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Gender Bias in Nursing:

A Scoping Review

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Attestation of authorship: I hereby declare that this submission is my own work and that, to the best of my knowledge and belief, it contains no material previously published or written by another person (except where explicitly defined in the acknowledgements), nor material which to a substantial extent has been submitted for the award of any other degree or diploma of a university or other institution of higher learning.

Signed:

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And to Charlie – the little boy I never knew I could love so much.

Contents

Abstract

Background: Gender bias is preference and preferential treatment for one gender over another. This has problematic implications for women and is well documented through the gender pay gap, the lack of women in leadership positions, and the amount of unpaid care work women undertake compared with men. This review examined how gender operates in nursing prompted by an awareness that much discussion about gender is about men, and this led to curiosity about how women and transgender people are represented and what their experiences are in relation to gender. This scoping review critically evaluated the research and grey literature to present an in-depth discussion of gender power in the nursing profession, with a particular view on Aotearoa New Zealand.

Methods: A scoping review was conducted. CINAHL, Scopus, Medline via EBSCO, Business Source Complete and Joanna Briggs Institute databases were searched with inclusion criteria of research from New Zealand, Australia, Canada, and the United States of America with an aim to establish a possible relationship between gender, nursing and Indigenous or First Nation people. Grey literature was included from the websites of New Zealand, Canada, Australia, and the United States nursing unions and registering boards.

Results: The findings highlighted four main themes of 1) touch, 2) money, 3) glass elevator and glass ceiling, and 4) gender identity and assumptions of nurses. 1) Men in nursing experience judgement from patients when required to perform touch as part of their clinical duties and this judgement may influence the area where a male nurse will work. 2) In careers where women are the majority and significantly outnumber men, gender bias exists for men to occupy more senior positions and better paid jobs. 3) Women in nursing experience a glass ceiling effect that prevents upward promotion yet men in nursing experience a glass escalator effect whereby they are more largely represented at leadership and management levels. 4) In nursing, gender bias is also present due to gender stereotypes of nursing being seen as women's work, and men in nursing are subject to negative stereotypes. Sub-themes within 'gender identity and assumptions of nurses' are gender role strain, gender as active challenge to social norms, sexuality, and the need for muscle. Men in nursing are often stereotyped as homosexual or less compassionate than their female peers and report frustration at the gender-based assumptions they are faced with.

Discussion: Men and women in nursing experience gender bias which operates in different ways. The research focuses on the experiences of men, leaving gaps in the literature for experiences of women, and people who are not cisgendered. Very minimal intersectionality occurred, leaving experiences of gender bias within nursing and people of colour, minority groups and religious perspectives mostly absent. The research focus of men in nursing reinforces the viewpoint that men's experiences are more valuable than women's, which strengthens the gender bias found in most healthcare systems. Additional research is required to include women, transgender, gender non-binary, and gender-neutral people's struggles of gender bias within nursing and a strong focus is recommended to recognise the weight of intersectionality within such research.

Chapter One – Introduction and Background

Introduction

This chapter introduces concepts of gender, gender in nursing, and gender bias. There is an explanation of the intersectionality that occurs when discussing gender. Traditional gender stereotypes of feminine and masculine are highlighted, and the impact of these stereotypes are discussed from a nursing perspective. There is a particular focus on Aotearoa New Zealand and the country's indigenous Māori population when discussing the relationship between gender stereotypes and culture or ethnicity.

Gender

Gender has an increasingly more complex definition and there is increasing recognition that gender can encompass social, behavioural, and psychological constructions for some people, yet can be as simple as biology for others (Hall et al., 2021). The World Health Organisation (2023) expands on the definition of gender being a socially constructed concept with girls and boys who learn to grow into women and men, whereas sex is biologically determined. Hall et al. (2021) reinforces this view by recognising that the public have varying and contradictory conceptions of how gender is defined. Additionally, Meyerson and Kolb (2000) recognise d that gender is an axis of power which "shapes social structure, identities, and knowledge" (p. 563). Gender binary norms are being challenged and recognition is evolving that multiple genders exist, which needs to be recognised, validated, and acknowledged without prejudice (Anderson, 2022). Gender, sex, and sexual identity are separate concepts but are often incorrectly linked or grouped together for the sake of convenience or naivety (West-Livingston et al., 2021). Recognising and understanding that the concept of gender is not easily defined can assist with reducing preconceptions and judgements and will be associated with more positive attitudes towards people who may not adhere to traditional gender stereotypes. Nursing is a female dominated profession made up of diverse groups. An intersectional approach explores power relationships across ethnicities, age, health status, gender, sexuality and sexual identities, and social class (Hill Collins & Bilge, 2020).

