in clinical placement or the university. The participants needed to be highly sensitive and skilled social actors in performing their identities as gay students within the university (Taulke-Johnson 2009) and clinical nursing spaces.

This chapter is sub-divided into three main sections:

1. I explore the space of the closet in relation to coming out, nursing and the space of the hospital. Within this context I draw upon and contextualise coming out by drawing upon Goffman's notions of performance and theories of coming out.
2. The negotiation of sexuality by participants within clinical practice placements (Private lives and professional performances) where I suggest that the public/private binary and the regulation of nursing practice influence the students' coming out decisions within their clinical placement. Here I draw upon Rubin's (1984) charmed circle to make sense of how gay sexuality is positioned within nursing and the space of the hospital.
3. Participants' identification of 'safe' and welcoming spaces which enable openness of sexuality (gay work and nursing practice) within the space of clinical practice and with patients. I suggest that for the majority of students I

interviewed, a very specific place, space and time is required to disclose their gay sexuality.

5.2 Coming out (of the closet)

A number of my participants utilised similar strategies for the performance, management and expression of their sexuality. For these students, the notion of what was private and what was public, in relation not only to their sexuality, but also their everyday lives, dominated discussions of coming out and the negotiation of their sexuality. Drawing upon Rubin's (1984) "charmed circle", I explore how the students' management and performance of their sexuality was moderated by the perceived acceptability of gay sexuality in very specific situations. These situations could include for example, the clinical ward area, the ward coffee room, and university lectures. Coming out can be understood as a recurrent process through which individuals, who self-identify as lesbian or gay, 'perform' their invisible sexual identity and adopt a non-heterosexual identity position in their family, social and working lives (Van Lear 2011).

Lesbian and gay people manage the expression of their sexuality using a number of strategies and there is a continuum of performative positions between being 'in the closet' and being 'totally out'. The metaphor of the closet has been in use since the early 20th century, but it was Sedgwick who used this spatial metaphor to analyse the oppression of gay people. She writes: 'The closet, is the defining structure of gay oppression this century' (Sedgwick 1990, P71). The closet symbolises the 'hidden' and 'private' nature of gay sexuality and represents the power heteronormativity has to press an individual to publicly deny their gay sexuality. If an individual seeks to come out of the closet they potentially open themselves up to discrimination and ridicule. Furthermore, Brown (2005, P1) suggests the closet is a term that describes 'the denial, concealment, erasure or ignorance of lesbians and gay men'. The closet as a term to deny lesbian and gay sexuality conveys meaning, in that it represents the homo/heterosexual power binary that contributes to the oppression of gay people and

it can describe a person's disclosure or non-disclosure of their sexuality. Being 'in' or 'out' of the closet describes figuratively the person's position in relation to disclosure, although it is accepted that one can be both in and out of the closet at different times and in different spaces. For example a person could be out to their close friends, but not to their work colleagues.

I explore in this chapter how, within the material spaces in which nursing takes place, the closet takes many forms. Within the space of the hospital, I explore how the main space of the ward compels nurses, both gay and straight, to 'closet' their 'real' or 'private' lives from the people they are caring for. The front stage (Goffman 1959) of the ward is where these performances of nursing and nursing professionalism take place. Thus, the nurse who has a strong religious conviction will not discuss their beliefs, the promiscuous nurse will not discuss the anonymous sex they have and the gay nurse may become closeted. As I discussed in previous chapters, the 'rules' of professional nursing have formed the basis of professional practice in some form or another for the last 100 years and which compel nurses to conduct themselves in a professional manner. Patients and relatives can disrupt this professional relationship by asking probing questions: 'Are you married?' 'Do you have children? Where do you live?' To patients these questions pass the time of day by engaging in everyday conversations. For nurses, finding the right answers can be extremely problematic for example, it would probably not be appropriate to answer: "No, I divorced him as he abused me" or something similarly personal and private. Responding in this way may make the patient uncomfortable and the focus of the interaction moves from the patient and their care, to the life of the nurse. Instead, the nurse presents a professional 'self' that upholds the integrity of the profession, an anonymous self, to ensure that our first concern is the patient and not ourselves. The nurse in these situations has to balance the public and private self and decide what, if anything they may reveal from the private. Justin stated in his interview that for gay students, he felt, the most difficult question a patient can ask is: 'Are you gay dear?'

a question I explore further later in this chapter in relation to this interviewee's response to such questions.

It is within this front stage of nursing activity that I offer an analysis of why these gay nurses may choose to deny and conceal their sexuality within the clinical area and how knowledge and power within nursing enact to closet sexuality more generally. Furthermore, I draw upon Sedgwick's notions of 'knowing by not knowing': the open secret that may be known but not confirmed (Brown 2011). For example, people may know a friend or fictional character is gay, but without that individual ever having said so themselves, or people might know that a particular street is gay without having been there.

The degree of disclosure, related to sexuality, that a person adopts may change depending upon the social and professional sphere of the interaction. As I explored in Chapter 2, Griffin (1992) in her study of lesbian and gay educators describes four different strategies for managing disclosure of sexuality: passing, covering, being implicitly out and being explicitly out. What I explore more explicitly within this chapter is how the gay nursing students I interviewed decided which strategy to utilise, in which clinical or university situation and what influences this decision. Within the interviews, it became apparent that the students ascribed themselves different roles in relation to their sexuality and being in or out of the closet – sometimes being both in and out simultaneously.

5.3 Private Lives and Professional Performances

All bar one of my research participants, adopted an initial stance of non-disclosure, of their gayness, within their clinical placements. Considering Weeks (2007) suggestion that major societal changes have improved the lives of gay men and lesbians in the Western world, the participants' initial stance of non-disclosure was surprising. The Royal College of Nursing actively promotes guidance on the care of LGBT patients and diversity and has a PROUD section that attends gay pride and

other events. There are many examples of the momentous change in attitudes towards lesbians and gay men over recent years. However, this does have to be balanced with the homophobic reactions of the religious right to the suggestion of gay marriage and the widespread homophobic bullying found in schools¹⁶.

Understandably, given the potential for negative reactions to their gayness, some of the students utilised strategies to gauge how acceptable disclosure would be. These included 'reading' the heteronormative discourses of the ward environment and moving between strategies of non-disclosure and disclosure to manage their sexuality. A common theme among participants who chose not to disclose their sexuality was a sense of a 'private' and a 'professional' life.

I'm very happy and content with my sexuality and what I am doing with my career. I think some people get too personal sometimes, I like to get to know someone before I start letting them know about my private life! I don't really like to talk about being gay at work, but some people are just nosey! (Jake)

Jake explicitly chooses not to disclose his sexuality in his placement initially adopting a covering strategy (Griffin 1992), where he is not occupying an overtly gay identity. However, he also chooses not to conform to a heterosexual identity, so when asked if he is gay, he does not deny it. His approach to the disclosure of sexuality on his placements is to try and separate his private, public and professional life. This is somewhat different from his family life where he is open about his sexuality and he has a gay brother. During the interview he states that he is happy with being a nurse and content with his sexuality. His ease was also apparent during the interview; he was chatty, talking about his experiences with confidence. However, his willingness to disclose his sexuality and his willingness to discuss some aspects of his life, such as the physical act of sex, varied depending on the context of the space and his role within that space. Jake presents a dichotomy in his interview, he is a confident and out gay man normally, but in his role as student nurse, he becomes less able to display his sexuality confidently. This raises three

¹⁶ Homophobic bullying continues to be widespread in Britain's schools. More than half (55 per cent) of lesbian, gay and bisexual pupils have experienced direct bullying.' http://www.stonewall.org.uk/at_school/education_resources/7957.asp

main issues: his use of privacy and how he deploys this to normalise his sexuality; what he finds acceptable in relation to his discussion of sexuality and how he perceives the professional environment of the clinical ward.

Privacy is not an individual entity that is readily controlled or defined. Privacy is linked in binary form to 'the public' sphere of life and is not characterised as being solely in the control of the individual. Jake asserts that he does not share his private life with people he does not know, implying that he indeed possesses agency in relation to this part of his life. In reality the realms of the 'public' control 'the private' – what we as individuals want to keep hidden or secret from public gaze. In the public/private binary, the discourse of public life is not only privileged, but forms the basis of what is private. For example the law in certain instances defines privacy: the Human Rights Act (1998) explicitly offers the public the right to privacy, which includes their family, home and correspondence. The moral codes of wider society also define what is private, for example how intimacy and the body is constructed as private (Bailey 2000) and the construction of the sex act as a private and not a public one (Donnan and Magowan 2009). As Bailey (2000) explains: 'The term 'private' in every day discourse refers to areas of social life which are protected from anything other than personal or domestic gaze.' (P384). He continues his discussion and attempts to define quite what is contained in the private and concludes that within the private there are areas that are ambiguous, such as the family, which has a private meaning for those individuals. Meaning that while family is quite visible in terms of who is related to whom, the actual relationships within the family matrix can indeed be kept very private, especially if they are problematic. He suggests that there are three dimensions of the private: intimate relationships, the self and the unconscious. What I am concerned with here is how intimate relationships and the self are enacted and deployed in the performance of the students.

Jake privileges intimate relationships over professional acquaintances by not talking about his sexuality with those with whom he does not share an intimate relationship. He talks in his interview about the openness of his family including his grandmother, in discussing his sexuality. Jake's construction of the intimate, private, sphere of his life corresponds to Bailey's (2000) suggestion of 'family, marriage, domesticity, love and friendship' (P391) as locations where the private occurs. By privileging intimate relationships over his professional acquaintances during clinical placement Jake is attempting to draw a clear line between his private and professional life and by doing so he does not have to consider the reactions of nurses on the ward to his sexuality. Jake's discomfort in the current climate of permissive sexuality may seem at odds with wider societal attitude towards sexuality. Rubin's (1984) charmed circle helps with understanding how sex and sexuality is either privileged or rejected by society. Here I will explore how Jake locates his sexuality to the private, public/private and professional spheres of his life by exploring the charmed circle. Rubin's theory is now twenty-eight years old and during this discussion I will locate gayness in contemporary culture within the charmed circle.

As I have previously discussed, the charmed circle (Rubin 1984) theorises how value systems in social groups attribute definitions to sexuality and how these are defined as either good/natural (the charmed circle) or as bad/unnatural (the outer limits). Rubin identifies how sexuality is constantly reconstituted by various discourses on sex, for example religious, popular, psychiatric/medical or political. These discourses define the sexual boundaries of human sexual capacity as sanctifiable, safe, healthy, mature, legal and politically correct. Those in the 'charmed circle' are 'the heterosexual, marital, monogamous, reproductive and non-commercial' (Rubin 1984, P279).

Jake, in relation to his private life, locates his gay sexuality within the charmed circle, despite not being heterosexual. He talked in his interview of his positive social and family life and how even his grandparents accepted both his and his brother's gayness.

I was fortunate in that we (Jake and his brother) come from an open, intelligent family, in the sense that they were all academics so they had very liberal views. He was fine with it – a very spiritual man. My grandparents and uncle and aunties now all know and although they don't agree with the lifestyle they do accept it. (Jake)

He firmly constructs both his sexuality and his private life in relation to domesticity and family. In his interview he talks about how he finds some people 'nosey' in relation to his sexuality. The stigma and stereotypes that continue to exist in relation to gayness (Harding 2007) mean that gay people can be objects of interest and that people are inquisitive about the practice of gay sexuality or more precisely sex. For example, a stereotypical assumption about male gay sex is that one partner will play a male part (colloquially known as the 'butch' guy) and one a female part (the 'fem' guy) and that anal sex takes place.

Jake talked about the inquisitive nature of people a number of times in his interview and while he was talking about life at university he spoke explicitly about how uncomfortable he was about discussing sex: 'I don't want to discuss the details of my sex life with people I hardly know, but they seem to want to talk about it...'. While it is reasonable for anybody, gay or straight, to not discuss his or her sex life, Jake is actively constructing a front stage self that is divorced from the act of gay sex itself. By doing this he ensures that his sexuality is associated with privileged sexual discourses of monogamy, marriage, partnered, in private. He thinks he makes his gayness more acceptable to his professional acquaintances by not talking about sex and this is possibly a construction of his sexuality he used with his family as well. It is possible, that the truly private aspect of his sexuality, the act of sex, is only

manifested between him and his partner, 'in private' and is not an item for discussion with friends or acquaintances.

The private status of gay sex was enshrined in law by the 1967 Sexual Offences Act, which decriminalised homosexual acts (excluding buggery and indecency in very limited circumstances. A number of conditions were associated with the Act: that the sexual act had to be consensual, take place in private and involve only people that had attained the age of 21. This was a higher age of consent than that for heterosexual acts, which was set at 16. Further, "in private" limited participation in an act to two people. This condition was interpreted strictly by the courts, which took it to exclude acts taking place in a room in a hotel, for example, and in private homes where a third person was present (even if that person was in a different room). This lawful construction of gay sex 'in private' has been in existence since 1967 and at the time it crystallised public opinion of homosexuality, further stigmatising gay men. However, there is now a new discourse of acceptance that has developed over the last decade or so.

The distinction of public and private is similar to the de-coupling of sex and sexuality that Jake practices in order to secure acceptance. Richardson (2004) suggests that since the conduct-based rights claims of earlier gay rights campaigns, which focused primarily on the rights of same-sex (male) consenting adults to engage in sex in 'private', since the 1990s there has been a gradual move towards focusing on identity and relationship-based rights claims. Warner (1999) suggests, furthermore, that this represents a decoupling of homosexuality and sex that he regards as central to the process of gay normalization. If this is the case the 'self' that Jake puts forward is relying on this notion of gay relationships and domesticity. The problem with this is that gay social spaces, such as nightclubs, bars and saunas are seen as, and usually are, places for sexual encounters to begin. Therefore it is difficult to distance or de-couple sexuality and sex.

For Jake, sexuality is an entity that moves in and out of the charmed circle depending on the time, space and place of his sexual subject position. In relation to his role as a student nurse, when pressed, he offers a version of sexuality that is professionally acceptable, associated with monogamy and domesticity and omitting the sexual act. Nursing at times is a conservative profession and his approach to negotiating his sexuality within his professional role is understandable due to the conservative beliefs within nursing. Nursing discourses of homosexuality and I would suggest, sexuality in general, live in the outer limits of the charmed circle and are therefore 'bad'. To reinforce this notion of nursing's conservatism I will offer three examples.

First, the widespread reaction to AIDS within nursing was particularly negative. UK surveys of nurses' attitudes to patients with AIDS in the 1980's portrayed them as fearful of AIDS, ill-informed, and negative and discriminatory in their attitudes towards people with HIV/AIDS (Tierney 1995). Although attitudes towards people living with AIDS have changed positively during the last decade, Peate et al's. (2002) survey of nursing students' knowledge of and attitudes to AIDS revealed that 16% of participants would feel uncomfortable caring for lesbian and gay patients, signalling an on-going level of conservative attitudes. Second, nursing has a long established concern with upholding a morally virtuous image. Since Florence Nightingale's establishment of professional nurse training, the image of Dicken's Mrs Gamp (which I explored fully in Chapter 3) has been replaced with one of middle class, virtuous young women. Nursing has never relinquished these aspirations of morality and virtuousness and examples such as unmarried nurses being required to reside in hospital nursing residencies survived until the late 1970's. Nightingale's legacy of morality is ever prevalent today in the form of the code of conduct and the ever-increasing pressure for effective regulation of the profession. Although a positive aspect of heightened professional regulation is the right for patients to expect safe care underpinned by equality and respect. Third, my own experience as a researcher examining the experience of gay students and the heteronormative attitudes that I encountered in relation to recruitment of participants

which are discussed in Chapter 3. Additionally, many of my colleagues have asked in the past how as a gay man I can be objective in my research – the underlying suggestion being that only straight people should research gay lives and why would I research gay nurses anyway – they are not that interesting are they?

Trey's approach to disclosure of his sexuality could at first seem very similar to Jake's. However, while Jake seeks to construct separate private and professional lives, Trey seeks acceptance and integration as a 'normal' gay man:

If someone asks me (about being gay) I tell them, but I don't tend to make a whole big fuss of it cos it's who I am, you don't see everyone else waving their arms and going 'I'm straight!' So I think, you know, I don't want to personally, yeah I just, I don't think, I don't want to er draw attention to it, I don't wanna ignore it or repress it completely either, I just want to carry on with my life.. (Trey)

Trey makes a comparison between his own gay sexuality and heterosexuality; he wishes to be viewed in the same way he conceives heterosexual people are. His assertion that straight people don't assert their heterosexuality by 'waving their arms and going 'I'm straight!'' emphasises his desire to be 'normalised' within straight society. However, as I have outlined earlier, the spaces the students are participating in are reflections of a society. Society privileges heterosexuality, and therefore his heterosexual colleagues and peers do not need to assert their heterosexuality. Heterosexuality continues to be the dominant discourse in society. Trey's account of non-disclosure demonstrates his dissonant position. He appears to desire acceptance within a heteronormative society, but this may only truly be achievable if you are a heterosexual participant in society.

Jake occupies a similar position to Trey, in relation to disclosure of sexuality. However, Jake does not appear to be seeking normalisation of his sexuality, but acceptability through the de-coupling of sex and his own sexuality and additionally by relegating his sexuality to the private. Trey appears to suggest that his sexuality should not be an issue at all, he just wants to 'carry on with my life'. Trey does not

discuss any political motivations that underpin his position, but his desire for normality or ordinariness is located in the politics of citizenship. Richardson and Munro (2012) suggest that it is understandable that lesbian and gay people desire to be understood as normal, because for many years homosexuality has been defined as inferior, abnormal, unequal and subordinate to heterosexuality. One way of achieving normality is for lesbians and gay men to emphasise similarity and commonality with heterosexuals and with mainstream society and norms. Their argument is that by de-coupling sex from sexuality and moving away from the notion of the promiscuous homosexual, who threatens the stability of society, towards notions of coupling, monogamy and stability, normality or ordinariness can be achieved. The practices that lesbians and gay men integrate into their own culture include, for example, civil partnership (Seidman 2002) and monogamy.

However, while Trey talks about his sexuality in terms of ordinariness or normality, which locates his own notions of sexuality within the charmed circle, the way he talks about his sexuality is as an 'outsider'. From being positive about his sexuality and explaining his position of wanting to be accepted in the way that heterosexuals are, rather than the banner waving queer that he alludes to, he then proceeds to talk about 'ignoring' or 'repressing' his sexuality. While Trey states he does not want to repress his sexuality, he does want to 'just carry on with life', it appears there is a balance he is trying to achieve between openness in relation to his sexuality and being accepted as a gay man. If Trey achieved this, he would benefit from the privileges of heterosexuality, for example acceptability, equality, respectability. Richardson and Munro (2012) suggest that:

Lesbians and gay men were previously constrained by representations of themselves as mad, bad or sad; it would seem that now they are being shaped through normative constructions of responsible and respectable sexual citizenship. (Munro 2012, P83)

While Richardson and Munro (2012) are very positive about the ‘ordinariness’ of lesbians and gay men within what is now seen as a more liberal society, Trey appears to struggle with the enactment of ‘respectable sexual citizenship’. His remarks about repressing his sexuality indicate his inability to just ‘live life’ and furthermore during the interview he was unable to provide specific examples of when he had disclosed his sexuality as a student nurse. He did talk about coming out at school and how traumatic this was at the time. During the interview I asked specific questions about discussions that take place between nurses in the back stage of the ward, for example during the time taken for breaks. My own experience of sitting in the sister’s office or coffee room for a break is that the time is taken talking about the mundane: what we did on our days off; our families; what is good on the television. In fact we would discuss anything except the work of the ward so that we could relax for 30 minutes. Sex, religion and politics featured heavily too – which were at one time issues to be avoided in polite company. However, Trey and the majority of the gay nurses I interviewed, struggled to be open about their lives in quite the same way that heterosexual nurses would be. For example, Trey offered no examples about when he disclosed his sexuality; alternatively Mike would use ‘covering’ strategies, by talking about his ‘partner’.

Pressure not to disclose sexuality on the ward may relate to the conservative nature of nursing and the expectations of the profession that I discussed earlier. However, Trey and the other students I interviewed also needed to negotiate the process of clinical assessment on the ward, which is subjective, with successful completion relying upon a good mentor/student relationship (Melia 1984). Trey spoke specifically about a problem he encountered on placement in relation to mentorship:

I didn’t get on well in my first placement, I found that the staff were a bit cliquey and they weren’t very nice to some people and they weren’t nice about the staff, the other nurses, erm I did have, my mentor when I started, she didn’t really bother at all and then later she said oh by the way I’m not here for the last three weeks, so I thought OK and one of the other staff nurses stepped in and he was really supportive and I think

if he hadn't stepped in I wouldn't have got through it cos the staff, the other staff were like they were just very rude and they wouldn't talk to me (Trey)

It is evident from Trey's narrative that his first placement did not go well and he was unable to form good relationships with the ward staff (this placement was an elderly mental health ward). If his everyday relationships with the other nurses were not good, then it would be understandable that he would not compound the situation by disclosing his sexuality. The assessment of clinical practice as part of undergraduate nursing degrees in the UK forms 50% of the overall academic assessment and therefore students feel tremendous pressure to conform to the practices, both clinical and social, on the placement. Mentors hold power, as they act as gatekeepers to learning opportunities and have to be 'kept happy' in order to achieve a good assessment (May and Veitch, 1998). Within the apprenticeship model that nursing education continues to be based upon, the power of the mentor is clear in that they control the working shifts of the student, the clinical experiences they participate in and ultimately whether or not the student is assessed as clinically competent.

Negotiating conversations with colleagues, for example in the staff room, where decisions of whether to disclose or not disclose sexuality are relevant can be problematic. Jake uses the term 'nosey', to describe his colleagues interest in his sexuality, which makes him uncomfortable, 'I don't really like to talk about being gay at work'. He has a clear strategy for dealing with such circumstances:

Being an auxiliary helped. I have always been generally aware of how to judge a situation and look at people's body language, tone, the situation itself etc. If someone is genuinely interested in my lifestyle, I will talk about it. I say I don't mind answering your questions, but not when we are out on the shop floor... (Jake)

Jake has previously worked within the hospital environment as a nursing auxiliary prior to commencing his nursing education. Using this past experience he suggests he is able to 'judge the situation' and control it. His past experience, as he discusses later, enables him to consider what are appropriate professional boundaries on what

he calls 'the shop floor' which he subsequently clarifies as an area where there are patients. Jake's previous experience in negotiating his sexuality generally and, more specifically, his experience of doing so in healthcare allow him to adopt a more powerful position than some of the other participants, enabling him to control the extent to which he discloses his sexuality. I develop ideas of professional behaviour and regulation later in this chapter; suffice to say for now that Jake is aware of his professional boundaries and attempts to ensure those around him respect the ward environment. Gay men regularly undertake an educational role within their social networks, similar to the role Jake sees himself undertaking here. This is seen as a useful contribution to minimising homophobia and heteronormativity. In Taulke-Johnson's (2009) study of university students the education role was between the gay student and their university accommodation flat-mate; for this student it is the education of new colleagues, many of whom will be registered nurses, rather than the student's peers. Additionally, being a nursing auxiliary has helped Jake in understanding the unwritten rules and regulations of nursing, he clearly understands that some discussions are for the front stage, 'shop floor' of the ward and others are to be kept closeted, back stage.

One student assessed the level of risk coming out in each placement posed. Joshua approached his clinical placements with a note of caution and takes the time to assess the heteronormative practices of the ward before deciding what level of self-disclosure would be appropriate to the situation. He does this by introducing gay issues into the workplace and then judging the reactions of those around him:

It really depends on how I perceive the staff attitude. For this, the *Sun*¹⁷ newspaper is really helpful! Bringing up some of the anti-gay slander pre-handover and listening to opinions. (Joshua)

¹⁷ The Sun is a UK tabloid newspaper, which is regarded as somewhat conservative in its political and social stance.

This enables Joshua to assess and control the balance of private and professional boundaries within his placements and ultimately whether to disclose his sexuality. As I discussed in Chapter 3, Joshua is a mature, confident and out gay man socially. He also has experience of being out within his previous employment as a bank manager. However, within this new field of work, the unfamiliar landscape of nursing, where possibly relationships with patients and colleagues are more intimate, he is unsure. Although Joshua appeared to be a very self-aware and experienced gay man, he and all of the students I interviewed had difficulty in really identifying and talking about the heteronormative practices on their placements that led them to be guarded about their gayness in their clinical placements.

During the interviews I asked the students about the conversations they had with colleagues and patients and very specifically about the staff room 'banter' and how they participated in these conversations. In Chapters 3 and 4 I explored in some depth how my own personal experience as a patient's relative made me aware of the heteronormative practices of the hospital space and how some spaces, such as the waiting room, made me feel hyper-visible as a gay man. Additionally I discussed the patient centred literature that demonstrated patients' heteronormative experiences. These experiences included being asked standard questions about sexual health, which are based upon the assumption of heterosexual, penetrative sex. I also explored how nurses make subtle, but important assumptions in everyday care, for example admission paperwork that continues to ask if patients are single/married or widowed, which reinforces the heterosexual institution of marriage. The students I interviewed did not see any of these issues as specific to nursing or the hospital. They seemed to assume that the ward was a reflection of society and hence they should be cautious about the disclosure of their sexuality for fear of negative reactions. There may be a number of reasons why this is the case. The students are novices and are learning the role of a nurse and negotiating their own role as student nurse. Additionally, the rules and regulations of nursing are generally unwritten and

where they are published, for example in the Code, how the rules are interpreted into the real world, where decisions have to be made quickly, is not consistent.

Dividing the private, professional and the public are not always as easily achieved as many of the students thought. To demonstrate this I explore two examples, firstly the 'outing' that one student was subjected to during a social event with his ward colleagues and secondly the stereotype of 'assumed' gay sexuality that male nurses seem to be ascribed.

The choice to decide the level of disclosure in relation to their sexuality, within the professional environment, is not always the student's and there is always a possibility that the personal, professional and private will collide. Here, Joshua recalls how he was 'outed' on his first placement:

On my colorectal placement (incidentally my very first experience of nursing), I was propositioned by one of the registrars at the Christmas party, a previous liaison that had slipped my mind. Basically, in a drunken state and in front of colleagues he asked me if I "fancied another fuck", something that I politely declined. That, of course, let the cat out of the bag so to speak and the ward was rife with rumours, forcing my hand and I then came out. The reactions were along the lines of "you don't look/sound gay", "what a waste" that sort of thing. (Joshua)

During the interview Joshua shared how he had met the registrar in a nightclub some weeks before his first placement on the ward. It had been a casual 'pick-up' in a nightclub, a one-night stand. Joshua was surprised to see the registrar was working on his first ward placement and had never approached the registrar to discuss their casual relationship. Likewise, the registrar had not approached Joshua. During their interactions on the ward their fleeting sexual relationship was relegated to the private, as both men understood the professional boundaries that are expected on the ward. However, their professional relationship was founded upon the traditional medical-nursing relationships where medical knowledge and actions are privileged over those of nursing. There is a definite power relationship here whereby medicine dominates and subordinates nursing. Additionally, Joshua is a 'lower ranking' nurse,

as he is not registered and the medical doctor is relatively 'high ranking', a registrar being the final position before becoming a medical consultant.

The fact that the registrar was drunk may be coincidental in this exchange. This fact may have lowered his inhibitions. However, I suggest that their professional roles, private lives and social interactions have become mixed. At work the registrar is able to dominate the student nurse through his position as a doctor and his seniority. This power is then transferred to the social and the doctor offers a performance, which demonstrates his dominance. Except, in this social situation, the usual rules of behaviour on the ward do not come into play. Indeed, the registrar demonstrates his power in three ways. He makes his suggestion of 'having another fuck' in public, in front of his and the student's colleagues, he uses language which would not be appropriate in a professional environment and most likely not in this context. Then, by suggesting a sexual encounter, he pushes Joshua out of the closet and declares his and Joshua's sexuality.

It was not clear in the interview if the registrar was open about his sexuality at work; given the homophobia that has been documented in the medical profession (Burke and White 2001), it is unlikely. This drunken dialogue, on a night out with the ward staff could potentially be embarrassing for the registrar. However, he knows that when everyone is back at work on the ward, his position as a senior medical doctor and the power associated with this will protect his public reputation.

For s, the consequences of this included him being forced out of the closet and potentially risking his relationship with the ward nurses, his mentor and staff generally. The closet is a very precarious place, rather than being a space of safety, concealing gay sexuality makes you vulnerable to private and professional lives coming together in a way that the individual, such as Joshua cannot control. Sedgwick (1991) suggests that the closet is an impossibly contradictory place. You cannot be in the closet, since you can never be certain that you have actually succeeded in keeping your gayness secret. Joshua talks about rumours being 'rife' on

the ward and how this ‘forced’ him to come out and declare his sexuality. Joshua appears to be powerless to control disclosure of his sexuality in this situation and denying his sexuality would make him all the more vulnerable. In this context, rumours relate directly to the issue of naming that I now discuss in relation to stereotypes and male nurses.

Many of the participants acknowledged that nursing is seen as a stereotypical profession for gay men to enter:

There aren’t many men in nursing still and the ones that are there are perceived to be gay and things. (Mike)

It also seems from their accounts that the assumption by some of the students’ colleagues, is first that they are gay. Mike’ statement concerning being perceived as gay due to being a male nursing student was a recurrent theme in the majority of interviews; furthermore it is implicit in Jake’s narrative that he was assumed to be gay. This is a significant difference in how these men are viewed differently in their professional roles as student nurses, based on their choice of career, which is often seen as feminine (Pullen and Simpson 2009), they are assumed to be non-heterosexual.

Heterosexuality is thought of as being the only “normal” and “natural” form of sexuality and produces unequal power relationships between the homosexual minority and heterosexual majority (Reingard 2010). The heteronormative dominance acts to produce power and control that limits the ability of gay and lesbian people to talk and construct their own identities. In a heteronormative environment, in which everybody is expected to have sexuality and in which heterosexuality is still considered as the unspoken norm, every-body is usually inscribed with heterosexuality, a label that can only be shaken off through actively embracing a homosexual identity (Van Laer 2011). Within the environment of the ward, as I explored in Chapter 2, heteronormative practices are (re)produced by

nurses, patients and families. There is no reason to dispute the fact that, as within wider society, within the ward people are ascribed as being heterosexual.

However, in relation to the male nurse their sexuality is questioned due to their choice of career. Nursing is seen as feminised and does not conform to the 'script of hegemonic masculinity' (Harding 2007), therefore male nurses risk having their sexual identity questioned. By choosing a workplace role that is considered unmanly they become associated with effeminacy and gayness, which in turn re-produces the feminised construction of gender essentialising identities for male, female and male gay nurses; as I discussed in Chapter 2, these notions are based upon essentialist beliefs that women are inherently 'mothering', 'caring' and 'feminine'.

For some gay male nurses, heteronormative assumptions about their career choice, masculinity and sexuality appear to invert normative assumptions of heterosexuality and lead to the ascription of a gay identity. This is important in relation to the negotiation of these students' gayness in the clinical workplace. In order to maintain a 'private life' they may have to make strategic decisions about how to negotiate discussions with work colleagues and choose to adopt a passing or covering stance in relation to disclosure or non-disclosure of their sexuality. Indeed, a number of the students did adopt a passing or covering strategy in relation to their sexuality for part or all of their clinical placements. However, with assumptions of gayness being made due to the dominance of hegemonic masculinity, covering or passing may not convince the students' colleagues and the closet may become untenable.

Trey talked about how he 'just want to carry on with life' and he aspired to be accepted as 'normal. However, he fails to acknowledge his position as a male in a feminised profession, one in which male nurses can be and usually are categorised as gay. Trey's sexuality may be something that is talked about when he is not present and therefore Trey would be outed without his desire. The 'rumours' Joshua talked

about in relation to his sexuality and the perceptions of gayness that Mike talked about, were recurring themes during many of the interviews.

The naming of someone as lesbian or gay due to assumptions, stereotypes and rumours is a documented aspect of institutional life (Ward and Winstanley 2005). Butler describes this as ‘the divine power of naming’ where to utter is to create the effect uttered (Butler, 1997: 32). Drawing on Althusser’s notion of ‘interpellation’, she writes:

Imagine the quite plausible scene in which one is called by a name and one turns around only to protest the name: “That is not me, you must be mistaken!” And then imagine that the name continues to force itself upon you, to delineate the space you occupy, to construct a social positionality. (Butler 1997, P33)

Furthermore, she suggests that naming can also happen without ‘the subjects knowing’, ‘out of earshot’ and without the person turning around and saying ‘here I am’. The problem for male nurses and specifically these students, is that once the name has been ‘uttered’, it will as Butler suggests, ‘force itself upon you’ and within the context of nursing ‘construct a social positionality’ which is gay. Joshua described this as ‘letting the cat out of the bag’ and certainly he felt that once this had happened there was little choice but to affirm his gay sexuality – ‘forcing my hand and then I came out’. Trey appeared unaware of possibly being labelled as a gay nurse within his placement area, but he did endure a difficult first placement which he could not explain the reason for.

For male nurses and specifically the male student nurses I interviewed, the power of naming was clearly linked to the feminised nature of nursing work and stereotypes related to male nurses being gay. The students appeared to have two choices in these circumstances – to deny their sexuality or to affirm themselves as gay, which is

similar to many other social contexts. However, as a gay male nurse this presented some specific difficulties, in particular the consequences of coming out in a placement where being gay was not accepted. This could mean being unsuccessful in that placement as mentors occupy a powerful position of assessing nursing students (as noted above). Some of the students talked about how likely it would be that their university or placement colleagues would assume they were gay. Mike suggested that 85 of 100 students in his cohort had assumed he was gay. Additionally, the assumption about the students' sexuality appeared to take place quite early in their professional relationship, meaning that the student has not been able to assess the likelihood of a negative reaction to their gay sexuality. Without assessing the attitudes of staff, for example in the way Joshua did using the newspaper, the students were more likely to deny their sexuality or avoid discussion of the issue:

They surmise at school [university, he is referring to the school of nursing] and in placement, I just say no. They are only asking what they really know is true! I just say I have got children! (Mike)

Mike has three grown up children from his previous heterosexual relationship and in this situation, where his sexuality is questioned, he positions himself as heterosexual, by demonstrating his ability to procreate. In doing so, he asserts both his heterosexuality and his masculinity in order to minimise the effects of being a member of a feminised profession and being labelled as gay. This is problematic as he is re-producing discourses based upon patriarchal, heterosexualised masculinities which further emphasise the construction of nursing as feminised. Furthermore, by re-producing these discourses the student not only emphasises feminised constructions of nursing, he also furthers the construction of male nurses as gay by having to deny this. In chapter 2, I explored how a discourse can have constitutive power (Kelly, Fealy and Watson 2011) and I suggest that the way in which Mike presents himself as heterosexual, constitutes the discourse of male nurses being gay as he gives it power through his denial.

Justin agreed that stereotypes about male nurses exist:

Yes, of course the typical stereotype would be all male nurses are gay I guess....which I think subconsciously was a plus point for me... (Justin)

However, he sees this as a positive issue. Justin was the only student I interviewed who maintained disclosure of his gay sexuality within clinical placement areas and university. As I explored in Chapter 3, Justin came out as a teenager at boarding school and since this time he has been open about his sexuality in his family, social and working life. For Justin, his open approach to disclosing his sexuality is natural and he suggests inevitable:

They just asked me.... Well I'm quite camp anyway so there's not much doubt in peoples minds anyway, oh he's a poofter! (Justin)

Justin's performance as a gay man is very different to that of the other students I interviewed. He seems unconcerned with the boundaries of private, social and professional. During our discussion he described, in a similar way to Jake, how people could be inquisitive about gay sexuality. However, unlike the other students I interviewed, Justin stated that the only thing he would not discuss openly was his bank balance. Talking to Justin, I could have assumed that he would place gay sexuality within the charmed circle; he talks about how his sexuality is accepted by his family, friends and colleagues. However, although Justin appears to be a very confident gay man and indeed somewhat effeminate in his self-presentation, he goes on to talk about his fears when he does disclose his sexuality:

...but I still find it quite hard (laughs) to say I have a boyfriend, I don't know why, but...just in the back of my mind I don't know why. It shouldn't be but er I just I think I am scared if the reaction ofthe next person and I hate to see a very negative, sudden negative change, but then its uncomfortable correcting people....is it a she...not it's a HE (laughs) (Justin)

Justin's fear of negative reactions towards his sexuality further demonstrates that gay sexuality is not universally accepted within wider UK society and furthermore, that

Rubin's (1984) assertion that gay sexuality is within the outer limits of society, continues, to some extent to be a reality for gay men. Fearing negative reactions to the disclosure of sexuality continues to be the prevalent issue that discourages coming out in the workplace generally (Ward and Winstanly 2005). Specifically, Stonewall's review of homophobic harassment within the health sector (Hunt and Cowan 2006) concluded that homophobia continued to exist and that it affected health sector staff at all levels and in all professions. They also identified that LGBT people were often reluctant to report homophobic victimisation or harassment. Justin, early in his nursing education, encountered negative reactions to his sexuality, as he recalls in this discussion that took place with a male patient, himself and a male auxiliary nurse:

The male auxiliary was there as well and he said erm so were you carrying a pink handbag then he kind of shut up. And then he said under his breath...but still quite loud...he said 'if I had my way I would shoot them all' he said.

So, how did you react to that?

Erm I went straight to the nurse in charge as sister wasn't there and told him what happened.

The nurse in charge was quite understanding, he is heavily straight...but he was very understanding, throughout that shift he just kept on making sure that I was comfortable and not too shaken. (Justin)

Justin was confident enough to report this homophobic incident to the nurse in charge and it appears that the issue was dealt with effectively. Justin went on to discuss how the auxiliary nurse was 'spoken to' and how the nurse in charge made sure that Justin was OK for the remainder of the shift. The reaction of the male auxiliary to Justin related to Justin's effeminate manner within the ward, the reference to 'pink handbags' being very specifically made to and about Justin. Using language that reinforces stereotypes of effeminate gay men, pink being traditionally associated with girls/femininity and handbags being part of women's clothing/accessories is intended to demonstrate the male auxiliary's power as a heterosexual man in this situation. By using very specific language the male

auxiliary attempts to embarrass Justin by emphasising the stereotype of gay femininity and in doing so he also demonstrates the patriarchal relationship between men and women. By asking Justin if he carried a 'pink handbag' the male auxiliary is implying that if this is the case it would be an affront to his masculinity because a handbag is an item used by women and women are subservient to men. In this situation the auxiliary is not only re-producing dominant discourses stereotypical about gay men, but also dominant discourses where women are dominated by men and anything feminine is seen to hold less value.

These actions indicate very publicly (in front of the patient) that the auxiliary nurse knows that John is gay and by talking about the pink bag he mocks Justin. This demonstrated the power of the assumed to be heterosexual nurse within this situation. As heterosexual masculinity is dominant, the nursing auxiliary possesses the power to dominate Justin by talking about the pink handbag, which is clearly a stereotype. Furthermore, the auxiliary nurse potentially embarrasses Justin in front of the male patient and he draws attention to Justin's sexuality. Potentially, this could disrupt the professional relationship that Justin has with the patient, by bringing Justin's unspoken sexuality to the fore.