Gender in Nursing

Globally, nursing is a women dominated profession. As a profession, it represents a substantial and international community, with a diverse workforce. According to the World Health Organisation (2020), about ten per cent of the workforce are men, but men tend to rise through the workforce quickly and sit in managerial and leadership positions (Gauci et al., 2022; Smith et al., 2021). New Zealand Registered Nurses who identified themselves as male sits at 9

per cent in 2019 (Nursing Council of New Zealand, 2019). More recently, intersectionality has framed the discussion about equalities in nursing, with the experiences of women of colour, including black women and indigenous women, and transgendered people widening the conceptualisations of equalities in nursing (Semu, 2020; Aspinall et al., 2022). In Aotearoa New Zealand, the experiences of Māori nurses are under reported and misunderstood (Hunter & Cook, 2020). The worldwide Covid-19 pandemic has brought these questions into sharp focus with the estimation of 115,500 healthcare worker deaths due to the virus (World Health Organisation, 2021) and an awareness of the underreporting and inaccuracies of data on the mortality of nurses linked to unavailability of personal protective equipment as determined in a scoping review with connections to eight countries (Vera-Alanis et al., 2022). The pandemic has highlighted the vital role of nursing, and the willingness of nurses to face personal risks for the health of communities as front-line workers.

Gender Bias

Nursing is a rare profession in which there are more women workers and managers than men, even with an increasing number of men entering the nursing profession (Berkery et al., 2014). Global healthcare is delivered by women and mainly led by men, where women hold 70 per cent of jobs in healthcare yet only 25 per cent of senior leadership or management roles (World Health Organisation, 2021). The World Health Organisation reported that out of 28.5 million nurses and midwives globally, only 4.5 million are men with men being more likely to be doctors, specialists, or in a leadership position than women (World Health Organisation, 2019). Caring work is gendered toward women, with emotion and self-sacrifice being commonly seen as attributes to being a good nurse. This type of work has historically been devalued and is linked to insufficient social and financial recognition and contributes to continuing labour and class divisions (Gunn et al., 2019). The struggle to strengthen nursing professional status may be underpinned by patriarchal social relations and the traditional male dominance/female subordination relationships conventionally seen in doctor/nurse roles (Gunn et al., 2019). Broadly, women are excluded from managerial positions which has an impact on overall labour productivity and income per capita, with men being promoted more rapidly to upper management positions (Belingheri et al., 2021; Turkmen & Bacaksiz, 2021; Mwetulundila & Indongo, 2022). Women may be disadvantaged or discriminated against in the workplace due career breaks and flexible working hours due to motherhood (Gauci et al., 2022). Women who become mothers are subject to a motherhood penalty where they often encounter per-child financial disadvantages in the workplace relative to women who have no children (Gurjar, 2021). In contrast, men who become fathers reap benefits of a fatherhood bonus where they

experience “a wage bonus net of their human capital characteristics” (Kmec, 2011, p. 446). This is due to bias toward who makes an ideal worker. Imbalanced leadership and senior nursing employment opportunities for women reduce job satisfaction and impact job retention (Gauci et al., 2021). Importantly, Soklaridis et al. (2017) and Gauci et al. (2021) identify that gender bias and gender discrimination is often denied by women; although a woman is disadvantaged because of her gender, she is unlikely to acknowledge the fact as a form of self-protection and advancing research on this topic may assist with women understanding more about how gender bias operates in the workplace. Women are more likely adhere to traditional feminine norms and suppress their own needs in favour of men as they fail to recognise how much they have to gain (Gauci et al., 2023). Compliance of gender norms makes it challenging to identify gender bias and therefore initiate change which adds complexity to this issue. Heightened awareness of, and education regarding gender related issues within healthcare may assist with reducing gender bias for example, from a recruitment perspective to aid with imbalances of genders in leadership and management positions.

Men in nursing as defined in sex segregation literature are an extreme minority and are more likely to choose certain nursing specialities that align with traditional male character traits such physical strength, technical aptitude, and composure during times of stress or pressure which reinforces the concept of traditional gender roles and sociocultural role expectations (Sasa, 2019; Smith et al., 2021; Mwetulundila & Indongo, 2022). Occupational sex segregation theorises that an employee will choose an occupation led by gender-specific affinity and ability, and stereotypes men as investing more time and energy in their employment than women, which allegedly increases their productivity (Steinmetz, 2012). Male nurses may be stereotyped as effeminate, homosexual, and less caring and compassionate than women which can be linked back to Victorian times when men who wished to assist with women’s work were categorised as undesirable and degenerate (Stanley et al., 2016; Blackley et al., 2019; Kearns & Mahon, 2021). Men in nursing report feeling marginalised, unwelcome by their female colleagues, apprehensive to provide personal care to female patients and frustration due to the higher proportion of manual handling tasks delegated to them; yet overall feel proud to identify as a nurse and experience satisfaction from providing care to others (Sasa, 2019; Smith et al., 2021). Kearns and Mahon (2021) recommended the challenging of traditional gender stereotypes from a school level to assist with boys knowing that nursing is a compelling career option. Men in nursing may experience professional benefits due to their ‘status shield’, whereby they are protected from the emotions and emotional labour of others and have a

decreased need to manage emotions when compared with women (Cottingham et al., 2014). Men in nursing – and in particular, white men – are also advantaged by the 'glass elevator effect' which contrasts with women who experience a 'glass ceiling effect' and experience career advancement to upper-levels of leadership roles faster than women (Brandford & Brandford-Stevenson, 2021; Smith et al., 2021). The number of men going into nursing in New Zealand is rising, the increase is nominal since 2006 at only one per cent (Nursing Council of New Zealand, 2020). Although there are automatic benefits to being a man in nursing, they also experience negative effects of stereotypes and judgments of their career choice. There is a push to recruit higher numbers of men into nursing and addressing gender stereotypes and the misconception of who makes an ideal nurse is a step toward encouraging more men into the nursing profession (Quinn et al., 2022).