The homophobic comment from the nursing auxiliary, 'if I had my way I would shoot them all', was the only example of overt homophobia shared by the students. Hunt and Cowan (2006) suggest such incidents do take place within healthcare and Justin was the only student who consistently disclosed his sexuality within placement and university spaces. Therefore, he may have been more prone to homophobic bullying than the other students. However, Fish (2006) suggests that homophobic bullying can result in depression and suicide and should therefore be treated seriously. In the following section I explore how students negotiate their sexuality specifically within their nursing practice.

5.4 Gay Work in Clinical Practice

One of the most pressing questions for the students is one which I have already touched upon in previous chapters: What do you say when a patient asks a question: ‘Are you gay dear?’ (Justin). All of the students spoke of similar concerns and all but one of them cited the use of covering strategies to avoid answering such questions directly:

Patients are an issue that I find difficult to negotiate. A lot of the older ladies do make comments like “not married yet?” or “seeing your girlfriend this evening?”, to which I used to reply “yeah” or make non-committal grunting noises. (Joshua)

Covering strategies are used by the students to avoid difficult questions about their sexuality, which could disrupt the provision of care, rather than pass as straight. Joshua’s non-descript responses to direct questions from patients about his social life were utilised by many of the students in similar situations.

The majority of the students recognised that coming out as gay to patients may be problematic, although collectively they were really unable to verbalise why this was the case. For many of them, coming out on the ward to colleagues was problematic for the reasons I discussed above and therefore there was never any question of coming out to patients if they had not disclosed their sexuality to the staff on the ward. However, what was missing from the students’ accounts were patient centred questions that would enable them to make professional decisions about the appropriateness of disclosing their sexuality to a patient. For example, would coming out enhance the therapeutic relationship? (Later in this chapter, I explore Joshua’s experience of coming out as part of a therapeutic nursing relationship). Whose needs would be met through coming out? What would happen if the patient rejected the nurse due to homophobic beliefs? One possible explanation is the students’ lack of experience in terms of negotiating complex therapeutic relationships more generally and a lack of experience in interpreting the rules of nursing practice that set nurses apart from patients, for example the Code (NMC 2008), that I explored in some

depth earlier. However, when the rules that govern nursing practice are disregarded or not understood there are consequences for the student:

I wasn't out to patients, but you know in a six bed bay erm.. and you're you're doing a bed that the patient has just gone and you're wiping it down clean and...and erm and er this staff nurse, she's a staff nurse that really loves gay men I think (laughs) and we're talking about this male celebrity and that male celebrity (laughs) and er you could just see her face just cringing (the patient's) and subsequently when I go over to help she like gives me a funny look and oops!

One of the senior staff who said....try not to.....try not to erm....expose your personal preferences to patients. Well OK what was I supposed to do? Just keep quiet and do our work....well if there were no patients there, you know....its hard isn't it? If I was talking over the patient it might be different. (Justin)

Within this account Justin is talking about everyday nursing work that takes place in the front stage of the ward. What he is unable to understand at this point of his career, as a student nurse, is how his actions may disrupt the normal pattern of nursing that takes place on the ward and his relationship with his patients. Justin has not learnt the social processes that govern nursing on this ward and how he is expected to behave in the main areas of the ward. He acts as though he were out with his friends, his comments about the nurse 'really loves gay men' suggests that he sees their relationship as very social and therefore he behaves in the way he would socially – talking about 'male celebrities' and as Justin points out himself in the interview, being particularly camp. At this point of his nurse education he fails to see the impact of his personal performance as a student on the patients who can see him. He may not be offering specific forms of nursing care at the time, but he is within the nursing environment.

When Justin was reproached about his behaviour he was offended and considers his actions to be the correct way to conduct himself as a student: 'what are we supposed to do, just be quiet and do our work?'. What he does not yet realise is that nursing work is a very specific kind of work and he has not yet learnt how to present a 'front'

(Goffman 1959) that is appropriate. The 'front' that nurses display to patients has been described as emotional labour:

This kind of labour calls for a co-ordination of mind and feeling, and it sometimes draws on a source of self that we honour as deep and integral to our individuality. (Hochschild 1983, P7)

In order to help patients feel cared for, nurses welcome patients, they are polite, respectful and considerate. In the course of nursing, they engage in various activities that correspond with caring behaviour, e.g. providing helpful information and advice; physically helping patients when necessary; engaging in supportive behaviour and administering technical care (McQueen 2004). Emotional labour is guided by 'feeling rules' derived from social conventions, the reactions of others or from within the individual (Hochschild 1983). In nursing when nurses do not feel as they think they ought to in particular situations, they engage in emotional labour to 'manage, control or alter their emotional status' to correspond with what they believe is appropriate for the situation (McQueen 2004, P103). Justin's experience suggests that he has not learnt the 'rules' of professional nursing behaviour and more specifically the 'feeling rules' or social conventions that form the therapeutic relationship nurses must establish with their patients. Justin has not learnt that his 'front' self will impact upon the way that patients react and interact with him and that this will affect his ability to nurse. In fact he sees that a patient is uncomfortable with the situation and he makes a joke of it 'oops!'. He may then have to escort this elderly patient to the toilet or assist with washing her and he may not then be able to develop an appropriate nurse/patient relationship.

In time Justin would have to learn how relationships with patients involve 'emotional work', how he will at times need to moderate his behaviour in the same way that he will have to manage instinctive emotions such as disgust, annoyance or frustration in patient interactions. He will have to try viewing the situation from patients' perspectives and empathise with their emotions. Nurses' facial expressions and behaviour can be managed to display caring behaviour (McQueen 2004) and Justin

will have to learn how his 'performance' as a student will need to be managed in the open space of the ward, differently to within his social life.

I remember reflecting on this interview afterwards and being concerned for Justin. Although this incident took place early in his life as a student nurse and was on an adult ward, he was in fact a child branch student. Being a children's nurse myself, I am acutely aware of how Justin could be seen as he describes in his own words 'being too much' on a children's ward. Meeting Justin also reminded me of how guarded and careful I was about the conversations I would have with most parents when I worked as a nurse, although I had no problem with disclosing my sexuality to nursing and medical staff where I worked. I was always mindful that the parents and children were the centre of my role and my care. Some time after meeting Justin, I learnt through an acquaintance, that he had in fact completed his university course and had registered as a children's nurse and I was relieved to hear that Justin had negotiated his way through the course and his clinical placements.

There were very few examples within the interviews I conducted where the students explicitly disclosed their sexuality to the patients they were caring for. Here I will explore the example that Joshua shared with me. This example exemplifies how specific environments can be conducive to coming out. Nursing takes place in many different environments and I suggest that some environments become more privileged than others due to the nature of the activity or the type of disease being treated.

This is similar to Rubin's (1984) theory of the charmed circle in that certain environments and diseases form the charmed circle and others are the outer limits of nursing. I would suggest that nursing children, midwifery, cancer care and emergency care are examples of the charmed circle of care environments. These areas are publicised within general society through the media, prominent charities raise millions of pounds for research in these areas and nurses that work in these

areas are 'angels'. The outer limits would include for example the GUM clinic and HIV/AIDS, mental health and elderly care. These areas do not attract a great deal of positive public attention and are somewhat marginalised within general society. Different nursing environments attract different people, for example high technology areas have more male nurses working in them than other areas of nursing (O'Lynne and Tranbarger (2006). I would suggest anecdotally that the GUM clinic and HIV/AIDS attracts a higher number of gay male nurses than other areas of nursing. This may be for two reasons, firstly these areas are the outer limits of nursing and secondly within both areas patients are generally open about their own sexuality, due to the sexual nature of the disease that is being investigated or treated.

Joshua stated that he was comfortable to disclose his sexuality in the GUM placement: 'all of the staff knew me and my orientation before I got there, as at least four of the staff had seen my genitals within the last six months, it caused no end of amusement!'. Although Joshua was comfortable in disclosing his sexuality to the GUM clinic staff, he still found 'negotiating patients' problematic except in this one situation which he recalled.

Joshua was working with a young man who needed advice on sexual health:

Even in the GUM clinic, I wasn't wholly comfortable [with patients], until I had a patient come in a bit younger than me, who needed some health promotion advice ASAP: he was another gay guy who had moved from a rural area, was feeling lost and had taken to late-night cruising in a local park. I felt comfortable giving him the benefit of my experience, and he seemed quite grateful for this. In general terms, though, how does one approach outing themselves to patients? Is it easier just to lie? I haven't quite decided yet. (Joshua)

Joshua appears to have selected this patient to disclose his sexuality to very carefully as he stated this was the only time he had come out to a patient. Furthermore, the patient had selected Joshua to talk to about these transgressive practices; Pryce (2001) found that patients visiting GUM clinics often felt relief in the telling of their story. Joshua recognised how vulnerable this young gay man was due to his

engagement in transgressive sexual practices, where he could be at risk of contracting sexually transmitted infections or homophobic violence. The nurse (Joshua) and patient clearly had experiences in common which helped them to form a therapeutic relationship. Unlike Justin, Joshua was able to assess the interaction and decide that coming out would enhance the advice he was offering the young patient, rather than disrupting their relationship. By doing this Joshua demonstrates his understanding emotional labour within nursing practice. He shows compassion and empathy toward the patient and draws upon his own emotional experience to offer advice. McQueen (2004) suggests that ‘The emotional work involved to achieve correspondence between the emotions experienced and behaviour demonstrated helps to give the behaviour authenticity’ (P104). Within this interaction, Joshua achieves ‘authenticity’ in his advice by disclosing his own gay sexuality and his own life story.

Following this interaction, Joshua is still left with the question many of the students posed: ‘In general terms, though, how does one approach outing themselves to patients? Is it easier just to lie?’. Suggesting, that for Joshua coming out to patients will occur infrequently, even within specific environments such as the GUM clinic. Instead, I suggest that he will assess the appropriateness of disclosing his sexuality, ensuring that both nurse and patient are at ease in the way this narrative demonstrates.

5.5 Conclusion

In this chapter I have explored how, within the material spaces in which nursing takes place, the closet takes many forms. Within the space of the hospital, I suggested the main stage of the ward compels nurses, both gay and straight, to ‘closet’ their ‘real’ or ‘private’ lives from the people they are caring for.

The management of the student’s sexuality was a negotiation of their private lives and their professional performance. With the potential for negative reactions to their

gayness, some of the students utilised strategies to gauge how acceptable disclosure would be. These included 'reading' the heteronormative discourses of the ward environment and moving between strategies of non-disclosure and disclosure to manage their sexuality. I have argued that when the students did discuss their sexuality within their clinical placements that they constructed their sexual identity in such a way that they made their gayness acceptable. The way in which they achieved this varied, for example Jake separated his private and professional life and when pressed to discuss his sexuality he offers a version of gayness based on monogamy and domesticity and he distances himself from the sexual act by refusing to enter into discussions which could contain sexual innuendo or banter. Trey constructed an identity where he could avoid questions about his sexuality unless pressed, he did not draw attention to his sexuality, he just wanted to 'carry on with life', and his overwhelming desire was to be seen as 'normal'. However, as demonstrated by Joshua's story, employing strategies of non-disclosure of sexuality can lead to being outed and possibly be disastrous. Where the students were open about their sexuality this was very complex and in one case led to an incident of homophobic abuse.

Negotiating therapeutic relationships with patients appeared to be deeply problematic for the gay students whether they disclosed their sexuality or not. I found that many of the students employed very specific covering strategies when building therapeutic relationships with patients which included avoiding difficult questions about the marital status and attempting to pass as straight. I argued that within the context of nursing and the expectations of professional practice that the students are novices and that they are keen to abide by the rules and social conventions of the profession which they are trying to navigate, learn and negotiate at the same time as their sexuality.

Within the student's stories of life on the ward I did find one example where a student purposefully came out to a patient. The student selected the patient to disclose his sexuality to very carefully and only did so as the patient clearly had experiences in common which helped them to form a beneficial relationship. Within this interaction Joshua demonstrated his understanding emotional labour within nursing practice, as well as compassion and empathy. I argue that this is a very considered and strategic deployment of the student's sexuality that can only occur in very exceptional circumstances.

In the next chapter I explore how the students negotiated their sexuality in the space of the university, where fifty percent of their learning takes place within nursing degrees.

Chapter 6: The Experience of Being a Gay Student Nurse: University Life

6.1 Introduction

In the previous chapter I explored the ways in which my research participants negotiated their sexuality within the space of their clinical placements. This is a ‘companion’ chapter in which I draw upon similar theories (i.e. binary notions of the private/public and the professional/personal, Goffman’s notion of performance and Rubin’s theory of the charmed circle) to explore how they negotiated their sexuality within the space of the university.

For many gay people, moving to university can be constructed as an opportunity for self-exploration and a time to ‘be themselves’ (Valentine, Wood and Plummer 2009, P1) since institutions of higher education may be perceived to be more liberal and accepting spaces of gay sexuality than general society (Taulke-Johnson 2010, Epstein, O’Flynn and Telford 2003). However, I argue that for these nursing students a number of factors influence and shape their performance of sexuality in university spaces. Also, although university space is viewed differently from the clinical space of the hospital, I argue that in both environments there exists a tension between the professional and public performance of sexual identity.

Nevertheless, I need to emphasise that a number of factors do differentiate the university environment from that of the clinical placement, and that therefore the gay nursing students’ experiences will inevitably be different in this environment. Additionally, it would be easy to assume that gay students’ experiences of university life are universal. In this chapter I explore how, for these gay nursing students, issues of professional conduct and the continued isolation of nursing students from other parts of the university influence the students’ levels of disclosure and university life more generally.

This chapter is subdivided into three main sections:

1. **University Performances:** I explore how these nursing students negotiated their performance of gay sexuality within the space of the university. I interrogate the three strategies these students employed, namely non-disclosure, universal disclosure and selective disclosure (the latter being the most utilised). I suggest that disclosure of gay sexuality is more easily achieved within the more liberal space of the university than in clinical placement.
2. **University Life:** I explore how and why the students I interviewed engaged / did not engage in wider university life outside of their course. For example, I examine their use or non-use of social spaces such as the students union, and of university services such as student counselling.
3. **Gay Sexuality and Nursing Curricula:** I argue that issues of LGBT health should be more visible within nurse teaching, and that LGBT students should not have to challenge heteronormative assumptions within nursing curricula.

6.2 University Performances

I have previously explored how the clinical spaces of the hospital are very specific, in that hospitals are organised in specific physical spaces of care (accident and emergency, intensive care and general wards), and how the performances of patients, relatives and healthcare professionals are all shaped by the physical and social space of the hospital. Furthermore, these performances are regulated by the rules that govern the social organisation of these spaces. However, the physical and social space of the university is very different to that of the hospital, and includes spaces for formal learning (e.g. lecture theatres, classrooms), informal learning (study spaces, libraries) and socialisation (cafeterias, bars). Hospitals do contain spaces for learning and socialisation during shift breaks, however for students undertaking clinical placement, the emphasis of their work is the clinical care of patients, whereas time in university is spent in learning environments.

In Chapter 5 I explored how all but one of my research participants adopted an initial stance of non-disclosure of their sexuality within their clinical placement. I suggested a number of reasons for this, including the conservative nature of the nursing profession that requires a 'sterile' and non-sexual caricature of gay sexuality to be presented within the space of the ward. Conversely, the majority of these gay men openly disclosed their sexuality at university. This coming out most often took place at an early stage of their course, although one participant came out half way through and another who was in the second year of his nursing degree was not out at all at the time of interview.

The level of disclosure (of sexuality) at university falls into three distinct categories - non-disclosure, total disclosure and selective disclosure. As in their clinical placements, unless students were pressed or questioned directly about their sexuality, they initially adopted a stance of non-disclosure at university. I have previously explored how Trey was reticent to disclose his sexuality within his clinical placements, and how he demonstrated an ambiguous (and perhaps never truly achievable) desire where he appears to want acceptance within heterosexual society. To achieve such an aim and to present himself as 'ordinary' within a society dominated by heterosexuality, Trey conceals his gayness. Seeking acceptance but not being open about his sexuality was also evident in Trey's university experience, as he demonstrated when recalling some of the conversations that take place in university break times:

Erm, (long silence), if everyone is talking about boyfriends or something I'll talk about, erm, well I don't know really. I don't really join into it. I don't really have a boyfriend myself so I don't really talk about that stuff at all, I just try and join in whatever people talk about really. (Trey)

Trey also states he is not open about his sexuality to the academic staff:

Yeah we have a good relationship (with his personal tutor). I haven't had my personal tutor for long, my first one retired, but I don't think it would be an issue. I wasn't out to my other personal tutor, there was no need. (Trey)

Unlike other students I interviewed, there was no difference in how Trey's performance of his sexuality in the space of his hospital placement and the space of the university. His desire to 'not make a whole big fuss of it' and to 'just carry on with my life' appears to span these spaces, despite other students' descriptions of university being more liberal and accepting, leading them to come out (Taulke-Johnson 2010), Trey chooses to stay closeted. While Trey wants to be seen as ordinary, the above interview extract shows he finds everyday conversations difficult to manage when subjects which could reveal his sexuality are discussed, specifically in this example the topic of boyfriends. Additionally, he does not see any benefit in discussing his sexuality with academic staff. While this stance is understandable since academic staff are in positions of power (e.g. marking coursework), Trey is unable to be any more explicit about why he has not disclosed his sexuality to his personal tutor other than in his opinion 'there was no need' (to come out).

Trey's perception of how he is viewed as a gay man in his placements, university life and in society generally appears to be universal for him. Trey talks about his sexuality in a way that indicates he perceives his sexuality to be within Rubin's (1984) charmed circle of acceptance. However, his actual performance of sexuality within the spaces of clinical placement and university suggest that there is a difference between how he constructs the back performance (Goffman 1959) and how he enacts this as a front (public) performance. While Trey perceives or wants to be accepted he continues to conceal his sexuality, even within the university, which, it has been suggested, is a more liberal space than clinical practice.

The second position in the performance of sexuality was to be out to everybody, including other students and academic staff. Only one participant (Justin) disclosed his sexuality universally at university, and it is not surprising that he also adopted a similar performance during his clinical placement where he was 'out'. In Chapter 5 I discussed how Justin was confident about disclosing his sexuality within his clinical placement areas, and how he had discussed the issues he faced with his personal

tutor during his clinical placement because of his sexuality. Within the space of the ward he appeared unable to understand or unwilling to abide by the social and professional conventions or 'rules' that the nursing profession and general society expect of a nurse. Justin demonstrates a similar approach within the space of the university, describing himself and his portrayal of his sexuality as 'in your face':

Me: OK being a gay man, well, being a gay student nurse at university, how do you find that? What's it like to be a gay student nurse?

Justin: Most female nurses love you (both laugh). I've got lots of female friends, I wish I had a bit more male nurse friends, they all, erm, seem to be straight, all the other men are a bit (pause) afraid of me (pause) maybe be because I am so loud or something, I can be quite camp and in your face sometimes I guess.

Me: Why is that?

Justin: Because it's so obvious or as my partner says 'not all people are as liberated as you my dear' (both laugh).

Me: But in terms of the female students you have lots of friends and they are all very accepting?

Justin: They've all been very accepting, there will always be one or two cows though, oh sorry!

By his own admission, Justin's behaviour is somewhat 'camp', and indeed while interviewing him I found him to be a very effeminate gay man. For example, he adopted behaviours that western society generally attributes to females (Ekert et al. 2002), such as a high-pitched voice and using exaggerated gestures to enunciate what he was saying. Additionally, he used words such as 'dear', and he drew upon gay stereotypes (e.g. 'most female nurses love you'). Justin's campness makes his gayness visible, being a deliberate masquerade of 'self-conscious homosexual discourse' (Mizejewski 1999, P238) which problematizes assumptions of space being supposedly 'naturally' straight (Bondi and Davidson 2004). The disruption of university space in this way is problematic, for even though it may be more liberal the conventions of social behaviour nevertheless still apply to this space – as they would in any other straight social space. While Justin seems content with his performance of sexuality, his campness overtly disrupts straight space and threatens

conceptions of hegemonic masculinity. This may be a reason for his lack of straight male friends, and why everyone does not accept him in his university group ('there will always be one or two cows'). The disruption of straight space by Justin's camp mannerisms is problematic within a patriarchal society where women and female characteristics are considered less valuable than the characteristics of men. Justin, by performing a version of masculinity that encompasses female characteristics, becomes a threat to men who wish to display hegemonic versions of masculinity.