Gender bias is defined as "any one of a variety of stereotypical beliefs about individuals on the basis of their sex, particularly as related to the differential treatment of females and males" (American Psychological Association, 2023, para.1). Broadly, gender bias continues to be prevalent worldwide as evidenced in a recent United Nations study covering 85 per cent of the global population and finding nine out of ten men and women hold biases against women (United Nations Development Programme, 2023). Gender bias intersects with other factors of discrimination such as ethnicity, socioeconomic status, disability, age, and sexual orientation and can produce inequalities that have social and economic consequences (World Health Organisation, 2023). This bias may be explicit or implicit; conscious or unconscious. The person may not know that they are experiencing gender bias due to the often systemic and historical nature of gender bias which can make it difficult to identify and prevent. However, quantitative data such as the gender pay gap and ethnic pay gap are being more widely reported on which may assist with making gender bias more explicit in everyday life. Given the nature of unconscious bias, certain behaviour and habits can be hard for people to change as they are unaware that their thoughts or actions are contributing to bias (Ministry for Women, 2023). Women are discriminated against in the job application process and are less likely than men to be short-listed particularly for leadership and management positions, with male candidates typically being offered an increased salary when compared with identical female counterparts (Soklaridis et al., 2017). Meyerson and Kolb (2000) developed a framework for gender equity and change with the goal of minimising the value of differences between men and women in workplaces so women can compete as equals, and to minimise the gendering of organisations or professions.

The glass ceiling is a term that refers to unofficial and invisible organisational and social barriers that obstructs progression in women's careers and can be linked to lower self-esteem within women who experience the glass ceiling effect (Mittal & Kaur, 2021). This is often seen in professions where women are dominant in numbers such as nursing and can cause a larger number of men in managerial positions despite being a minority. In contrast, men in nursing receive the benefits of the glass elevator effect whereby they are promoted more rapidly or are provided more career opportunities than their female peers (Punshon et al., 2019). However, the glass elevator is a racialised concept and does not apply equally or equitably to male nurses of colour or those of minority ethnicities (Brandford & Brandford-Stevenson, 2021; Punshon et al., 2019). Gender bias through inhibited career progression for women and fast promotion of men is a cause of the gender pay gap which, in Aotearoa New Zealand, sits at 9.2 per cent in 2022 with Māori, Pacific and Asian women earning less than European women (Ministry for Women, 2023).

Nurses in Aotearoa New Zealand who are employed by government agency Te Whatu Ora have recently accepted a historic pay equity settlement which recognises the gender-based inequality nurses face and is a step toward addressing gender-based discrimination (New Zealand Nurses Organisation, 2023). Pay transparency is being encouraged to reduce gender and ethnic pay gaps (Ministry for Women, 2023) however more systemic and complex issues such as institutional racism and unconscious stereotypes also need to be addressed (Punshon et al., 2019; Came et al., 2020). Discrimination that occurs against women in the workplace is often difficult to quantify due to its inherent nature. There is an intersectionality within the concept of the glass ceiling that needs to be recognised and acknowledged as a starting point to organisations making changes for their employees.

Indigenous nurses experiences

Indigenous nurses experience colonially imposed hierarchies of race, gender and occupation which can impact on traditional views of sex roles, particularly in regions where Florence Nightingale's nursing model historically allowed admittance to nursing training to women only (Kalemba, 2019). Generally, nurses are employed within establishments that have historical hierarchical and patriarchal cultures, and the mixture of this combined with under-represented

races and complicated gender dynamics can inhibit opportunities for some nurses (Aspinall et al., 2021). Intersectionality can express how an identity such as culture can compose meaning through its relationship to another identity such as gender (Green, 2017). Huria et al. (2014) determined that racism is an issue challenging Indigenous nurses across all career stages in New Zealand, Australia, Canada, and the United States and can be linked to detrimental health outcomes and unsafe working conditions. Further, colonisation is linked to inequities in health outcomes in Indigenous populations in New Zealand, Australia, Canada, and the United States of America (Komene et al., 2023). Māori nurses are under-represented in Aotearoa New Zealand due to a systemic lack of Māori representation in decision making, strategic leadership and health and leadership strategies (Pipi et al., 2021). Māori nurses also endure institutional, interpersonal, and internalised racism at work (Huria et al., 2014), with some feeling tired, undervalued, and unrecognised as Māori within a Western healthcare system and a largely biomedical way of practising (Komene et al., 2023). Komene et al. (2023) highlighted the importance of maintaining visible Indigenous nursing leadership as a way of improving health inequities and Indigenous peoples' healthcare experiences. Healthcare organisations and those in leadership roles are not doing enough to encourage all nurses to become culturally competent and take on these roles to assist with already overloaded Māori or Pacific nurse responsibilities, which is an example of institutional racism (Huria et al., 2014). These examples in addition to a lack of access to quality career information, include barriers for Māori not continuing on career pathways and is a likely reason why Māori are not represented in nursing leadership or managerial roles (Ratima et al., 2007).