While Justin's position of universal disclosure of his sexuality reflects a more liberal acceptance of gay sexuality within society more generally and a position that many gay men aspire to, his inability to recognise social and professional boundaries appears to limit his social interaction within the university space. As discussed in Chapter 5, his 'in your face' approach to the disclosure of sexuality was problematic in his placement (he was asked not to 'expose personal preferences to the patients'), and this also appears true even within the more liberal and social space of the university. Justin's performance of his sexuality and his own perception of his sexuality, his front and back performance (Goffman 1959) are identical and it appears unchanging no matter what kind of social or professional space he is within. While Justin may see his sexuality as acceptable and within the charmed circle (Rubin 1984), his 'in your face' approach means that the people he is interacting with may find his style of sexuality unacceptable and outside of the charmed circle. What is interesting in Justin's performance of sexuality is that while gay sexuality may be acceptable and within the charmed circle, only certain forms of a 'gay performance' may be included within the circle. One reason for Justin's performance not being as acceptable as other performances of gay sexuality may be that his performance threatens not only masculinity, but heterosexuality more generally. Specifically, his performance of his sexuality is not one that attempts to mimic or copy heterosexual performances of sexuality and the normative expectations of gender, but instead is a performance that threatens and disrupts these notions.

The majority of the students I interviewed adopted the third position: selective disclosure of their sexuality. First I present three narratives from my research interviews to demonstrate the students' similar positions regarding their disclosure of sexuality. Second, I offer an analysis of this strategy of coming out, drawing on Rubin's theory of the charmed circle and Butler's 'divine power of naming'.

I'm out to all of my university friends: I came out quite early on, as one of the young ladies was taking an interest and I thought it unfair. Most of the academic staff know, primarily for two reasons. First, most of my assignments do have a gay slant to them, for example the ethics of HIV pre-test counselling, or gay men's healthcare access issues, to name just two! Secondly, I lost an ex-partner to small cell lung cancer in January, so needed a week off: my friends informed lecturers, as my personal tutor didn't, as she didn't feel comfortable revealing my sexual orientation. All bar one of my friends are female, and of a cohort of 120, there are only three men remaining, and the other guy is children's branch, so we don't really mix. By now most of the students know I'm gay, but that doesn't bother me, there was bound to be a bit of gossip! (Joshua)

Within his clinical placements Joshua had been guarded about disclosing his sexuality and had utilised specific strategies for assessing the potential effect of coming out on each new placement. However, within the more liberal space of the university he felt able to disclose his sexuality to his close friends at an early stage of the course.

Mike offers a similar account relating to his university experience:

I have never had a hard time, there are 100 in my [university] group (cohort/intake), and I'd say at least 85 of them assumed I was gay. I haven't told the whole group that I'm gay, just the people I hang around with, but others assume. I've never had a hard time, never had any attitude, never a word said to me. Christ it was only last week one of the girls apologised for saying I was gay, I said it made no difference to me, at least 85 of them thought I was gay anyway! (Mike)

Mike had also been reticent to disclose his sexuality while in clinical placements and had employed 'covering' strategies (such as talking about his now grown-up children) to conceal his sexuality. Within the university he has disclosed his sexuality to his close friends, and other students within the university nursing

cohort/intake have assumed that he is gay. Mike identified some character traits that may have led people to infer that he is gay:

My mannerisms, my voice, my appearance, I'm always clean, tidy, always took pride in my appearance, until I lost my hair! (Laughs) And that's the reason why (people assume he is gay). (Mike)

Like Justin, when I interviewed Mike I thought him somewhat effeminate, a view the above narrative indicates he shares about himself. However, Mike's front performance of himself is vastly different to Justin's 'in your face' campness. He presents himself in what I thought was a gentle manner, and he does not use camp or stereotypical language. Unlike Justin, Mike appears to recognise 'straight' social conventions and expectations about how to present himself in social situations. While he is 'out' to a number of students within his course, he nevertheless appears to conform to normative social discourses, and by abiding by these he gains acceptance within his peer group as a gay man.

Epstein and Johnson (1998) explore how gay male identities are split into two categories: those that are acceptable and those that are unacceptable. The 'good gay' and the 'bad gay' are related to:

...simple polarisations of good and bad: the exemplary versus the deviant; the socially central versus the marginal' (Epstein and Johnson 1998, P23)

Furthermore they go on to suggest that:

Sexual identities take the weight of these pressures in a particular way, partly because invisibility is an available strategy, partly because sexuality, in contemporary discourse, is seen to go to the heart of personal identity. (P24)

The level of acceptance may be based on whether one adopts the position of the 'good homosexual' who behaves 'with as much conformity to, and with as little

disturbance of, the central categories as possible', or the 'bad homosexual' who 'is politically active and culturally assertive' (Epstein and Johnson 1998, P23).

At the time Epstein and Johnson suggested this idea, there was considerable political discussion about gay sexuality in the UK. Additionally, the early 1990's saw the emergence of a political movement known as OutRage¹⁸ that campaigned for gay rights using non-violent direct action. This movement was 'in your face' and represented 'the sickeningly up front (gay) sexuality of the United States' (Epstein and Johnson 1998, P26). The direct nature of OutRage's campaign, which included protesters invading the BBC newscast and abseiling into the London Parliament, was perceived as unacceptable by the media and possibly wider society.

Although such radical political movements are now able to engage in mainstream politics, the notion of good gays and bad gays continues to exist. Good gays conform to the 'normative constructions of responsible and respectable sexual citizenship' (Richardson and Munro 2012, P83) - for example, civil partnership and monogamy. Conversely, bad gays 'camp it up' and immerse themselves in gay culture, which may include transgressive practices including promiscuity, unsafe sex and sex in public spaces. Thus, Peter Tatchell as the leader of OutRage was labelled as a bad gay by the media at that time. However the notion of the good gay and bad gay is related to the attitudes of society at the time. Now, sixteen years later societal attitudes have changed and the polarisation of good and bad has shifted somewhat left, in fact Peter Tatchell could now be described as a good gay, accepted for his campaigning of human rights, running his own charity and described by the *Independent on Sunday* as: "One of the most influential gay men of this century"¹⁹.

In the space of the university, normative social constructions of sexual identity continue to be dominant discourses. They position Justin as a bad gay because he is

¹⁸ 'OutRage! is a broad based group of queers committed to radical, non-violent direct action and civil disobedience to: ASSERT the dignity and human rights of queers; FIGHT homophobia, discrimination and violence directed against us; AFFIRM our right to sexual freedom, choice and self-determination.
<http://rosecottage.me.uk/OutRage-archives/>

¹⁹ <http://www.petertatchell.net/about.htm>

effeminate, camp and 'in your face', and Mike as a good gay who although possessing some effeminate traits does conform to what is decreed socially acceptable behaviour. By socially acceptable, I mean behaviour, which society endorses as standard and that can be performed in mainstream society. The consequences of being a good or bad gay for these two students are significant: the bad gay, Justin, is accepted by his immediate student friends, but not by the whole of his university group. Conversely, the good gay Mike does appear to be universally accepted: 'I've never had a hard time, never had any attitude, never a word said to me'. Interestingly, this notion of good and bad gays was not restricted to straight students' views of gay students. By chance I interviewed a gay student who was in the same group as Justin, and he clearly wanted to distance himself from Justin's 'camp', stereotypical image of gay identity to preserve his own more acceptable 'good gay' identity:

All my university friends are girls. There are a few men in my year, but I don't tend to talk to them much. One of them is gay, but he is just too loud and a bit rude, I don't get on with him and steer clear if he's around. (I will not attribute this to the student concerned to ensure confidentiality as the students were in the same year/group)

Jonah tells a similar story to the quote above about coming out at university, although he did not accept his sexuality and come out in either his personal or university life until the second year of his degree:

I had a good group of friends, as you do on any sort of course, especially something like nursing, you're working closely with people and you're learning to do a lot of things and for a lot of us it's the first time, you see a lot of things you got to do in nursing and you do get close to people, there are times you need your friends. They were pretty much all girls, all roughly my own age. And so when I was coming out it was ok, I think, I told couple of people I was close to on my course. It's just the way it happened. (Jonah)

In Chapter 5 I explored how the majority of the gay student nurses I interviewed located their sexuality within the private sphere of their lives while working in their clinical placement areas, and were reluctant to come out to colleagues or patients in these settings. Within the space of the hospital, maintaining the privacy of their

sexuality was at times difficult, and by employing covering strategies or ensuring that their gayness was performed in professionally and socially acceptable ways, they invested much work and commitment to non-disclose. However, within the space of the university some of the students have become far less concerned with maintaining such regimented divisions between the public and private. Indeed, the majority of them were out at university. I suggest there are three reasons for this change in position. First, the relationships that are formed at university are more enduring than in clinical placements. The placement is a transient experience of typically between two and eight-weeks duration, and the student may not re-visit the placement area again during their degree. However, the students spend three years at university undertaking their degree. Therefore, they may invest more time, effort, energy and more of their personal or private selves in these relationships.

Second, university consists of both formal learning space and social space, whereas the clinical placement has far fewer social spaces that are used only for short periods of time. Coming out in a space that is social in nature, where everyday conversations take place and where there is time to relax, may be more conducive to a public performance of gay identity. For example social spaces are often places that individuals choose to interact in and an individual may choose social spaces that offer a certain amount of safety or acceptance. Within social spaces such as the university, individuals will also choose whom to socialise with within their peer group. Within the work environment there is little choice about whom an individual will socialise with during break-times or communicate with during working hours, which may make coming out difficult and less safe. As Ward and Winstanley (2005) point out, there is often dissonance between the social identity and work identity of lesbian and gay people.

Third, university space may be more liberal than other spaces (Taulke-Johnson 2010), although as noted by Epstein, O'Flynn and Telford (2003) it may also be a place where 'the attainment of formal adulthood carries with it expectations of

impending 'settling down' redolent of the heterosexual imperative' (P149). In Chapter 5 I suggested that within the professional spaces of the hospital ward and clinic, gay sexuality was on the outside or towards the edge of Rubin's (1984) charmed circle. Furthermore, for some students sexuality was an entity that moved in and out of the charmed circle depending on the time, space and place of specific clinical experiences. I suggest that at university gay sexuality is located within the charmed circle. Without the constraints of expectations of professional social etiquette that are apparent within clinical practice, gay sexuality becomes more acceptable at university – as evidenced by the gay students I interviewed feeling more able to disclose their sexuality there.

There is however a contradiction in the way some of these students present themselves within clinical practice, disclosing their sexuality after some time and negotiation, if at all and the university where many of the students disclosed their sexuality to friends and in some cases colleagues. Within clinical practice, the same sets of students from university will be present in the same or nearby clinical areas; therefore the students risk being 'outed' while in their clinical placement. While the students were unable to explain this contradiction, I suggest that what is at risk in clinical practice, the signing of competencies to complete the course, competes with the risk of being outed and the risk of coming out and the student privileges the relationship with their mentor (which I previously identified as a pivotal relationship, as demonstrated by Melia's 1984 study) over the desire to be open about their sexuality and the risk of university friends or peers outing them. Further pressure, in the form of nursing's professional boundaries and expectations is present in the students' clinical placement, reinforcing the need for the student to hide their sexuality as I explored in the previous chapter.

The shift from the outer edge towards the centre of the charmed circle and acceptability within the university may be attributable to the liberal environment of university space. Liberal attitudes towards gay sexuality are easily identifiable in

many large UK universities as they support student gay societies, participate in Stonewall's *Workplace Equality Index*²⁰ and have developed key policies addressing student dignity and equality.

While the majority of the students chose to come out to their close university friends, other students on their courses also knew about their gay sexuality. All but one of the students I interviewed stated that their gay sexuality had been disclosed outside of their close friendship circles, and attributed this to 'gossip', 'rumour' or assumptions. Within some of the students' stories of clinical placements the issue of 'naming' (Butler 1997), where a person is named or labelled as lesbian or gay due to assumptions or stereotypes, was a prevalent issue, despite them not formally coming out in their placement. This institutional phenomenon also occurs within the university, and can also be magnified. Within clinical placements (Chapter 5) I discussed how small teams of people may name the student as lesbian or gay, within the university it may be a whole cohort of students while in Mike's case it was 85 students and 120 in Joshua's case. The practice of naming someone as lesbian or gay within the university may occur for two reasons. First, the university is an institution like any other and students adopt institutional behaviours in a similar way to within a workplace or a ward. Second, over the period of the course, even large groups of students will become at least familiar with each other. Moreover, the university is also a social institution, and so during break periods there is time for social discussion where 'naming' may take place on a large scale. Having discussed how the students negotiated their sexuality (and specifically coming out) in university space, the next section of this chapter will explore how they participated in university life.

²⁰ Stonewall's 2012 Workplace Equality Index included five universities in the top 100 employers, with only one of these being based in London. http://www.stonewall.org.uk/at_work/stonewall_top_100_employers/default.asp.

6.3 University Life

University structures such as the students' union are central to many students' experience of university life. However, Epstein, O'Flynn and Telford (2003) found that many gay university students used the local gay scene as their major source of socialisation. Subsequently, the university students in Taulke-Johnson's (2010) study regularly utilised the students' union, despite the space at times being a site of traditional hegemonic masculinity. Gay students' increased use of university social spaces such as the students' union may indicate a further shift in liberal attitudes towards gay sexuality within university during this period of time. Furthermore, one of Taulke-Johnson's students stated that he felt safer on the university campus than in the social spaces outside the institution – even to the extent that he felt comfortable holding hands with his boyfriend on campus. However, there are demographic differences between the students in these two studies and the nursing students I interviewed. The most prevalent difference is age. Telford's (in Epstein et al. 2003) and Taulke-Johnson's students were traditional students who had recently completed their A-levels and started university as the next stage of their education. As I discussed in Chapter 3, my participants were mature students who entered the university through non-traditional routes.

Traditional university students such as those in Telford's and Taulke-Johnson's studies leave home at the age of eighteen to commence university and gay students often move to a new geographical area, for example with a larger gay scene as in Telford's research, to explore their sexuality away from their family. The purpose of university life for these younger students is not only to achieve an educational qualification, but also to explore their gay social identity. Conversely, my participants entered the university specifically to become registered nurses and had already experienced leaving home, working in a variety of settings and for some, had come out to family. My participants, to varying degrees, already had established social and family networks when entering university and had already spent some time developing their gay social identity.

The students in my study did not use the university as a major source of social interaction outside of their course:

I don't socialise with students outside of university, I might not know all their names, but I do know their faces. We all get on in uni OK. No one ever asks if I'm gay now, but they have known me a year! (Mike)

It was, cos I was a mature student, my university experience was when I was 19, so the social life was different and the reason for being there was different...this time I really decided what I wanted to do and I was serious about my degree, I wasn't out mixing with the younger guys socialising cos I had been there and done that! (Jonah)

My participants had already developed their social networks before commencing their nursing degree, and many of them were in long-term partnerships. Therefore, they did not feel the need to extend their social networks. In some ways this made the management of their gay sexuality easier as the students tended not to form close friendships at university:

But they were fine (coming out to friends in university), I wasn't best friends with them, they were just friends from the course, so if they didn't like it (being gay) then that was fine, I wasn't going to break my heart over it. I was more worried about my close friends at home, it was quite safe coming out to people at university. They are all pretty level headed and non-judgemental, so it was fine. (Jonah)

In this narrative Jonah recalls his coming out experience at university as being 'safe' as he did not have social or family ties with his fellow students. Coming out in a social, rather than family space, made it easier for him because there was little to lose if the disclosure was reacted to badly as it was less threatening. Conversely, Jonah had never come out on his clinical placement because he did not think it was appropriate in his role as a nurse. One of the reasons he felt safe disclosing his sexuality at university was his impression that his fellow students were, in his words, 'non-judgemental'. A non-judgemental attitude is an expectation of any nurse made by the Nursing and Midwifery Council as part of The Code of Conduct (2008). However, as I discussed in Chapter 5, a non-judgemental attitude within the profession and by individuals cannot be relied upon (I offered the example of HIV and AIDS care), and I suggested that nursing remains a relatively conservative profession. Furthermore, while Jonah said that he was unconcerned with potentially losing university friendships by coming out ('I wasn't going to break my heart over

it'), Jonah had previously stated that friendship was important to him on his nursing course: 'you see a lot of things you got to do in nursing and you do get close to people, there are times you need your friends'. Additionally, his non-disclosure within clinical placement could not be assured as one of his fellow students may inadvertently 'out' him.

Although by coming out at university the students appear to relinquish part of the private/public divisions that clearly were highly important within their clinical placements, fundamental parts of their gay lives do remain private. For example, there is little discussion about partners, which is a topic that remains relatively private. The private/public division is made clear not only by the students' non-participation in the social life of the university, but also by the fact that only one of them had introduced his male partner to his student friends. The reason for this continued privacy around an issue that is fundamental to gay identities is unclear. It is unexpected as these gay men perceive university space and fellow students as liberal enough to disclose their sexuality, yet remain unwilling to share aspects of their private social gay lives. One reason for this discrepancy may be the mature nature of these students, they do not want to disrupt their normal social networks. Additionally, in a similar way to the use of private and public divisions in their clinical placements, the students may want to maintain a distance between their work as a nurse, university life and their private lives.

Although the space of the university can be seen as being more liberal for students generally and these students specifically (as indicated by them coming out), the conservative expectations of the nursing profession do penetrate this university space. The rules and regulations that enforce professional behaviour in clinical practice also penetrate university space, it is an expectation of all healthcare regulatory bodies²¹ that universities providing healthcare courses have fitness to practice processes similar to the regulator themselves, thereby ensuring that students are fit for nursing registration on the completion of their course. The Nursing and Midwifery Council published 'Guidance on professional conduct for nursing and midwifery students' in 2009, which is based on the code for registered nurses. One of

²¹ This includes the General Medical Council, The General Dental Council and Nursing and Midwifery Council, and the Health and Care Professions Council.

the key elements in this document is to ‘uphold the reputation of the profession’, not only within clinical placement areas, but also in all other areas of the student’s life. This requirement may place professional expectations of appropriate behaviour upon nursing students that students on other university courses may not have to consider. For example, being arrested for a minor drunken brawl outside a nightclub may have no consequences for a student studying English or history, but may involve a fitness to practice investigation for those studying healthcare, law, teaching etc.

A number of the students I interviewed talked about what they perceived as appropriate and non-appropriate topics for discussion related to their sexuality, both within clinical practice and university:

Drama queens, that’s what I find uncomfortable, over the top. They don’t care what people think of them and they are who they are. They are out to shock with their sexuality and can be quite crude sometimes. It’s not right on the wards or at university. You don’t have to be camp at work, you just need to be a nurse. (Mike)

Here Mike is referring to other students he has met while on his course, not specific students in his year. Like other students I have cited earlier, he considers ‘over the top’ behaviour as inappropriate for a nursing student. Although Mike is not explicit about conforming to the NMC guidance for students, he is clearly aware that the professional values and expectations that are present in clinical placements apply equally to the social situations of the university. Furthermore, Mike perceives university life as ‘work’ in the same way as he perceives the ‘shift-work’ of clinical placements as ‘work’. Thus, the expectations of professional behaviour apply equally to both settings, and possibly limit the liberal space of the university. The limitation of university liberal space and behaviour could be quite stark, for example while a student studying a non-vocational course such as English is bound by the regulations of the university, they do not have the regulations of a professional regulator to also abide by.

In addition to non-participation in university social life, few participants access student services such as counselling or personal tutors. Three of the students had disclosed their sexuality to their personal tutor. Justin did so when he sought help

with issues he faced on his first placement concerning his camp behaviour. Earlier in this chapter I related how Joshua had queered his coursework by tacking gay issues in it, and how he had requested time off due to his ex-partner's illness. Jonah met with his personal tutor for support when he came out in his personal life:

Well, she (the personal tutor) was supportive in that she didn't have a go at me about my late coursework! It wasn't important coursework, but I hadn't kept on top of it. She was brilliant, but I wasn't close to her, we saw her once a year, initially as a big group, but then we had her email and if we needed to contact her we could, but generally I didn't, I didn't need to. I got on with the coursework myself and she was there if she was needed. The gay thing, she was understanding and listened and just she said you know where I am if you need me. I saw her once or twice. I wasn't struggling with the coursework so I didn't need to see her after that.

Is there anything else you would have liked her to have done?

Erm, not really, with the gay issue? No she did all she could. I didn't ask her to do any more, she helped me with more time for that essay! I went to student counselling as well, it was free, so I thought it might be useful, but I only went once as I had it all sorted out already. (Jonah)

The three students who came out to their personal tutors had very specific reasons for doing so: problems in clinical placement, needing time off for a funeral and explaining late coursework due to the stress of coming out. As I mentioned earlier, personal tutors are in positions of power and so it may be understandable not to disclose gayness to them for fear of negative reactions. Coming out to a personal tutor only when there is a problem can be precarious though for as in Joshua's case, they may not have the knowledge, experience or confidence to take any appropriate action. This situation causes complications, since Joshua's fellow students had to explain why he was not attending university to other members of staff when his ex-partner died from small cell lung cancer.

Some of the students felt dislocated from the main university and the opportunities it offered. This arrangement is not uncommon for nursing students as often schools of nursing continue to reside in the original NHS-funded buildings they were established in, and these are typically some distance from the main university campus. Jake noted this separation when I asked if he was a member of the university gay society:

I don't know if there is a GaySoc in this university, there was one when I did law in Derby, but I never went along. The main part of the university is over there, look you can see it over the dual carriageway, (he points out of the classroom window where the interview is taking place and I can see the university logo above a large building) but we don't go over there! There isn't any need really and it's just too far in a lunch break. (Jake)

Joshua commented that his university was not known for being gay friendly:

I attend XXXX XXXXX University, and they are not really renowned for their track record on LGBT rights. There is no LGBT association, and although I don't think they could really ban such a society, I don't think anyone has the balls to set one up. (Joshua)

For another student the perception of support was also poor:

Do you think the university could do anything else to support you as a gay student?

Very hard erm (thinking about this question), I think a lot of what they do is like lip service, they say yes, yes, yes we offer you support I think it's quite...they would not want to go down that route really (use of a diversity policy). I'm not sure but I don't think they would encourage you to do it...unless that person was gay themselves, as in the personal tutor or counsellor. Heterosexual staff they try to be understanding, but once it becomes too messy or too much work they try to get out of it I think. (Justin)

Poor integration into mainstream university life may be an issue for many nursing students, and schools of nursing have for some time been attempting to improve this situation by ensuring course start dates coincide with fresher's events. The Equality Challenge Unit report (Valentine, Wood and Plummer, 2009) on the experience of university students suggested that LGBT students were able to find support at university, both from other LGBT students and from formal services offered by the institution. It is likely that the 2,704 students who responded to this survey were undertaking non-healthcare university courses, and so did not have to manage the above issues and complexities of working in clinical placement, the professional expectations of nursing, or being off-campus. The complexities of the course, placements and location may mean that LGBT nursing students find it more difficult to obtain adequate support at university. The final section of this chapter will examine the students' experiences of being taught about LGBT issues at university.

6.4 Gay Sexuality and the Nursing Curricula

The Nursing and Midwifery Council has recently introduced a new set of standards in the UK for universities to apply when designing nursing curricula, to be implemented by the end of 2013. A review of these standards reveals that while issues of equality and diversity are noted, the specific health needs of the LGBT population remain absent. This is a notable omission, as the UK Department of Health (Fish 2007) has recognised that LGBT people may be at higher risk of anxiety disorder, depression, more likely to smoke and use illegal substances, and are more likely to drink alcohol than the general population.

Within the UK there is limited literature specifically exploring nursing people from the LGBT community, although there is an increasing amount of attention being paid to the health of LGBT people, for example Wilton (2000), Fish (2007), Stonewall (2008b) and Stonewall (2012). Brennan et al. (2012) recognise an absence of specific LGBT content in nursing curricula. During the interviews I asked my research participants about LGBT issues in their course:

I think they (lectures) are quite all encompassing, they don't talk about gay men and lesbians specifically, but the answers the students give back to the lecturers when they are asking questions, when the teacher ask questions people are not ashamed to say same-sex parents or gays or lesbians.....I haven't felt that gays or lesbians have been left out there. (Justin)

As far as I know, it (gay health) is mentioned from an HIV/STI prevention angle in our health promotion module, but no further. Then again, most tutors are extremely reluctant to deal with any issues relating to sexuality, an attitude that I have observed on many occasions. (Joshua)

I don't think there's been anything specific, but I haven't felt uncomfortable at all talking about equality, I don't see it as a problem. I think we did have some sessions about equality and stuff and it's good that everyone has awareness about being non-judgemental and stuff, I don't think it's a cause for concern really. (Trey)

The responses from all the students about LGBT issues taught in the nursing curriculum indicate three main themes. First, within some schools of nursing there seems to be a palpable reluctance to clearly address issues of sexuality, whether these are related to LGBT people or not. Second, some student satisfaction that LGBT

issues are mentioned at all. Third, both LGBT and straight students appear to champion LGBT issues when they are not appropriately included in the curriculum as suggested within Justin’s narrative.

This situation is a problem for both LGBT students and straight nursing students, as such non-discussion means they may not be able to appropriately assess and manage the care of LGBT patients. Brennan et al. (2012) suggest that nurses should be equipped with the following skills and abilities to care for LGBT patients:

‘Skills to provide quality nursing care to the LGBTI community include the ability to perform developmental assessment, complete a comprehensive health history, and sexual history and physical assessment. Student nurses need to develop communication skills and, in many cases, increased comfort with interacting with patients or clients whose backgrounds, beliefs, and identities or orientations may be different from their own. Developing the ability to do sensitive psychological assessment is also necessary to screen for the variety of psychological stresses or diagnoses that may impact on an LGBT individual and family.’ (P102)

Table 2. presents Brennan et al.’s (2012) suggested LGBT content for modern nursing curricula. Without a formal LGBT component in nursing curricula, the health needs of this group will not be met in either the US or the UK. Since 2003 the Royal College of Nursing has published ‘The nursing care of lesbians and gay male patients or clients - guidance for nursing staff’. However, it is unsurprising that in a curriculum dominated by heteronormative assumptions of health and well-being, none of the students cited this document as a source of teaching. What may be specifically problematic for these gay male nursing students is the need to raise LGBT issues themselves in the lecture theatre or classroom. In challenging the ‘hidden curriculum’ of heteronormativity which includes ‘the attitudes, assumptions and

Table 2. Suggested LGBT Related Nursing Curricula Content:
Attitudes and beliefs:
Identification of own beliefs
Impact of attitudes
Knowledge:
Developmental issues (adolescence to aged)
Health promotion/disease prevention
Mental health
Care for transgender persons
Care for persons with disorders of sexual development
Barriers to healthcare
Legal issues
Policy issues
Brennan et al. (2012)

implicit knowledge of students, as well as those embedded in the taught curriculum, structures and practices of the university...which includes the presumption of normative versions of heterosexuality that pervade social life' Epstein, O'Flynn and Telford (2003) (P123), the student can be at risk of becoming unpopular. By challenging assumptions of heterosexuality within the nursing curricula the student risks being labelled as gay-friendly, and having suspicion cast on his or her own sexuality. They also risk being ascribed a 'bad gay' identity, as being someone who only ever talks about gay issues. This resonates with some of my own recent experiences since commencing this research. At times when I raise LGBT issues, or arrange a visit from an LGBT-oriented speaker from another school, I sometimes feel a sigh in the room which almost says: 'there he goes again!'

6.5 Conclusion

In this chapter I have explored the experiences of gay male undergraduate nursing students within the space of the university, and I have contrasted this with their experience of attending clinical placements in the space of the hospital (as was discussed in the previous chapter). What I argue in the first section of this chapter is that the disclosure of sexuality in the university is as complex as in clinical practice for these student nurses and that this complexity is riddled with contradictions. While the students do see university as being a more liberal space to disclose their sexuality, this disclosure remains selective for all but one of the students. One student is not out at university or in clinical practice. I argue that the negotiation of the student's sexuality in the university remains reliant on the student's notions of the public and private, although some of the students have become far less concerned with maintaining the regimented divisions between the public and private that they adopted in their clinical placements. Although physically away from the demands of clinical practice and the accepted social conventions and behaviours expected of a professional nurse, within the university space the gay student continues to employ boundaries which ensure their behaviour is acceptable. While the students shift the balance of public and private lives by coming out, they remain reticent to involve university friends in their everyday lives.

Furthermore, I argue that in the university normative social constructions of sexual identity continue to be part of the complexity of negotiating sexuality, with one student being seen as a bad gay because he is effeminate, camp and 'in your face', and another as a good gay who conforms to what expected as socially acceptable behaviour. The consequences of being a good or bad gay are significant: the bad gay is not accepted by many of his peers and the good gay appears to be accepted. Furthermore I argue that this complex social discourse of acceptance and non-acceptance is not particularly based on notions of heteronormativity as one gay student clearly wanted to distance himself from the 'camp' student to preserve his own 'good gay' identity.

Further complexity is seen in the student's negotiation of university life when ease of coming out to fellow students is contrasted with a reticence to disclose their gayness to academic staff or to utilise wider university resources. I argue that poor integration into mainstream university life coupled with a lack of LGBT visibility within the nursing curricular and nursing more generally contributes to the student's decisions of disclosure and non-disclosure of their sexuality.

Considering that all of the universities these students attended had in place either equality and diversity policies or specific LGBT inclusivity policies, it is surprising that these gay nursing students has so little awareness of or interaction with wider university life. A number of the students also attended universities that received Stonewall's equality index award, which is given to institutions, which demonstrate 'gay friendly'²² workplaces.

In the next chapter I examine the students' experiences of being gay men and carers within the female-dominated context of nursing. I explore the use of 'self' within the students work as nurses and how they negotiate issues of the body as men and gay nurses.

²² http://www.stonewall.org.uk/at_work/stonewall_top_100_employers/default.asp?fontsize=large. Accessed: 10th April 2014.

Chapter 7: Gayness, Masculinity and the Performance of Nursing

7.1 Introduction

In the previous two chapters I have explored the ways in which my research participants have negotiated their sexuality within the spaces of their clinical placements and the university. In the previous chapters I have addressed the ways in which these gay students have managed their sexuality through the process of coming out (or not) and by exploring the private and public lives of the students' and I have argued that the negotiation of sexuality is a complex and contradictory process for each of the students. What I have not so far explored in any depth are specific issues of how these students constitute themselves as nurses and providers of care. Specifically in this final data chapter I explore the students' perceptions of the 'self' and how they suggested that their 'gay-self' contributed to their nursing practice in a number of ways: the student's notions of caring and nurturing as gay men; the experience of coming out and how this contributes to their understanding of patient experiences and issues of caring for the body.

I explored in Chapter's 2 and 4 how nursing practices are inherently gendered and feminised. The literature exploring the performance of men as nurses is sparse, but suggests that male nurses use their masculinity to distance themselves from feminine forms of caring, in their performance of nursing (Patterson 1986) and, in doing so, male nurses re-produce gender essentialising identities, which further perpetuate nursing stereotypes. In contrast, I argue that gay men negotiate their performance in a way that mobilises both masculine and feminine attributes. Furthermore, in negotiating their performances the gay men I interviewed drew upon their personal experience of coming out and being different to inform their performance of nursing. However, the gay students performance of nursing poses specific problems, relating for example to notions of chaperoning and self-protection from allegations of inappropriate behaviour. These negotiations are made problematic due to heterosexist attitudes and a lack of appropriate attention to heterosexism within the profession. The problems that men in nursing negotiate due to the gender imbalance are the same for all male nurses irrespective of sexuality. However, what is different

for these gay men is the process of negotiation that takes place specifically around issues of sexuality.

7.2 'The Self' - Being Gay, Being a Nurse

The performance of nursing care by male nurses is influenced by a number of very specific categorisations which male nurses learn to negotiate, manipulate and ultimately hone to produce a performance that is believable and acceptable in relation to professional boundaries and the expectations of the profession. In achieving a credible performance as a nurse he is therefore able to integrate into the feminized profession of nursing. The categories the male nurse must negotiate are the discourses of masculinity, stereotyped sexualities and the prejudices contained in the area of practice the male nurse chooses to work within. These particular categories have to be negotiated in order for male nurses to distance themselves from the way that nursing is constructed as a feminized profession; otherwise the construction of their identity will be problematic, in a similar way to the problematic construction of women as nurses. For example, Holyoake (2001) in his ethnography of a mental health unit identified clearly that masculinity within that setting was based upon heterosexual assumptions and enacted in ways that reflected Connell's (2005) notions of hegemonic masculinity. These categories ultimately construct the male nurse's identity of himself, Goffman's front stage performance. Furthermore, Holyoake (2001) suggests that the 'soft masculinity' demonstrated by male nurses is part of a constructed identity: 'that is, male nurses have a sense of self and, therefore, present the image they wish to portray to others. This image is fashioned within nursing culture and experiences encountered in clinical practice' (Holyoake 2001, P34).

The gay male nurses I interviewed discussed how knowledge of the 'self' and their sexuality, underpinned their ideas of caring. This is a difficult notion to unpick, as it is indeed stereotypical in its origins. Images of 'the caring gay man' come to mind, an idea that is linked to the stereotypes of femininity and discourses of caring as women's work, constructed through essentialising gender identities. However, all except one of the gay men I interviewed talked openly about their motivation to

become a nurse and their idea of being ‘caring’. Here, Joshua makes clear reference to his choice of career and his personal ideology and sense of himself:

After thinking about what I am good at and what I wanted to really do, I decided it was to take care of people (Joshua)

For Joshua his career choice was dependent upon his self-perceived ability to be caring and care for others. For Joshua his new career as a student nurse was a marked change from his former career as a bank manager, a role traditionally seen as a ‘masculine role’. Justin talks of similar notions of caring and makes a broader statement about his sexuality and the idea of caring, for him caring and his perception of himself and others is part of being a gay man:

Well some gay men are caring...I wouldn’t say all gay men, but some gay men, especially if they go into nursing, I would say 95% of them are genuinely caring I think (Justin)

For these gay men, their performance is a self-identified notion of caring, in its broadest sense. This may be part of the stereotype that exists about gay men and men in feminised professions (Harding 2007), however it remains part of their story and an underpinning category in the negotiation of their performance as nurses. While stereotypes of femininity and caring can be seen as negative portrayals of gay sexuality, for these men it was clearly a positive attribute, so much so that it influenced their career choice. The construction of their caring identities, ‘the self’, is distinct from heterosexual, masculinised identities of straight male nurses which the straight male nurses in Harding’s (2007) study developed in order to not to be constructed as gay.

Gay men constructing themselves in this way can therefore make the front stage or substantive performance more believable for all involved by reinforcing the ‘gay male nurse’ stereotype. Justin goes on to identify what he thinks public perceptions of male nurses are:

Erm, I erm, you would think (pause) are probably gay and kind and caring’ (Justin)

The discourse stereotyping male nurses as gay is described by many authors in a variety of cultural contexts (for example, Bohan 1997, Isaacs and Poole 1996, Meadus 2000, Williams 1995). According to Salvage (1985, P24), 'there does appear to be a higher proportion of gay men in nursing than in the male population at large, although of course there are no figures to prove it'. This stereotyped discourse reflects Justin's assertion that the public assumption is that male nurses are gay. This can be of benefit to gay male nurses who are constructing their identity as nurses, as this form of identity, as suggested by Holyoake (2007) conforms to notions of soft masculinity and reinforces the feminised (and more acceptable) notion of nursing as women's work. As female nurses often themselves portray nursing work as mothering, nurturing and caring (Poole and Isaacs 1997) a gay male nurse portraying this type of 'soft masculinity' in the profession of nursing may be more acceptable than other, more masculine images that heterosexual male nurses may portray. However, as I explored in Chapter 2, the portrayal of nursing work as mothering, nurturing and caring is based upon gender essentialising identities that are problematic, as not all women really possess these qualities and many men do. Furthermore, gender essentialism reinforces women's powerless position in relation to men. So the discourse of stereotyping gay men as caring (as well as effeminate) further affirms women's (and nurses' and gay male nurses) subordinate position within patriarchal society. Later in this chapter I explore how the gay men I interviewed had a sense of 'self' as a gay man which they felt contributed to their role as carers and in this discussion I attempt to move away from the gendered and stereotypical notions of caring towards an understanding of personal narrative.

The phrase 'caring' used by the gay students represents themselves as feminine. O'Leary (2006) identifies in his study of male nurses that the language heterosexual male nurses use is deliberately masculine in origin and that they avoid language that may portray them as being anything less than heterosexual. For straight male nurses, the stereotype of the gay, caring, male nurse is something to avoid for fear of subjugating their heterosexual masculinity. Harding (2007) suggests that heterosexual male nurses will avoid contact with gay male nurses and overtly express their heterosexuality to avoid the stigmatising assumption that they are gay. This construction of gay men as effeminate further exacerbates the problematic way in

which nursing, nurses and women are constructed in feminised and gender essentialistic ways.

However, because the gay student nurses I interviewed use the word caring, it does not mean that they are caring or any more caring than any other nurse or healthcare professional. However, their self-concept is a notion of being caring and they are clearly able to clearly articulate this without fear of stigmatisation, unlike their heterosexual counterparts.

Later in the interview, Justin talks about the experience of coming out and how he sees this as a universal experience amongst gay men and that however supportive family or friends may be, the process of coming out is always one to be worked through (I explore this further in the following section 7.3). Corrigan et al. (2009) also identified the universality of the coming out experience when exploring stigmatisation, identifying clear costs and benefits during the coming out process.

Links between gay men, the coming out process and being seen as caring are not confined to my study or nursing. Dune's (2000) study of ninety gay fathers identified them as being more sensitive and caring than heterosexual men and Hayes (1989) identified that men who enter traditional female concentrated professions are 'sensitised' towards the profession due to their previous personal and educational experience. Hayes (1989) research identified that sensitisation was prevalent in nursing and social work as opposed to other female concentrated professions. While this work does not explore the role of sexuality in relation to sensitisation towards a professional pathway, it is possible that the experience of coming out could influence the perception of another's suffering – in the case of nursing, that of our patients.

7.3 The Use of the Self in Caring

The experience of coming out for lesbian and gay people is almost universal, the process may be more problematic for some, but it is an experience all lesbians and gay men undergo. Plummer (1995) asserts that coming out narratives play a significant role in gay and lesbian histories and in the lives of many gays and lesbians. Furthermore, Savin-Williams (2005) recognises the changing attitudes of

society, identifying that the difficulty of coming out for young gays and lesbians has decreased with every decade. For those of us from previous generations, the experience of today's LGBT youth is almost unimaginable.

Coming out features in the narratives of the gay student nurses in a number of ways, as one would expect. One focus of their stories shows that the coming out experience for these students relates directly to their experience as nurses, the performance they engender and their practice of masculinity as nurses.