Regardless of culture, race, or ethnicity, leadership styles have been dichotomised as masculine (competitive and authoritarian) and feminine (collaborative and relational), with men being more likely to be recruited and selected for leadership or managerial roles (Roth et al., 2016). It is especially challenging for female Māori leaders working in Pākehā dominated workplaces to enact their cultural identity while maintaining 'culturally appropriate' leadership and managerial attributes (Holmes & Marra, 2011). Pipi et al. (2021) recognised the difficulty of Māori women being seen as natural leaders in their communities yet are an 'oddity' as employees in the healthcare system. A lack of Māori and Pacific people in leadership positions can reinforce feelings of distrust of Māori and Pasifika intelligence by European people which is a cause of institutional racism (Came et al., 2020). Racism is a determinant of health and those who experience racism directly or indirectly can experience social stress, mental unwellness

and physical issues (Anderson, 2012). Came (2013) advocated for conscientisation around issues such as internalised racism and encourages effective activism through further research into the influences of racism and privilege particularly within the public sector and suggests customised anti-racism training. It is vital that strategies are put in place to diminish patterns that lead to the under-representation of minority ethnic groups to ensure commitments are made to reduce the ethnic pay gap and challenge racial stereotypes.

Any research conducted in New Zealand is of interest to Māori, and any research involving Māori is meaningful to Māori. This review acknowledges the articles of Te Tiriti o Waitangi as communicated by the Waitangi Tribunal: Tino Rangatiratanga, equity, active participation, options, and partnership (Waitangi Tribunal, 2019). It is recognised that assumptions held by the researcher should not made as Māori have historically struggled to maintain control over research practices and aims to adopt a cross-cultural approach to ensure cultural safety and recognise the principles of Te Tiriti o Waitangi (Ware et al., 2018).

Gender fluidity and non-binary genders

Language around gender and gender identity continues to evolve and there is an increasing number of terms used to define and redefine gender identity. For the purposes of this scoping review, commonly used terms within this review will be defined however this does not constitute all terminology relating to gender and gender identity. Although gender identity terminology will be attempted to be defined, self-definitions may differ to those described. Gender identity is recognised as a multidimensional construct determined by an individual which may develop or change over time (Egan & Perry, 2001; Wood & Eagly, 2015). Gender non-binary is an umbrella term for gender identities that sit outside male/female binary whereas gender fluid refers to a non-binary term that shows movement between different genders (Te Kawa Mataaho Public Service Commission, 2023). The term cisgender refers to a person who identifies as the same gender they were assigned at birth (Pride Pledge, 2022). Gender identity terms within this review are from a Pākehā/western understanding and it is acknowledged that Māori and Pacific people may ascribe to different identities that may align more with their cultural background (Tan et al., 2019).

More recently, there are calls to understand non-binary experiences of gender in health care to become more inclusive and reflective of the wider community. The continuing reinforcement

of prescriptive gender binary terms in society can be harmful to those who do not identify as cisgendered due to possible feelings of inauthenticity and distress through social dysphoria (Dray et al., 2020). Seemingly simple acts such as the recognition of genders other than male and female on forms or using gender-neutral language on webpages means certain people will not feel invisible or dismissed and will aid with normalising gender diversity and will represent inclusivity (Kellett & Fitton, 2017). As a way of respecting an individual's right to gender self-identification, the Nursing Council of New Zealand recently added a gender diverse option to their register and reported that one person had used this option and no members have changed from male to female or vice-versa (Nursing Council of New Zealand, 2020). Nursing Council of New Zealand deem gender to be a complex or sensitive type of data and do not include this information in their quarterly reports as a way of protecting the privacy of the very few people who choose the gender diverse option when updating their nursing registration data (Nursing Council of New Zealand, 2023). Although nurses can self-define their gender and alter a form in their workplace for themselves or their patient, this may not be widely known or promoted (New Zealand Nurses Organisation, 2016). It is likely that the number of gender diverse people will rise with more fluid gender so any additional awareness to the issues discussed will be meaningful (Nursing Council of New Zealand, 2020). The Nursing Council of New Zealand has signed a Pride Pledge as step toward ensuring nurses and patients feel safe and inclusive when giving or receiving healthcare (Nursing Council of New Zealand, 2023). The New Zealand Nurses Organisation (2016) recognised the heteronormative assumptions of being cis-gendered and heterosexual as normal and highlights the risk factors associated with these beliefs. The Nursing Council of New Zealand (n.d.) identified that not all people feel comfortable providing their gender identity on a form yet now require all nurses who renew their annual practising certificate to provide their gender. Australia's largest nursing union recognises the prejudice non-cisgendered people fear when needing to disclose their gender and states that non-cisgendered people from other marginalised populations are likely to experience heightened discrimination if they reveal their gender (Australian Nursing and Midwifery Federation, 2021). The World Health Organisation (2020) calls for gender-sensitive nursing workforce policies that focuses on the needs of nurses as women, yet do not recognise or quantify genders other than male or female in the published data. If organisations demonstrate more sensitivity to becoming gender neutral, this may also assist with challenging gender stereotypes and biases, and ultimately recognising that a person's gender doesn't define their characteristics or qualities, nor does it determine how well they can do a job. It is recognised that there is a tension because of the risk of discrimination that a disclosure will not

result in fair treatment. Without recognition, responsibility to provide fair treatment cannot happen and so further work is required to decreased poor outcomes when people do disclose.