Here, Justin considers the life experience of gay men to be a powerful influence in his negotiation and performance of care:

Errr....I dunno....eeem, if I would say that both gay men and heterosexual men just one and both of them are very caring then what a gay man can give a bit more of is maybe understanding to a patient who is going through a crisis or cancer or something because gay men have gone through coming out, being gay at school errm so coming out on the one hand I think we have a bit more to give, a bit more understanding to give our patients.
(Justin)

During the interview Justin disclosed that he attended an all boys boarding school and that he came out at an early age (around 14) at school and to his parents. In his description of his experience he alluded to the difficulties he encountered and clearly the coming out experience was significant for him. For Justin his self-identification as a gay man and his experience of coming out is pivotal to his approach to care as it was for a number of the students:

You do see quite a lot of negativity towards patients, not while they [nurses] are with them, but in the staff room or office, 'oh that patient blah, blah, blah'. I think people can be quite judgemental about who they have looked after. I don't think it's possible to not judge at some point, you know, but I don't think you should let it affect what you do in your care. I think being gay helps me to be less judgemental, coming out is hard and some people make it even more difficult because of their attitudes.
(Trey)

Yeah, I think you have to be compassionate, you have to be as a nurse. And you have to be open minded, by default, gay men are,

because of what they stereotypically go through when coming out, they do have an open mind because they are exposed to things that a heterosexual might not be, you know. They are more aware of what else is out there because of their personal experiences, they are open minded, they are compassionate, well caring, more so I think. I try and take the time to understand and talk to my patients. You can't tar everyone with the same brush though! But the gay men I know tend to be less judgemental than other people. (Jake)

Griffith and Hebl (2002), recognise the significance of coming out as 'one of the toughest issues gay men face as it involves considerable emotional turmoil and fear of retaliation and rejection' (P1191). They proceed to identify that those gay men who do not come out report lower levels of psychological wellbeing and life satisfaction, which is a clear link between self-identity, coming out and personal well being.

Justin, Trey and Jake suggest that the emotional turmoil around coming out makes gay men more attuned and empathic with the situations some patients may face. While everyone has life experiences that will underpin their empathy with patients, this is very often limited to specific disease processes, for example: my friend/relative/I have cancer/diabetes, etc. I suggest for Justin and the other gay students I interviewed, there is a more global understanding of emotional turmoil due to the necessity of coming out, which can be repetitive at various points of a gay person's life, for example changing job and that this experience increases their spectrum of empathy.

Illness and especially chronic illness is not just about suffering, but as a number of researchers have shown (Bury 1982, Charmaz 2002, Williams 1984), illness can sometimes challenge the biographical sense of self and present the person with a chronic illness with issues of stigma. The challenging of ones sense of self and the association of stigma is similar to the experience of coming out, which as I cited earlier is one of the most significant experiences in the life's of LGB people. Bury (1982) describes the experience of people with rheumatoid arthritis and describes how the experience of chronic illness leads to a loss of confidence in the body and flowing from this a loss of confidence in social interaction or self-identity, which he calls 'biographical disruption' (P169). Furthermore he suggests that the meanings of chronic illness are also not just personal, but are also the product of shared

experiences with others, including the re-negotiation of relationships. Charmaz (2002) describes how people with chronic illness move through the process of biographical disruption:

‘When a story becomes tied to self, images of self and indications of moral status within it become defining. A revised self emerges as these new views supersede past, likely entrenched images.’ (Charmaz 2002, P314)

What I have identified here are clear parallels in the experience of living with illness/chronic illness and how these experiences contribute to the person experiencing a period of what Bury (1982) describes as biographical disruption. For the person coming out their sense of self changes as they experience life as a gay person and for the person, including the views of others around them and how relationships may change as the person expresses their sexuality openly. For the person with chronic illness their sense of self changes as they come to terms with the illness, the potential for disability and stigma and a revised self-image emerges. In a similar way to the gay person coming out, the process of biographical disruption does not occur in isolation or in realms of the private (see my discussion of the private in Chapter 5). Instead, the adaptive processes of living with a chronic illness occur in the realm of the public and are subject to the views and expectations of wider society.

The notions of compassion, caring and being non-judgemental, that the students attributed to the significance of the coming out experience is more complex than merely having more tolerant views generally. I argue that the students sense the similarities in the experience of illness and coming out, in that life, relationships and the sense of self is threatened (or as Bury 1982 suggested, disrupted), re-shaped and consequently a revised self (Charmaz 2002) emerges. For gay people the experience of coming out is repeated over time (in Chapter 4 I discussed the number of times I disclosed my sexuality and relationship status during my relatives hospital admission) and although subsequent experiences of coming out may not be as intense as the initial disclosure of ones sexuality to parents and family, the sense of oneself can still be threatened. So for the gay student nurse the experiences of coming out remain contemporary for them to draw upon when faced with caring for someone

who is suffering from ill health. Furthermore, in the performance of the nurses compassion the students mobilise forms of caring that are not traditionally attributed to men or male nurses, including offering space, understanding and time to talk.

7.4 Gay Men, Femininity and Masculinity in the Space of Caring

I have previously identified that the coming out experience for gay men is a shared experience that plays a large part in our personal histories and contributes significantly to our self-perception (See Chapter 5). Using Goffman's (1959) analogy of performance, it is clear that the coming out experience and the experience of being gay per-se will be a central part of the student's self-perception and influence the props and performance employed in every day life. The experience of coming out is so pervasive that it influences all aspects of our lives as gay men, both personal and professional (Van Laer 2011). For the gay male nurse, the coming out experience will be a clear influence upon their professional practise. How gay men manage and negotiate the performance of nursing and nursing care I propose is different to both female nurses and male heterosexual nurses.

The current discourse within nursing concerning femininity and masculinity focuses on a number of key elements, for example the gendered division of labour, the organisation of the NHS, the influence of gender identity within the profession (Davies 1995), poor representation of men within the profession (O'Lynn and Transbarger 2006, Stanley 2012), whilst men hold a disproportionate number of senior posts (Ford, Santry and Gainsbury 2010). For some time, the influence of gender within nursing and specifically the gendered differences in caring have been explored (Wingfield 2009, Brown 2009). Here the binary of feminine and masculine is divided into fairly stereotypical traits, female nurses being naturally caring, while male nurses, due to their hegemonic masculinity are not naturally caring. Of course the exploration of these notions is much more complex than this and I will explore them in some depth in the forthcoming discussion. However, what I argue is a third way of considering the gender binary in nursing, the idea of a different professional performance, where masculinity (in its traditional, if not hegemonic sense), is challenged by sexuality. This notion involves the gay male nurse crossing the traditional gender binaries and negotiating a unique professional performance,

formed through their experience of being a man, coming out and being gay and not based upon gender essentialising traits of 'natural' caring.

For the gay students in this study the feminine/masculine binary was a problematic issue. For some, issues of masculinity were key features of their professional lives that included their lack of status, money and leadership in comparison to their friends in other, more masculine occupations such as finance. For others heterosexual masculinity was deeply problematic in their professional relationships with other male nurses, being unable to find common ground for social discourse and thus undermining the development of their collegiate relationship.

Here Joshua comments specifically on his perception of heterosexual men in nursing:

Heterosexual men go into erm nursing, I would say so. But I haven't seen a lot, but what I have seen they seem to be quite, erm, ambitious in where they want to go. (Joshua)

Joshua is recognising the masculinity that male heterosexual nurses use to underpin their role and position as nurses. It is widely accepted that male nurses are promoted more readily than their female counterparts, although no studies so far have compared promotion of gay and heterosexual male nurses. Another participant recognises that the practice of masculinity by heterosexual nurses is not confined to the aspirations of promotion or social talk in the staff room, here Andrew recognises how masculine practices can divide the labour of caring:

Having observed other men on wards, it seems that they get allocated the more technical tasks: drug rounds, placing NG tubes, changing giving sets, putting a line in etc. Rather than the washing, feeding, mouth care etc. that the ladies seem quite content to get on with. (Andrew)

For male nurses it appears that masculinity is a set of practices that are clearly evident in their professional lives, in this case demonstrated by male nurses engaging in technological forms of nursing. This mirrors more general thinking on gender and technology where Bray (2007) suggests that gender is expressed in any society by technology and Lohan and Faulkner (2004) assert that: 'Since technology and gender are both socially constructed and socially pervasive, we can never fully understand

one without the other.’ (P319). It is accepted that gender is an enormous influence upon our personal and professional lives and for those in non-traditional gender dominant occupations, such as male nurses, this becomes magnified. Halford and Leonard (2002) recognise the influence of gender upon the performance of nursing identities, asserting that gendered nursing identities are constructed within the organisational space where nursing takes place and that this often leads to multiple professional performances that are formed through the power of the organisation in the organisation of the space, the place that nursing takes place (type of ward/hospital) and the nurse’s ability to move between multiple spaces. All the men in this study recounted their experiences in acute care, where Halford and Leonard (2002) found that gender was more evident due to the number of male nurses in clinical and managerial positions, when compared to smaller community hospitals in their research.

The performance of nursing identity by women is often constructed by society and female nurses themselves within a stereotype of feminine attributes and women being ‘ideally’ placed as carers due to their ‘sensitive’ nature and ‘mothering’ abilities. For heterosexual men within nursing this may challenge their traditional notions and performance of masculinity (Lupton 2000). Simpson suggests this is further exaggerated by ‘role strain’, trying to maintain their notion of masculinity, while in a female profession and experiencing loss of status and money (compared to their counterparts in male dominated professions). Evans (1997) found that male nurses downgraded the organisation of their work in order to avoid person centred activities and undertake activities that are more task oriented, such as those identified by Andrew in his observation of nursing activities by men in his placement.

As Wingfield (2009, P5) states:

Jobs predominantly filled by women often require “feminine” traits such as nurturing, caring, and empathy, a fact that means men confront perceptions that they are unsuited for the requirements of these jobs.

Furthermore,

In encounters with patients, doctors, and other staff, men nurses frequently confront others who do not expect to see them doing 'a woman's job' (Wingfield 2009, P11)

As I explored in Chapter 2, the essentialist gender notions dominant within nursing and about gender identity are problematic. This is because these gender identities produce and re-produce nursing work in relation to gender and not patients. This is problematic as nursing becomes constructed as feminised, which for both male and female nurses further reinforces the position of the profession and women as subservient to both men and medicine.

For heterosexual male nurses the performance of nursing and care is not only problematic due to the deeply feminised notions of care, but indeed leads some men to perform care in a different way, which can enable male nurses to establish their masculinity. Part of this performance is also an act to rebuke any ideas that the heterosexual male nurse is gay. Harding (2007) explored discourses that stereotyped male nurses as gay, finding that despite the majority of male nurses in fact being heterosexual, this stereotype persists. Holyoake (2002) found that the heterosexual male nurses in his sample developed a form of 'soft masculinity', where they maintained their notion of hegemonic masculinity but demonstrated being 'in touch' with their feminine side because of the nature of their work. This enabled the male nurses to also maintain their heterosexuality. One of the nurses in Holyoake's sample went as far as to say:

It doesn't matter what orientation a person is, as long as they're a good nurse... being gay doesn't mean you're any less of a man.

(Holyoake 2002, P36)

Nurses continue to define themselves in terms of a relationship demarcated by their close proximity to patients (Peter and Liaschenko 2004). Furthermore the spatial organisation of nurses' work provides them with a sense of identity, self-esteem and autonomy especially because it provides them with a way to distinguish themselves from other healthcare workers (Allen 1997, Sandelowski 2002). Proximity to patients

is not without its problems and as identified by Peter and Liaschenko (2004) 'proximity compels nurses to experience their moral responsibilities as acutely as they do...' (P221). They go on to state that it is likely that making decisions that affect others negatively, such as budgetary, service and staffing issues are decisions more easily made at a distance. By not engaging in the 'everyday' work of the nurse such as washing, dressing, socialising with patients, male nurses not only reject forms of care that are stereotyped as feminised, they also relieve themselves of close proximity to patients. By not being spatially close to patients, male nurses are distanced from the 'perils' (Peter and Liaschenko 2004) of moral distress. Additionally, by not being spatially close to patients male nurses are distancing themselves from the profession itself as proximity to patients is one of the key ways in which nurses distinguish themselves from other healthcare workers.

For the gay men in this study, the hegemonic performance of masculinity by male nurses is problematic in two ways. First, in relation to the students' development of their nursing identity, unable to relate to heterosexual male nurses, there is little opportunity for role modelling. Second, in seeking 'permission' to practice and perform caring in a different manner which is not constructed within the notion of hegemonic masculinity or essentialising gender identities.

Justin was somewhat shocked in his first clinical placement:

I have always thought of nursing as a gay world, except for the female nurses, but I am yet to meet another gay nurse in my placement, although one of the students in my group is gay.
(Justin)

For Justin the stereotype of nursing being a 'gay world' was not in fact reality and although as I have identified previously he struggled with negotiating his nursing identity as a gay man, being told by the ward sister to 'tone down' his demeanour. However, he offers examples of how he utilised his experiences as a gay man, what he saw as his pivotal coming out experience to influence his performance with patients:

I was talking to this man, a single man who lives with his sister. I was talking to him cos it was Sunday afternoon shift and there

wasn't much to do...and one of the outcomes of this course is communication with the patients so I thought I would sit down and have a chit chat with him because he quite liked me and I quite liked him and he was calling me things like a Johnny bach and things like that and I thought awww sweet and he said er oh I'm going home in the weekend and then oh I I said and I didn't hear anything in the handover about him going home at all and er he said oh yes I'm going at the weekend and blah de blah...so I thought I better change the subject so I asked him where he lived...and he said he lived in Nelson and a beautiful place and blah de blah....

I try to be myself all the time, this is me and the caring and the understanding and making sure they (the patients) are clean and tidy and comfortable comes first before my sexuality, but if you want to know, yes I will gladly tell them. (Justin)

In these excerpts from Justin's story he is telling us how he performs care and it is clear that unlike Andrew's observations of male nurses as task oriented, being concerned with the insertion of tubes and technological activities, Justin's performance centres upon him wanting to be himself. As part of this performance he embraces what are seen as feminine activities, he listens, talks and is concerned that his patients are clean and comfortable. Here Justin, is constructing his own unique professional identity, one that is different to that of his female and male colleagues.

7.5 Intimate Care and Self Disclosure

Being a nurse will inevitably involve forms of intimate care, the cleaning of bodies, observation and examination of areas that are normally clothed and insertion of equipment and medicines vaginally, anally and urethrally. Intimate care is concerned not just with care of the body, but also the wider relationship nurses and health professionals have with their patients. Huebner (2006) describes intimate care as 'professional intimacy' and offers the following definition:

Professional intimacy includes emotion, physical touch, and intense feelings, but it differs from other types of personal intimacies in that it also requires long-term study and the mastery of specialized knowledge. Professional intimacy is a set of labour skills and strategies that are learned on the job through trial and

error and from the knowledge of more experienced nurses. It is another layer of professional skill, after technical and medical skills are mastered. (Huebner 2006, P5)

Whoever performs these parts of nursing, there are, as I have summarised in Chapter 2, always issues of gender that are problematic in some form. It is widely accepted that female nurses can provide intimate care for male patients. However, the media have in the past been used to sexualise women and nursing and make this problematic, Barbara Windsor playing the ‘busty’ and ‘flirty’ nurse in Carry On films comes to mind. For male nurses the issue of gender is not only problematic, but also at times insurmountable, with male nurses requiring chaperoning or not being allowed to care for female patients in intimate ways.

Intimacy also involves interactions that are personal in nature and may involve disclosure of deep feelings or problems by both the patient and the nurse. Again these interactions are gendered and are seen as feminine activities, best left to female nurses. With regards to physical care, until relatively recently there were some anomalies which offer a fascinating symbolic dimension to this discussion. For example, in the past female nurses were not allowed to urethrally catheterise male patients, leaving male nurses and medical doctors to undertake this task. So, in this case the male nurse or doctor using the urethral catheter penetrates the male patient, breaching the boundaries of normality first in that the man is being penetrated and second that this is conducted by a man. In this discussion I demonstrate that intimate care in both physical and emotional forms is a problematic area for gay male nurses to negotiate, not only regulated by gender based expectations, but also sexuality.

The issue of male nurses caring for female patients was evident in a number of participants’ narratives and were concerned with physical forms of intimate care:

I don’t know if it is a written policy or more of a cultural thing that it is best to bring someone with you and do it with you
[Intimate care] (Justin)

I have experienced some degree of sexism: on my stroke rehab placement, the sister was adamant that I was not to wash any of

the female patients, as it was 'inappropriate'. When I challenged this I was told not to argue and to get on with my work. (Joshua)

For these gay nurses the issue of intimate care, as it is for their heterosexual counterparts, is bound to social and cultural practices based upon gender stereotypes that portray men as sexualised and predatory: Although, it has to be accepted that these constructions of men are based upon real acts, for example domestic violence. Gay men do breach cultural norms and boundaries about bodies (see my discussion of the charmed circle in Chapter 1), however as nursing students the context of the bodies and boundaries that have been normalised are in a different context to their everyday lives. Inoue, Chapman and Wynaden (2006) found that male nurses, when caring for female patients found gay stereotypes were problematic:

They struggled with social stereotypes of male nurses, including being reminded regularly that nursing was not a man's job and the widespread belief that all male nurses are homosexual:

I am concerned that it's difficult for a male nurse to be a caregiver for women clients because nursing itself is not widely accepted as a male profession. There are some prejudices or opinions from people in society about men nurses that they are gay or homosexual. I think that this is one of difficulties [in caring for women clients. (Participant 3) (Inoue, Chapman and Wynaden 2006, P563)

The above quotation cites explicitly that prejudices connected to gay sexuality impact upon these straight nurses' ability to provide intimate care for female clients, however there is little exploration of the underpinning values and assumptions that lead to this assertion. I would contend that the men in this study struggled with their self-image as men and nurses and found the stereotype of gay male nurses problematic in totality across their professional lives. For the gay male nurses I interviewed, being gay did not appear to be a major obstacle in the practice of

intimate physical care. Indeed Joshua felt compelled to challenge this view on his placement. Being gay may in fact facilitate intimate care in some cases as it removes the stereotyped prejudices of men as being heterosexually sexualised and predatory. For some intimate care is viewed at a functional level:

Just cleaning their (the patient's) private parts, whether they are male or female, I mean most of the time if I can get them to clean it themselves I try to do it, but erm, if someone says carry on then I have to do it (laughs) (Justin)

It is Justin's first clinical placement and the physical washing of 'private parts' is probably his limited exposure to intimate care at this time. However, he gets on with the job and gender does not appear to be an issue for him. For gay men, the issue of gender becomes very confused in relation to intimate care. Gay men, like their heterosexual counterparts, are stereotyped as sexualised and predatory. And so, when performing intimate care for male patients they may be vulnerable to accusations about their conduct, in the way heterosexual nurses would be with female patients. The problem here is not based upon sexuality, or exclusively gender, but upon the stereotypes society perpetrates in relation to intimacy, whether gay or heterosexual, male and female nurses are in a vulnerable position when conducting intimate physical care practices with all clients, irrelevant of sexuality.