In Aotearoa New Zealand, the most recent fully published nationwide census from 2018 reports 49.3 per cent male residents, and 50.7 per cent female residents with 2023 being the first year a person was able to identify as anything other than male or female (Statistics New Zealand, 2018). Statistics New Zealand (2019) recognised the need for statistical reporting to be flexible with minimal limitations in adequately reflecting the whole population including minority groups and intersex people. A more recent Household Economic Survey in Aotearoa New Zealand determined 0.8 per cent of the New Zealand adult population identify as transgender or non-binary and recognised that language related to the LGBTQ+ population is quickly evolving and may mean different things to different people (Statistics New Zealand, 2021). There are benefits to gender diversity in nursing such as visibility which may encourage others with a similar background (ethnicity, gender, or sexuality) to request support and feel safe and more involved in having their health needs met (Quinn et al., 2021). The significance of the findings of this review will be in the validation, and advocacy for, addressing gendered inequality in the nursing professions, with potential to contribute to national professional dialogues regarding issues relating to pay equity, gender inequalities or inherent power imbalances. It may also highlight additional ways to ensure gender diverse or gender non-binary people have an inclusive work environment.

Positionality

I acknowledge my standpoint as a European cisgendered woman, and I am highly aware of the privilege that comes with such a title. I recognise that I have very little direct experience of Māori tikanga despite having lived in Aotearoa New Zealand my entire life and strive to be humble when learning about Māori protocols and practices. I remain grateful for the research that is readily accessible to me. I position myself as a strong advocate for women and their rights, and I believe this feeling was heightened as this dissertation was written while pregnant and on maternity leave. My own challenging experience with attempting to return to work in a part-time capacity after completing maternity leave has further deepened my determination to complete this research. I regularly reflected on my own position and biases and would discuss these with my supervisor. I recognise when change needs to occur and am hopeful this scoping review may facilitate conversations at the very least.

Aim of the scoping review

An initial search of databases identified that most literature focused on the experiences of male nurses, with no research found focusing on people who are gender non-binary or gender diverse. Scoping reviews are not widely used, instead integrative reviews, survey studies, and phenomenological or grounded theory qualitative design studies appear to be more commonly seen. In May 2023, an Australian study entitled 'Workplace gender discrimination in the nursing workforce – An integrative review' (Gauci et al., (2023) was identified and recognised most of the research on the topic of gender discrimination is from the perspective of men and stated "it is important that the pursuit of greater representation of men in nursing does not result in strengthening patriarchal advantage" (p. 17) and implies traditional gender roles and norms be challenged to assist with decreasing bias in the nursing workforce. This study used similar search terms to this scoping review and has included five articles also used for this review. Given that gender bias in nursing and particularly gender bias with a focus on women in nursing is an emerging topic, this article highlights reasons why gender bias occurs and emphasises the impact patriarchal cultures have on women. This article acknowledges the difficulty in challenging behaviour and attitudes that are often invisible and generally culturally accepted. The authors strongly recommend additional research on gender bias in nursing focusing on women. This article is critical in its timing and given the rigour of the research, this article provides strong evidence of the importance of this topic.

This scoping review aims to critically evaluate the research and grey literature to present an in-depth discussion of gender power in the profession, with a particular view on Aotearoa New Zealand.

Focus of Inquiry:

How is gender bias defined in nursing research?

How do nurses experience gender bias in the workplace?

How does gender bias operate to sustain or prevent inequalities for nurses' career advancement?

Aims:

- To analyse the accepted and contested areas of gender bias in nursing
- To describe the impacts of gender bias on nurses

- To critically analyse how binary and non-binary conceptualisation of gender is present in the nursing literature

- To critically evaluate gendered power structures within healthcare settings to discuss how gender and power operate to sustain or prevent inequalities for career advancement

Structure of the dissertation

The dissertation is organised into four further chapters:

Chapter Two: Methodology – This chapter will explore the methodology that was considered and an explanation why a scoping review is ideally suited for this topic of gender bias in nursing. An outline of guidance documents for standardisation purposes is provided and inclusion and exclusion criteria are outlined with rationale. Search terms are specified, and grey literature inclusion is outlined. The search outcome is explained and a table demonstrating the PRISMA findings is accessible. Quality appraisal occurred and is outlined. A description of how themes are determined is provided and the finalised themes are given.

Chapter Three: Themes – Findings from the review are detailed and an outline of the articles included in determining the themes. The themes of touch, money, glass escalator and glass ceiling, and gender identity and assumptions of nurses are explored.

Chapter Four: Discussion – Chapter five will discuss what the key findings are in the scoping review regarding wider literature. Gaps found in the literature will be highlighted.

Chapter Five: Conclusion and Recommendations – An overall conclusion will be outlined and recommendations for future research will be provided.

Conclusion

Nursing is a women dominated profession and represents a large global community. The concept of gender is complex and difficult to define with gender norms being increasingly challenged in everyday society. People who do not conform to traditional gender stereotypes of feminine and masculine are likely to face biases, prejudices, and judgements. Men in nursing experience stereotyping as they are not conforming to the traditional expectation of masculinity and as a result may be stereotyped as homosexual or less compassionate than women. However, men also experience benefits such as being more represented in leadership and management positions than their female colleagues, often called the glass escalator effect. Women in nursing are impacted by the glass ceiling effect and are more likely to have reduced job satisfaction due to witnessing men rise quicker into upper management positions than women. Women also experience discrimination as they are more likely to require a career

break to have a child; this goes against the qualities an ideal worker should have. Gender bias in nursing is often difficult to recognise and quantify which is why women may deny its presence and extent.

Patriarchy and hierarchy exist in healthcare which makes breaking down traditional male dominance/female subordination roles difficult. Expected gendered behaviour of women as carers means women's work is often devalued as caring is seen as innate and unskilled. Women are more likely to be excluded from managerial roles based on gendered stereotypes and are more likely to disadvantaged due to the possible need for maternity leave through the glass ceiling effect. Men are more likely to be celebrated once they become fathers and even reap the benefits of a fatherhood bonus. Additional research on gender stereotypes and gender bias is recommended as gender bias is often denied by women due to how unconscious and culturally engrained the behaviour is.

Men in nursing are a minority and experience stereotypes such as assumptions of their sexuality and being less caring their female peers. Men in nursing may also feel frustrated due to having certain manual handling tasks delegated to them more readily and report feeling marginalised. However, men in nursing are more likely to be promoted than their female peers due to the assumption that men have the natural qualities to in leadership positions. Highlighting the impact of adhering to traditional gender stereotypes may assist with breaking down barriers to encourage more men into the nursing profession.

Gender non-binary people are largely unrepresented in the nursing profession and there is a push to remove assumptions that being cis-gendered, and heterosexual is normal. Gender can be fluid for some people and can be a complex concept for others, so assisting with breaking down stereotypes can help with creating a more inclusive and safer environment. Recommendations such as creating gender-sensitive nursing workforce policies and using gender-neutral language within the workplace may make people who are not cis-gendered start to feel included and aid in breaking down gender stereotypes and biases.

Ethnicity and culture are important intersections within gender in nursing due to minority ethnicities being under-represented and more likely to experience institutional racism. In Aotearoa New Zealand, Māori nurses may feel unrecognised as Māori due to working in a Western, largely biomedical healthcare system. Māori nurses may struggle to maintain their cultural identity in the workplace yet are regularly called upon for cultural advice. It has been recommended that further research occurs looking into the influences of institutional racism and privilege with a goal of reducing the ethnic pay gap and challenging racial stereotypes.

Chapter Two Methodology

Introduction

This chapter provides an explanation of the suitability of a scoping review for this topic. An outline of the methodology is provided along with rationale behind the chosen method and reasons why alternative methods were not utilised. The search details the databases used, search terms, inclusion and exclusion criteria, critical appraisal, and how themes were determined. A description of grey literature used is included.

Methodology

Prior to commencing the search for literature, different types of reviews were studied and narrative, integrative, scoping, and systematic reviews were all considered. Although a narrative review could be written in a few months and by an inexperienced author, this method was discounted as narrative reviews have no accredited guidelines for writing (Ferrari, 2015). An integrative review was considered as it offers a comprehensive understanding of a new or mature topic using empirical and theoretical literature (Oermann & Knafl, 2021). Although gender bias in nursing is an emerging topic, integrative reviews seek to inform policy and practice which is not the overall goal of this research (Whittemore & Knafl, 2005). Integrative reviews also typically require multiple researchers which is not possible for the writing of this dissertation (Torraco, 2016). A systematic review was studied as an option however this type of review typically requires a narrow, direct question that can take 12-24 months and a research team to complete (Toronto & Remington, 2020).

A scoping review was chosen for this dissertation as they are an ideal tool to establish coverage of a body of literature on a topic and give a distinct indication of the volume of literature and studies available as well as an overview of its focus (Munn et al., 2018). According to Arksey and O'Malley (2005), scoping reviews are appropriate for broader topics due to the breadth of research that may be found however given the breadth of research that might be found, the researcher may need to place additional limitations on their search terms. In this scoping review, the identification and clarification of themes and characteristics from published studies is the goal which is why broader scope is required. Scoping reviews can be undertaken in the short term with one to two reviewers (Grant & Booth, 2009). A scoping review may be completed as a precursor to a systematic review which is another reason why a scoping review was deemed more appropriate: if additional research is required after submission of this

review, a systematic review may be an appropriate choice (Gupta et al., 2023). Scoping reviews are being more widely used across multiple fields and are a type of evidence synthesis used to compose existing research and elucidate an evidence basis (Munn et al., 2022). Quantitative and qualitative research can be included in scoping and systematic reviews, however different approaches such as a meta-analysis review only allows for quantitative studies (Harris et al., 2013). Scoping reviews are used to clarify a complex concept and narrow down consequent research inquiries (Levac et al., 2010). The data extracted and evidence found (or not found) within a scoping review offers ideas for future development and potential new research (Pollock et al., 2021). However, scoping review findings should not be used for changes in policies or practice as quality assessment often does not occur (Grant & Booth, 2009). In this instance, quality appraisal occurred for some of the research found for this scoping review. Grey literature in the form of websites, news articles, and theses can be included within a scoping review and all relevant literature may be included, regardless of methodological quality (Gill, 2021; Pollock et al., 2021). The inclusion of grey literature is a benefit to scoping reviews as emerging topics may not have many peer-reviewed publications or research (Pollock et al., 2021).