The provision of intimate care is problematic for both patient and nurses, whatever their sexuality or gender. Male nurses can see themselves as vulnerable when providing intimate care:

For men nurses, the stereotype of men as sexual aggressors is compounded by the stereotype that men nurses are gay. These stereotypes sexualize men nurses' touch and create complex and contradictory situations of acceptance, rejection and suspicion of men as nurturers and caregivers. They also situate men nurses in highly stigmatized roles in which they are subject to accusations of inappropriate behaviour. For men nurses, this situation is lived as a heightened sense of vulnerability and the continual need to be

cautious while touching and caring for patients. Ultimately, this situation impacts on the ability of men nurses to do the caring work they came into nursing to do. (Evans 2002, P1)

The problem for gay nurses is the interpretation of policies and practices that make assumptions about men, masculinity and sexuality. In the provision of intimate care to patients with learning disability Carnaby and Cambridge (2006) identify that same gender intimate care is desirable if not essential to ensure dignified and safe care. Within their research of intimate care giving practices they did recognise this policy as problematic:

Same gender intimate care policies have in-built short comings, being based on sexist and heterosexist assumptions about caring roles and gender. They failed to recognise or respond to the risk of sexual abuse to male service users or neglected the risk of physical abuse more widely. In particular they tended to ignore the needs of LGBT identified staff who were expected to undertake same-gender care within the blanket policy:

(research participant) 'same gender intimate care does nothing to protect them (gay men). As an out lesbian within the team, I also find working intimately with women difficult and sometimes wonder what my colleagues are thinking. (Carnaby and Cambridge 2006, P21)

While the recognition of same gender intimate care is problematic for lesbian and gay nurses, there is little indication within the discussion of possible solutions or any challenge to the many assumptions that underpin same gender care and chaperoning policies. In a subsequent chapter McCarthy and Cambridge (2006) explore the issue further:

Some LGBT staff may feel anxious about providing same gender intimate care because of the homophobic prejudices of others.

Any prejudices that surface will need to be vigorously challenged in services, to avoid reinforcing such barriers and the outcome of LGBT staff not engaging positively and safely in intimate and personal care in the same way as other staff. Gay identified men risk particular vulnerability when providing intimate care to men in a similar way that heterosexual men might feel if expected to provide intimate care to women, when referencing the evidence on sexual abuse. (McCarthy and Cambridge 2006, P55)

Although there is a clear recognition in this review of intimate care that same gender care can be problematic for lesbians and gay men, there is little supportive dialogue for lesbian and gay nurses faced with decisions of providing intimate care. There is a real recognition here that for gay men especially, there is a 'risk' and 'vulnerability' similar to heterosexual men. In pragmatic terms I would agree, however, like the policies of same gender care and chaperoning, the values that underpin this are flawed and based upon assumptions of hegemonic masculinity and heterosexism. The ability to challenge prejudices that arise from gay men delivering same gender intimate care is problematic in itself; it assumes that the gay nurse is open about their sexuality and that they are confident to challenge colleagues or superiors when confronted with heterosexist or homophobic attitudes. What MacCarthy and Cambridge (2006) are really asserting is the status quo and by doing so society in its widest sense will be appeased that female patients are not at risk of abuse, when the reality is much more complex. For men in nursing whether gay or straight, intimate physical care requires coping strategies, which Inoue, Chapman and Wynaden (2006) state includes self-protection from misunderstanding, suspicions and/or rejection from female patients/clients.

As a part of the status quo, the rights of lesbian and gay nurses to deliver intimate care within societal and institutional policies that offer safety from false accusations of sexual misconduct are ignored. Later, MacCarthy and Cambridge (2006) suggest that gay men providing intimate care for men with learning disabilities, who have sex

with men, may be beneficial in the provision of health promotion advice and role modelling. I would suggest that their views are liberal in nature to an extent that they are not congruent with current societal values and that promoting positive gay lifestyle choices as part of care of any form, may be problematic and expose gay nurses to a heightened level of vulnerability. Within the complexities of intimate care provision women are seen as the universal-care giver, if a man is not available they provide care to men and to women and are seen as unable to perpetrate abuse (something which recent cases of child abuse have discounted, the most prominent being the Vanessa George²³ case), while men are identified as predatory and sexual, whether heterosexual or gay. For gay men attempting to negotiate these complexities, there is little choice that makes any sense, providing intimate care for women, who they have no sexual interest in would reduce vulnerability for the nurse and the patient, however current attitudes and policies would prohibit such actions. In addition the gay nurse would have to be open about their sexuality in the workplace and confident in discussing this with patients. Intimate care giving for gay nurses remains a problem that is governed by societal and institutional attitudes towards men; sexuality and caring that cannot easily be overcome or mitigated.

Emotional intimacy is also a key concept in the exploration of care in nursing practice and has been subject to considerable discussion within the profession. Here I focus on the idea of intimate disclosure in the nurse/patient relationship. Williams (2001) recognises that the nurse/patient relationship has changed considerably in recent years moving forward from the conventional ideology of emotional detachment and distancing which were values upheld by the profession, to being an integral component of nursing practice, which is therapeutic in origin. This is an important ideological shift in the way that patients and nurses interact and one that I will explore in relation to self-disclosure by gay nurses.

The nature of self disclosure in nursing is usually the patient or client disclosing personal information, which would usually be viewed as private and which the patient may not have even shared with their family or partner. Williams (2001) recognises that verbal intimacy, involving the disclosure of personal information,

²³ In 2009 Vanessa George was sentenced to seven years in prison for sexually abusing children in her care.

with the expectation of understanding and acceptance is universal among the caring/psychological disciplines and is rarely reciprocated by the professional.

My earlier discussions have identified that the use of self by some of the gay nurses is key to their individual concept of caring, the coming out experience underpinning their understanding of other people's emotional pain and challenges. But how does their use of self become part of their practice as nurses and part of their therapeutic relationship with patients? When is self-disclosure an acceptable part of this relationship which is based on assumptions of power and authority? Coming out in itself may not be an issue for some gay men, it is widely accepted that the default assumption is that all male nurses are gay and for male nurses like Justin, his persona reinforces these assumptions further. Justin describes himself as 'camp' and clearly recognises the assumptions people make about his sexuality – and he is happy with this. He reflected upon how at times being openly gay enhanced his relationships with patients and recalled conversations with patients and relatives which clearly were not confined to their nursing care and included a certain amount of self disclosure on all sides. For example, patients and relatives asking what Justin and his partner had done over the weekend etc. In his re-telling of these stories he says he expects some people to not be receptive to him, due to his sexuality and he expects to just get on with the job at hand. So he reduces his personal intimacy with these patients in order to protect himself and focuses not on building a relationship, whether therapeutic or not, but upon nursing 'tasks', which will be physical in nature.

Conversely Joshua describes himself as a six foot four 'man' and when exploring this he attached hegemonic qualities to his perception of manhood and masculinity. He does not think people assume he is gay and while he does not see himself as 'out' all the time he has no problem being open about his sexuality. He centres on physical care and says that his relationship with patients is an area he needs to work on, he feels constrained by the time taken for physical nursing.

Men in general do tend to get used as ballast or as a hoist when the batteries are flat! ... the work was quite difficult, as it was a sixteen-bedded unit and all 16 patients were female. (Joshua)

As long as we're speaking anonymously, caring doesn't much come into my current practice. I am often so overwhelmed with the sheer amount of work (I normally get the double-handed patients to wash alone, as I'm 6'4") that I become quite task-orientated: something that is never a desirable quality in a nurse. (Joshua)

But when he is placed in a situation where he feels it appropriate to use self-disclosure and intimacy he cannot decide which approach to take: 'is it easier just to lie? [about your sexuality] I haven't quite decided yet!'

Self disclosure and the level of personal intimacy used as part of their professional relationship with patients, is clearly an issue which gay nurses have to negotiate and which appears be different, depending upon the type of work, the environment of work and previous experiences of self disclosure. Joshua hasn't been able to form therapeutic relationships or relationships he views as intimate in his previous placements, however in this specific situation when working with another gay man he find it appropriate to self disclose his own sexuality and experiences at a very personal level. His ability to do this is enabled at both personal and organisational levels. Personally, he feels that his patient is going through a similar experience to his own coming out experience and there is a direct connection. He feels by disclosing his experience he can help this young gay man to have some control in his life. At an organisational level, Joshua was enabled to develop this therapeutic relationship, as the demands for physical care are not apparent in a GUM clinic, there is time to talk. Additionally, GUM clinics are places where discussion of sex and sexuality is commonplace and he is supported in being open about his sexuality. This is important; his previous experiences of being a male nurse have been based on stereotypes that he felt compelled to challenge at times, whereas in the GUM clinic he feels accepted as a man and a gay man.

Self-disclosure for gay nurses may not always directly include coming-out, but some form of sharing and understanding. Huebner (2006) recognised that intimate care of any kind in the professional context is learnt and mastered and gay men have to master the negotiation of their sexuality in relation to intimate relationships. Gay nurses may already be out in their non-professional lives and have experience of negotiating coming out in this context, but moving these experiences to the

professional context will require further reflection, learning and honing of their performance as a nurse. Within the professional context gay nurses will additionally have to consider conformity with the general expectations of non self disclosure and the idea that although intimate relationships are seen to be central to our relationship with patients, they are expected to be one sided, with the patient being the one offering self disclosure. Justin and Joshua take very different approaches to forming relationships with patients and sharing intimate self disclosure, however for both of them three conditions need to be met for them to use this personal form of care: an environment which is supportive physically (privacy etc.) and emotionally (staff being accepting of gay men), a patient who is receptive to the gay nurse and whose situation induces empathy and the professional context in which the use of self is acceptable.

Within nursing, the use of self-disclosure is not usually part of the discourse of intimate care:

‘The self disclosure in a verbal sense was perceived by some nurses to focus largely on the patient rather than the nurse, who felt less free to disclose.’ (Williams 2001, P660)

This may be for a number of reasons, persistence of old attitudes to nurse/patient relationships where distance in the relationship was required to retain authority, a simplistic and perpetuated interpretation of nursing ethics – it wouldn’t be right to tell the patient about yourself – and the rigidity of the Nursing and Midwifery Code and its interpretation. Other professions, for example psychotherapy, use self-disclosure as part of a therapeutic relationship with up to 90% of therapists using self-disclosure at some time (Henretty and Leavitt 2010). Although they recognise that the implications of self-disclosure are unclear with studies having divergent results. Within their review they identified two studies that examined sexual orientation and found that gay men preferred therapists that self disclosed their sexuality, although this only seemed to be favourable when both client and therapists were of a minority sexual orientation. Within the ‘talking’ professions the use of self-disclosure between therapists and client, appears to be more acceptable than self-disclosure between nurse and patient. However I would contend that other

professions do not interpret professional and ethical behaviours in such a subjective way as nurses do.

Male nurses employ a number of strategies for negotiating intimate care of both a physical and emotional nature, including: moving into nursing roles which minimise physical care; maintaining the formality of their role; working with teams which include a larger number of women; delegating intimate care and modifying procedures to minimise patient exposure (Evans 2001). Gay male nurses may also utilise these strategies for negotiating intimate care. However in addition they must negotiate their sexuality in the context of nursing and caring, which may necessitate self-disclosure to colleague and patients. Strategies for negotiating this include Justin's 'campness' to test people's reaction to him, which will ultimately influence the depth and intimacy of his therapeutic relationship.

7.6 Conclusion

In this chapter I have explored the experience of my research participants in their clinical placements with a specific focus upon the performance of nursing, rather than the issues associated with negotiating sexuality, which I explored in Chapter 5. I commenced this chapter by arguing that male nurse must negotiate the discourses of masculinity, stereotyped sexualities and the prejudices contained in the area of practice the male nurse practices within, for example mental health, adult or children's nursing. And that it is only by negotiating these discourses that the male nurse can develop a professional performance is believable and acceptable, while at the same time promoting masculinity within a feminised profession.

Developing these notions of identity I then explored the student's perception of themselves as gay nurses. Due to stereotype of male nurses being gay this was a complex discussion. Images of 'the caring gay man' come to mind, an idea that is linked to the stereotypes of femininity and discourses of caring as women's work. All except one of the gay men I interviewed talked openly about their motivation to become a nurse and their idea of being 'caring'. I argue that for these gay students', their performance of nursing is underpinned with what they called 'caring'.

Furthermore I suggested that while the stereotype that exists about gay men and men in feminised professions, caring was a central part of the student's story and an underpinning category in the negotiation of their performance as nurses. I argue that while stereotypes of femininity and caring can be seen as negative portrayals of gay sexuality, for these men it was clearly positive.

The experience of coming out as a gay man had clearly been a pivotal moment in these student's lives, as it is for many gay men and I argue that these experiences form a major part of the student's identity as a nurse and contribute to their performance of nursing. During the interviews the student's talked about how the caring and compassion they were able to show patients was enhanced by their experience of coming out and I suggested that coming out was similar to the biographical disruption experiences by those with chronic illness (. I identified that there are clear parallels in the experience of living with illness/chronic illness including a changing self-identity and the potential for stigma. I argue that the experience of coming out is unique, intense and one that is repeated over time and in many situations and therefore is a constant part of the gay student's lives and their developing identity as nurses.

I then turn to the issue of gender and explore how the students performance of their nursing role is different to both traditionally feminised and masculinised notions of nursing. What I argue is that these students performance of nursing demonstrated a different professional performance, where masculinity is challenged by sexuality. This notion involved the gay students crossing traditional gender binaries and negotiating a unique professional performance, formed through their experience of being a man, coming out and being gay. I utilised Justin's accounts of caring to illuminate this argument, specifically how he embraced what are seen as feminine activities: he listens, talks and is concerned that his patients are clean and comfortable. Concluding that he constructs his own unique professional performance that draws on his gay masculinity.

The final section of this chapter argued that intimate care, both physical and emotional is a complex endeavour for these gay students to negotiate. I argue that for the gay students the issue of intimate care and gender becomes very confused. I suggest that gay men, like their heterosexual counterparts, are stereotyped as sexualised and predatory and that male nurses are in a vulnerable position when conducting intimate physical care practices with all clients, irrelevant of sexuality. I then proceed to explore what became a recurring theme in my data, emotional intimacy and self-disclosure of sexuality to clients and patients. I explored Joshua experience of sharing his experiences as a gay man with a client in the STD clinic and I argue that self-disclosure of ones sexuality and the level of personal intimacy used as part of their professional relationship with patients, is clearly an issue which gay nurses have to negotiate. The negotiation of emotional intimacy appears to be dependent upon the type of nursing work being undertaken, the environment of work and how accepting of alternative sexualities colleagues are and previous experiences of self-disclosure.

The final chapter of this thesis will now consider the implications of this research for gay male student nurses, employers and universities who recruit nurses, patients and educators.

Chapter 8: Conclusion

8.1 Introduction

Men have been part of the nursing profession for over sixty years and currently the number of male nurses registered in the UK remains static at around 10% (NMC 2011). Nursing continues to be a female dominated profession and caring continues to be associated with femininity, both of which have a direct impact on the stereotypes associated with male nurses. Notions of gender essentialism construct nursing in a feminised way that is problematic to male and female nurses, as well as the profession. In this context, in the early chapters of this thesis I explored how I was interested in the differing spaces of the hospital and university and how, within these spaces, gay male student nurses negotiate their gender, masculinity and gay sexuality. Furthermore, I explored how these negotiations take place within the professional boundaries of the nursing profession. I drew attention to how Goffman's (1959) theories of performance and presentation of self and Rubin's (1984) 'charmed circle' framed the theoretical lens through which I examined the experiences of the gay nursing students I interviewed. Using these frameworks and through in-depth interviews this study has shown how gay nursing students engaged in multiple performances of the self in order to negotiate the differing spaces of university and the hospital placement. Furthermore, this study shows that the lives of these students' are fraught and precarious due to the complexities and boundaries of nursing roles in contemporary healthcare.

I asked the following research questions:

- 1a. How do gay male student nurses negotiate their sexuality within both the education and clinical context
- 1b. What effect does being gay have upon the experience of being a nursing student?
2. Why do gay men choose to study nursing?

I conclude by drawing out the following key arguments and discussions. First, I have shown that the spaces of the university and clinical placement, for the gay student, have significant differences in the way that sexuality was negotiated. Within the university, students found these negotiations easier and less fraught with concern. Whilst, negotiating sexuality in clinical placement was something that was either

avoided or took place in very specific clinical situations. Second, that being a male student nurse presented its own challenges, especially relating to the care of patients. Third, that being a man in a feminised profession appeared to offer significant challenges as well as the negotiation of sexuality.

8.2 Being a Gay Student Nurse

I commenced this thesis by exploring the complexities of being a gay researcher researching gay students and by contextualising this study within modern healthcare and men in the feminised profession of nursing. Utilising Goffman (1959) and notions of performance and identity work, which I then coupled with the charmed circle (Rubin 1984) I explored the performance of gay sexuality in the spaces of the clinical placement and university. What this study has unearthed is the complexity that the gay nursing students in this study had to negotiate to develop their identity as male nurses. Furthermore, the complexity of these endeavours was not restricted to issues of disclosure or non-disclosure of their sexuality, but much more engrained and fundamental to the development of their performance of nursing and their professional identity as nurses. The complexity of these negotiations is somewhat surprising considering Weeks (2007) assertion that major societal changes have improved the lives of gay men and lesbians and momentous changes in relation to LGBT people that have occurred in the last few years, including the UK Equality Act (HMSO 2010) and this year's inauguration of gay marriage. While these changes in societal attitude signify a more liberal attitude to sexualities, the professional lives of these gay students was fraught and complex.

The management of the student's sexuality was a negotiation of their private lives and their professional performance whether this took place in their clinical placement or the university. With the potential for negative reactions to their gayness, some of the students utilised strategies to gauge how acceptable disclosure would be. These included 'reading' the heteronormative discourses of the environment and moving between strategies of non-disclosure and disclosure to manage their sexuality (Griffin 1992). I have argued that when the students did discuss their sexuality within

their clinical placements that they constructed their sexual identity in such a way that they made their gayness acceptable and although everyone regulates their sexuality in public and professional arenas, the construction of an acceptable form of gay sexuality is important due to heteronormative attitudes that may be encountered by the students. The ways in which the students achieved a believable performance of both their sexuality and their role as nurses varied and involved complex decisions and negotiations including notions of privacy (Bailey 2000). The decision to disclose or not to disclose one's sexuality appear to be linked with the acceptability or not of sexuality within specific clinical spaces and the space of the university (as in Rubin (1984) and the charmed circle). The students also want to fit in both with their peers and with the professional expectations of nursing and it seems they are engaging in what Richardson and Munro (2012) term as responsible and respectable citizenship. For students deciding not to disclose their sexuality and attempting to adopt what Van Lear (2011) describes as a visible heterosexual identity, life is precarious. Butler's (1997) concept of 'naming' (P32) is a real one and those students not disclosing their sexuality could be subject to 'gossip' amongst their peers and clinical colleagues. For one student the experience of having his sexuality 'outed' in front of his placement colleagues was not only embarrassing, but potentially devastating in terms of his progression through the course.

Negotiating therapeutic relationships with patients appeared to be deeply problematic for the gay students whether they disclosed their sexuality or not. I found that many of the students employed very specific covering strategies when building therapeutic relationships with patients which included avoiding difficult questions about the marital status and attempting to pass as straight. While students wanted to participate in what McQueen (2004) described as emotional labour (nursing work), I argued that within the context of nursing and the expectations of professional practice that the students are novices and that they are keen to abide by the rules and social conventions of the profession which they are trying to navigate, learn and negotiate at the same time as their sexuality.

Where students do disclose their sexuality to clients or patients, this is exceptional and happens only in very specific circumstances. McQueen (2004) suggests that 'The emotional work involved to achieve correspondence between the emotions experienced and behaviour demonstrated helps to give the behaviour authenticity' (P104). One student by coming out to a single patient demonstrated how he achieves 'authenticity' in his advice by disclosing his own gay sexuality and his own life story so that he could help the patient to understand his own predicament.

Due to stereotype of male nurses being gay the issue of caring was a complex discussion. All except one of the gay men I interviewed talked openly about their motivation to become a nurse and their idea of being 'caring'. I suggested that while the stereotype that exists about gay men and men in feminised professions, caring was a central part of the student's story and an underpinning category in the negotiation of their performance as nurses. I argue that while stereotypes of femininity and caring can be seen as negative portrayals of gay sexuality, for these men it was clearly positive.

I argue that the experiences of coming out form a major part of the student's identity as a nurse and contribute to their performance of nursing. Plummer (1995) suggests that coming out narratives play a significant role in LGBT identities. During the interviews the student's talked about how the caring and compassion they were able to show patients was enhanced by their experience of coming out and I suggested that coming out was similar to the biographical disruption experiences by those with chronic illness (Bury 1984). I identified that there are clear parallels in the experience of living with illness/chronic illness including a changing self-identity and the potential for stigma. And I argue that the experience of coming out is unique, intense and one that is repeated over time and in many situations and therefore is a constant part of the gay student's lives and their developing identity as nurses.

It is evident that some of the students participated in very specific forms of intimate care, which Huebner (2006) asserts can be both physical and emotional. Physical intimate care was problematic for many of the students. For men in nursing whether

gay or straight, intimate physical care requires coping strategies, which Inoue, Chapman and Wynaden (2006) state includes self-protection from misunderstanding, suspicions and/or rejection from female patients/clients. For the gay men in this study, the hegemonic performance of masculinity by male nurses is problematic in two ways. First, in relation to the students' development of their nursing identity, unable to relate to heterosexual male nurses, there is little opportunity for role modelling. Second, in seeking 'permission' to practice and perform caring in a different manner which is not constructed within the notion of hegemonic masculinity.

The complexity of performing nursing for these gay students was formed by their experiences of being gay men, coming out and the professional expectations of being a nurse. What I argue is that these student's performance of nursing demonstrated a different professional performance, where masculinity is challenged by sexuality. This notion involved the gay students crossing traditional gender binaries (Evans 2001) and negotiating a unique professional performance, formed through their experience of being a man, coming out and being gay. These performances included embracing what are seen as feminine nursing activities: he listens, talks and is concerned that his patients are clean and comfortable (Harding 2007) and in one case disclosure of the student's sexuality to a patient. I suggest that these performances of nursing are not the forms of soft masculinity, which Holyoake (2007) suggests heterosexual male nurses develop to maintain their notion of hegemonic masculinity, while also being as accepted as a nurse. But, instead I suggest that these are performances of gay masculinities within the framework of nursing.

8.3 Implications for Policy and Recruitment

This study has gone some way towards understanding that the negotiation of masculinity and sexuality by gay male nursing students is a complex process of socialisation within the profession. What has become clear in this study is the lack of role models for gay student nurses to learn professional boundaries from, a lack of guidance for male nurses related to conduct of care and intimacy and a lack of education pertaining to inclusive healthcare for patients and staff. The male nurses in this study negotiated their own way through their nursing education with little

explicit support and at times this was problematic not only for the student, but also their patients, mentors and academic staff. For example, the negotiation of intimate care for patients was problematic as I discussed in Chapter 7 and at times relationships with mentors and academic staff lacked openness. A number of actions could be taken by key policymakers/professional organisations to address these issues: 1. The RCN has an LGBT network which could be promoted more actively to LGBT student nurses and staff. The network could consider developing a student LGBT network to support LGBT nursing students. 2. The RCN LGBT network needs to promote the work of their members so that LGBT nursing role models are visible. 3. The current RCN guidance on caring for LGT patients was updated in 2012. When next updated, the guidance should be extended to include guidance for LGBT staff to support them in being open about their sexuality in their workplace. 4. The current NMC educational standards for equality and diversity are very broad and the NMC should be encouraged to produce more specific standards for the teaching of LGBT issues across the curriculum. 5. The NMC should provide guidance/information specifically addressing the challenges male nurses face and specifically their over-representation in fitness to practice cases.

Recruitment was not a key issue within this study. However, I did explore why these gay men became nurses and I found that for the majority of them there was a familial link to health or social care professions or that they had previously been carers in some paid capacity. I identified that, using Simpson's (2004) categorisation of men in feminised occupations, all of these students were 'seekers'. They had previous working lives and sought out nursing as a specific career choice. It was surprising that none of the students I interviewed were traditional university entrants, in that they would have been 18 years old. Within my own institution the majority of male nursing students are also non-traditional entrants. Those recruiting nurses on to university programmes, which include the NHS Careers service and universities, should actively promote nursing as a career choice for men. Additionally, these organisations and the nursing profession should promote positive male role models more generally. Being gay did not appear to influence the career choice of these gay students, although there were some expectations of nursing being a gay career, based

on un-true stereotypes that were not borne out. While not wanting to perpetuate the stereotype of nursing as a career for gay men or indeed that all male nurses are gay, it is important that those recruiting student nurses and those employing registered nurses promote workplace equality and support nurses who wish to be open about their sexuality.

This research has revealed a professional space that I have shown to be deeply problematic, and it makes a significant contribution to the body of knowledge concerned with LGBT issues. In exploring the lives of these gay undergraduate nursing students. I have contributed to the development of research in nursing that explores diversity — an area that requires further development and discussion in the profession. Furthermore, this research contributes to the wider field of student experience in higher education and more specifically to research on gender and sexualities in higher education. It is important that I disseminate this research in the form of a briefing paper to key policy makers such as the RCN, NMC and NHS Executive, for the reasons I have outlined above. It is equally important that this research is published to develop the debate in professional and academic arenas and therefore I plan to submit papers to *Nursing Inquiry*, the *Journal of Advanced Nursing* and the *British Journal of Sociology of Education*.

8.4 What Does this Research Mean for Patients?

Within this research I have only briefly touched upon issues directly related to patient however, any research involving nurses has implications for patients. First, I believe that the issue of men as care givers is problematic for both male nurses and patients. All patients, both male and female should be able to choose the gender of the person who is providing intimate care for them, the default position seems to be that female patients have a choice and male patients do not. Second, the men in this research found that negotiating their sexuality was a problematic experience within the field of clinical practice and there is evidence that LGBT patients find disclosing their sexuality to healthcare providers is problematic. Institutions providing healthcare services should address these issues and attempt to make healthcare environments welcoming to all service users. For LGBT patients this may be as

simple as displaying a poster stating that LGBT patients are welcome in the organisation. Education of healthcare staff and students about LGBT health issues is addressed in the next section.

8.5 Working with Stonewall: Creating an inclusive LGBT curriculum

The university that I work at is a Stonewall Top 100 LGBT employer and has been in the *Workplace Equality Index* for some years. Currently there are four universities in the top 100 LGBT employers list. Stonewall has already undertaken some collaborative work with the university and last year a new collaboration examining our nursing curriculum commenced. Due to my on-going interest in LGBT issues and of course this research, I was invited to be part of the collaboration. This project resonates with the stories of the students' in this research, as they recounted that little focussed LGBT content existed in their university nursing education. As I discussed in Chapter 6, none of the students could identify teaching content that Brennan (2012) cites as being essential for understanding LGBT issues or any of the RCN LGBT guidance.

The Stonewall collaboration is a pilot project with the aim of delivering an inclusive LGBT healthcare curriculum, so that healthcare students are educationally prepared to give inclusive healthcare to LGBT patients. We know from the literature that the experience of LGBT patients is extremely variable and that their specific healthcare needs are rarely met (Stonewall 2012). We also know that those LGBT patients are often met with heterosexist attitudes and a lack of understanding (Fish 2006). Examples of heterosexist healthcare can not only be shocking, but possibly life threatening as shown in this excerpt from Stonewall's research:

I was treated for cervical cancer after receiving a positive smear.

I was originally told that I didn't need a smear as I had never had sex with a man. Francesca. (Stonewall 2012, P8)

The pilot involves the planning and production of a training day, a briefing document and an online training resource that aims to inform, educate and challenge healthcare academics' knowledge and attitudes towards LGBT healthcare. Anecdotally, LGBT

issues are often dealt with alongside wider issues of equality and often the gay lecturer, like myself, is expected to deliver this teaching.

By educating healthcare academics about LGBT issues, it is hoped that over time, education of LGBT issues will move away from being a single lecture that is quickly forgotten by the students, to the application of LGBT issues across the curriculum. The training day not only informs academics of the issues, but also, using a toolkit approach, empowers them to examine their own teaching and to identify where they could incorporate LGBT issues. This project also addresses other forms of diversity during the training, for example race, ethnicity and disability as part of encouraging inclusive healthcare and curricula.

The current pilot is taking place with one nursing curriculum in one academic school and will be evaluated. The long-term aspiration of Stonewall and the project is to roll out the training and resources across the university and then to other universities. At the same time Stonewall continues to offer advice and training to NHS staff to improve LGBT patients experience (Stonewall 2012).

8.6 Limitations and Further Research

While I feel that this study has offered a useful insight into the experience of gay male nursing students and their negotiations of masculinity and sexuality and useful suggestions for policy makers, there are some limitations in what has been presented here. Were I able to undertake this research again, without the time limitations of conducting PhD research, I would follow students in a longitudinal study which would enable me to engage with the key points of their educational journey.

Difficulties in recruitment to this study, coupled with time restraints have meant that I have only been privy to a snapshot in these students' lives. By chance alone, the students I interviewed were at differing points of their courses; two had just completed their first clinical placement, three were in their second year and three were in their third year. Two of the third year students were about to register as nurses and had obtained employment. A longitudinal study would most likely take longer to recruit to and take longer to complete, as ideally students would be

followed from year 1 to year 3 of their courses. However, this would enable a more developmental view of how the students negotiate their masculinity and sexuality over time, as they become further embedded within the profession.

Additionally, as I explained in Chapter 3, due to time constraints in-depth interviews were my only source of data, which is a limitation, especially in relation to exploring the space of the university. Had there been more time available, it would have been pertinent to observe not only nursing lectures, but also a range of lectures and students from other disciplines and professions to explore how university life is constructed for them. By doing this, I would have been able to consider how variations in culture and professional practice may inform the different constructions and performance and identity in the space of the university.

I believe that future research needs to be conducted with gay male and female registered nurses to see what their working experience of being a gay nurse is. While there is some literature exploring the lives of lesbian and gay nurses (Röndahl, Innala and Carlsson 2007) this is somewhat limited to workplace issues of acceptance and discrimination, rather than the complexities of actually 'doing nursing work'. Additionally, while I acknowledge there is research exploring the experience of LGBT patients (Stonewall 2012 is an example) this is by no means prolific or representative of the issues LGBT people must negotiate. More specifically, LGBT patients' access to and use of healthcare services requires further research, especially in the case of younger and older LGBT people. Finally, I believe that further work needs to be undertaken examining the complexities of caring and being a male registered nurse. Currently this research depends on self-reported narratives, much like this research. Future research could go further by developing ethnography of male nursing to explore both the nurses' and the patients' lived experience.

8.7 Concluding Remarks

In this final chapter I have drawn together the main themes of this thesis (the experience of university, clinical placement and the performance of nursing) and I have identified the key implications of this research for policy-makers, those who recruit nurses, those who educate nurses and patients. I have argued that the experience of being a gay, male, undergraduate nursing student is a difficult one and that the negotiation of masculinity and sexuality is not straightforward in the context of modern healthcare. Furthermore, I have argued that despite the challenges, a number of the students that I interviewed used their life experience as gay men to inform their performance of the caring role and in doing so they rejected the traditional and sometimes stereotypical notions of masculine and feminine forms of caring. This study contributes to the body of work that is growing in terms of LGBT healthcare, but further research exploring the working lives of LGBT nurses, to inform practice and employment policy is required. Additionally, due to the limitations of this study, further research exploring patient and academics attitudes towards LGB student nurses would be useful.

Epilogue

My original intention of conducting a longitudinal study proved impossible early in the conduct of this research. However, I do know what happened to some of the students that I interviewed, either by chance or because they emailed me after I had met them. Justin registered as a children's nurse, Jonah, Jake, Andrew, Joshua and Dylan as adult nurses and Thomas as a mental health nurse. Ivan became the deputy matron of a nursing home not long after registering as an adult nurse and Jonah was working on an acute medical ward and had not come out to his colleagues. I have no information about Mike.

Three weeks after Molly our St Bernard died, we met a three-legged American Bulldog cross who needed new home and we adopted her. She now lives happily with our two other dogs.

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Appendix 1: Recruitment Poster

GAY?

GAY MALE NURSING STUDENTS NEEDED TO PARTICPATE IN RESEACH

This is a qualitative study which is investigating the experience of gay male nursing students, I am a Lecturer in Nursing completing this study as part of PhD Studies.

If you identify as gay/bisexual or a man that has sex with men your participation would be useful and will include:

- Two 1.5 hour interviews in a location near you*
- Maintaining contact through a journal which you contribute to as much or little as you like*

Confidentiality is assured

Contact: gmnsr@cardiff.ac.uk
<http://www.freewebs.com/gmnsr/>

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Appendix 2: Participant Information Leaflet

Research Information Sheet

Research Title: Gay male undergraduate nursing students: an investigation of their educational and professional experience.

I am really glad that you have taken the time to think about taking part in this research. If you have any questions or want to contact me to take part please email me: gmnsr@cardiff.ac.uk.

If you know of anyone who may be interested in this research please feel free to pass this information sheet on to them.

What is the purpose of the research?

The research will look at the experience of gay men who are at University, studying nursing as undergraduates. The experience of gay men within University and within nursing is an issue which does not get researched often and I hope you consider joining the study.

Who is the researcher?

I am a nurse lecturer working in Cardiff and I am doing this research as part of my PhD. I am interested in the experiences of gay men in nursing courses as a nurse, a gay man and a researcher. I trained as a nurse 17 years ago and although there are now many more men in nursing I am concerned that gay men continue to be a hidden minority or a stereotype within the profession. I hope my research will help me and others to understand what it is to be a gay male nursing student in today's society.

Can I participate in the research?

I am looking for any men who have sex with men (or think about it) and are currently nursing students to take part in this study. If this is you I would be glad to discuss the research further and hope that you want to take part.

How will you assure confidentiality?

Being a gay man I know how difficult it can be to be open and honest with everyone in our lives. It may be important for you that no-one knows you are taking part in this research.

All of the people taking part in the research will be anonymised and any written, tape recorded or computer information involving people taking part in the research will not be identifiable. It is likely that I will at some point in the future, publish and present the research findings, again I will make sure that no-one that takes part is identifiable.

Does the research have any specific aims?

I am really interested in what it means to be a gay male nursing student and how being gay can affect our professional lives. I have a number of questions I want to answer through this research which include why gay men choose to study nursing? What is the experience of being a gay male student and what is the experience of gay male nurses on clinical placement?

How will I be expected to be involved in the research?

Depending on which stage of your course you are at I will want to meet with you on two occasions (one if in the final year) to conduct an interview which will last approximately 1.5 hours. You will not have to prepare in any way for the interview. The interview will take place at an agreed time and place and will be tape-recorded.

The two interviews will take place approximately one year apart. Within this time you will be asked to add experiences and information to the research through the use of a secure online diary, how often you do this will be totally up to you.

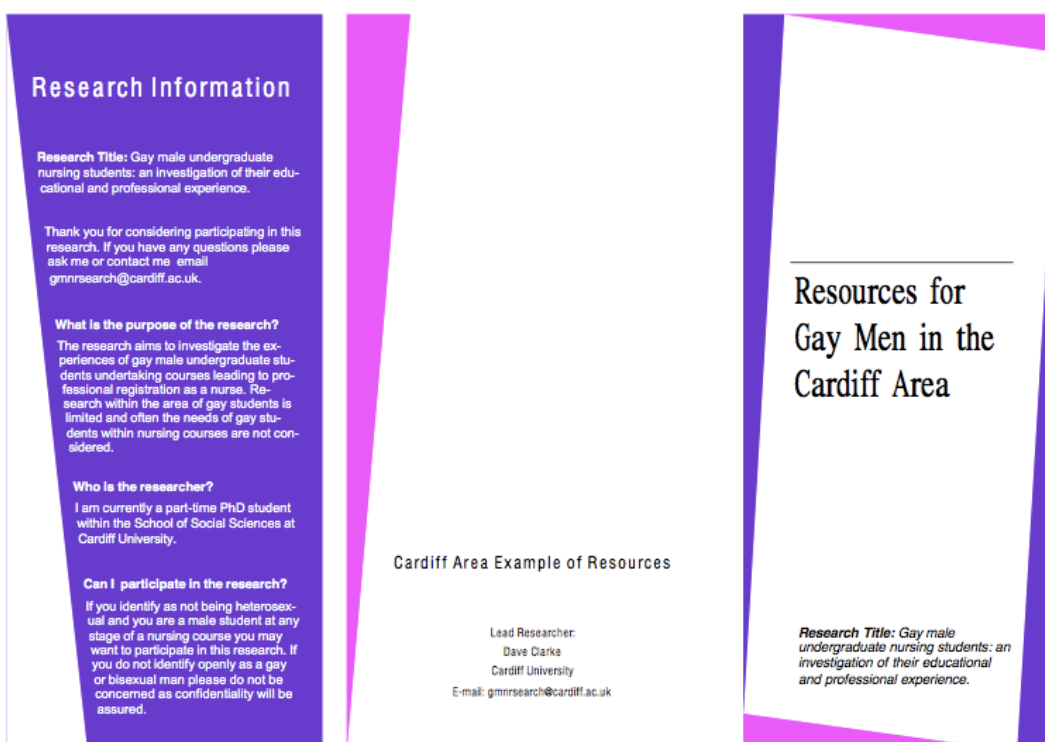
If I decide I no longer want to be part of the research is this OK?

If you decide at any point that you do not want to continue taking part in the research this is OK, you just need to let me know.

I really do hope that you find this research interesting and that you think about taking part. If you know anyone else who may be interested please pass this leaflet to them.

Dave

Appendix 3: Example Resources Information Leaflet



Support and Information

Cardiff University LGBT
Cardiff University LGBT
Students Union
Park Place
Cardiff
CF10 3GN
Tel: 07729 597668

People may join their mailing list for information on various events by sending an email to lgbt@cardiff.ac.uk

Meets most Wednesdays in the Meeting Rooms, top floor of the Student's Union, Park Place, Cardiff.

Website: www.cf.ac.uk/suon/lgb

Cardiff Gay & Lesbian Switchboard
029 20340101
8pm-10pm Tues-Sat

Nightline 148 Colum Road: Tel 029 2022 3993

Cardiff University Student Support

Cathays Park campus:

Phone us on: (029) 2087 4966, or 74966 (on an internal, University phone)

Email us at: counselling@cardiff.ac.uk

Call in (9.30 a.m. to 4.00 p.m.) at 50 Park Place

Heath Park campus

Phone us on: (029) 2074 2070, or 2070 (on an internal, University phone.)

Email us at: counselling@cardiff.ac.uk

Call in (8.30 am to 4.30pm) at Student Support Services, 2nd Floor, Cardigan House and ask for an introductory appointment.

London Lesbian And Gay Switchboard

Internet Address: www.llgs.org.uk

Tel: 020 7837 7324 (helpline); 020 7837 6 24hr telephone information, counselling and referral service for lesbians and gay men. Keeps a list of sympathetic solicitors and health services throughout the country.

Local Pubs and Clubs

Golden Cross Pub

283 Hayes Bridge Road
Cardiff, CF10 1GH
Tel: 029-2034 3129

The Kings Cross

25 Caroline Street
(Opposite Marriott Hotel)
Cardiff. CF10 1FF
Tel: 029-2064 9891

Bar Icon

60 Charles Street.
Cardiff.
Tel: (029) 2066 6505

Club X

35 - 39 Charles Street
Cardiff, CF10 2GB
Tel: (029) 2040 0876

Exit Club

48 Charles St.
Cardiff.
Tel: (029) 2064 0102

Gay Wales Guide: <http://www.gaywales.co.uk/index.html>

Terrence Higgins Trust: <http://www.tht.org.uk/>