For standardisation purposes, this scoping review will be written based on direction from the Joanna Briggs Institute Manual for Evidence Synthesis (2020). As per recommendations, the title should identify the document as a scoping review. An abstract is required which provides a structured summary and the introduction includes rationale and objectives of the review. The methods chapter requires information on eligibility criteria, sources of data or information, as well as how the search process occurred. The methodology chapter will detail how data is sourced and methods used to record the data including any variables. The critical appraisal technique used will be outlined along with how results from the data are produced. The results section will provide information around the selection of sources, characteristics of sources of evidence, results from individual sources and a summary of the results. The discussion will discuss a summary of evidence, limitations, conclusions, and recommendations based on the data.

Basing this review on guidance from a protocol will assist with reducing bias and ultimately help develop a better-quality review (Peters et al., 2022). Studies with a similar topic that have utilised a scoping review may be used as guidance to assist with modelling this review on as

they reinforce the justification of using a scoping review for the topic of gender bias (Belingheri et al., 2021). A review of the literature was undertaken, guided by the PRISMA framework. There is limited research on gender bias within nursing and as such the electronic databases of CINAHL, Scopus, Medline via EBSCO, Business Source Complete and Joanna Briggs Institute were systematically searched using key words. These databases were chosen for their popularity, reliability, and quality sources of information. Qualitative and quantitative articles are included. As guided by Pollock et al. (2021), a librarian was contacted during the development of the search to assist with search terms and narrowing down possible databases for searching. Key words were identified from the aims of the review, in consultation with a librarian and from examination of the key words used in literature found pertaining to the topic. To be included in this review, studies had to meet the following inclusion criteria: focus on nurses of any gender and workplace bias; published between January 2016 and 2022; published in English; full text available; country of origin being New Zealand, Australia, Canada, or the United States. The country of origin was included as it was established early in the search there is a relationship between gender bias, nursing, and indigenous populations. The search occurred from April 2022 to June 2022.

The searches limited articles published from 2016 to 2022 however did not exclude articles that included research undertaken prior to 2016. 2016 was chosen as a starting point to determine any contemporary or emerging research or concepts within the topic of gender bias and nursing. The New Zealand Nurses Organisation (2016) issued a position statement determining the evolution of self-definitions and highlighted considerable social and legal changes in the field of gender diversity since their previous statement on nursing and gender diversity in 1997. Due to the want to focus on indigenous populations and the relationship with gender bias and nursing, research from New Zealand, Australia, Canada, and United States were included in the search. There is also recognition that New Zealand, Canada, the United States and Australia all experience cyclical nursing shortages and rely on internationally qualified nurses to fill these employment vacancies (Nursing Council of New Zealand, 2013).

Search terms

The key words searched were:

man OR men OR male OR female OR woman OR women OR non-binary OR gender diverse AND nurse OR nurses OR nursing AND bias OR discrimination OR stereotype OR judg*.

Searches were attempted using these key search terms in the title, and an additional search was undertaken using the key search terms in the abstract. A total of 336 articles across CINAHL, Scopus, Medline via EBSCO and Business Source Complete were found with eight articles being highlighted for possible inclusion. Due to these limited results, the search was expanded to:

man OR men OR male OR female OR woman OR women OR non-binary OR gender diverse AND nurse OR nurses OR nursing AND bias OR discrimination OR stereotype OR judg* OR gender pay gap OR sexism OR gender OR gender inequality OR gender inequity OR gender bias OR career progression.

The search was limited to include research published from 2016 to 2022 however research obtained prior to those dates were included, full text articles and those written in English. Certain additional research papers found during this initial search were included as part of potential inclusion for this revised topic. To expand results without resulting in outdated literature, the search was repeated with the date range having been increased from 2012-2022. A total of 229 articles were found with 9 highlighted for possible inclusion. Due to the limited amount of research articles found in the search, the reference lists from the selected articles were scanned for additional appropriate articles that may meet the inclusion and exclusion criteria. As a result of this, an additional 24 articles were highlighted for possible inclusion. Grey literature was included and was sourced from the websites of New Zealand, Canada, Australia, and the United States nursing unions and registering boards, to access freely available policies. These organisations were chosen to provide country-specific evidence to further the data extracted from the studies found in the search process. The grey literature search provided evidence relating to the positioning of the leading bodies on gender issues. The following organisations websites were searched:

New Zealand: New Zealand Nurses Organisation and Nursing Council of New Zealand.

Australia: Australian Nursing and Midwifery Federation and Nursing and Midwifery Board of Australia.

Canada: Canadian Federation of Nurses Unions and British Columbia College of Nurses and Midwives.

United States of America: National Nurses United and National Council of State Boards of Nursing.

It is clear from searches within the above websites that conversations are occurring regarding gender bias and gender discrimination in the workplace. Information around gender definitions and an awareness of the evolving nature of language around gender is available on some of these sites. This information is somewhat primarily directed toward safe patient care however more reporting is occurring on making workplaces safe for nurses regardless of their gender, sexuality, or race. There is not specific information pertaining to issues around gender bias toward women nurses, yet information is available demonstrating improvements that need to be made to retain men in nursing. Men are visually represented across these websites in photos and interviews.

Search outcome

The 41 articles found for possible inclusion in this scoping review were reviewed. Several articles were duplicates and some were excluded as they were integrative reviews or concept analyses. A few articles were excluded as the study did not take place in New Zealand, Australia, Canada, or the United States. Only one article from the second expanded search from 2012 was included, indicating the recent developments in the gender bias conversation. Four articles were published in 2016 with two most recent articles being published in 2022. Thirteen articles were narrowed down for inclusion in this review, with six of qualitative design and seven of quantitative design. Of the participants included among these articles, 12.86 per cent are male, 87.06 per cent are female and the remaining 0.08 per cent were a small group of patients who were included in one study. Two studies have been excluded from these percentages as one study contained data from four decades of information collected and another included over 400,000 people but with no differentiation for male or female registered nurses.

PRISMA 2020 flow diagram which includes searches of databases only.

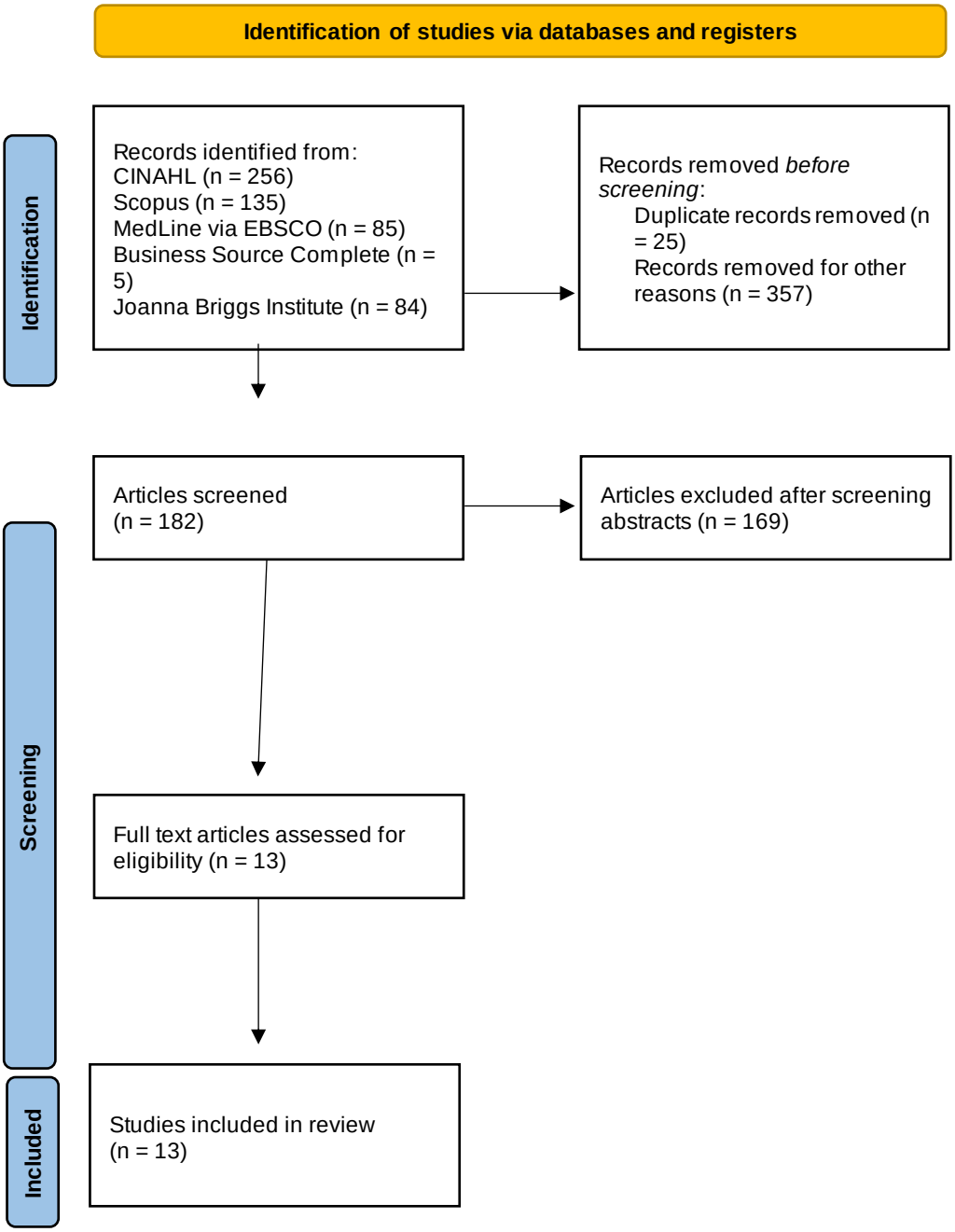

Figure 1, PRISMA diagram (PRISMA, 2023).

A total of 565 articles were identified from five databases. 382 of these articles were removed before screening due to duplications or not meeting the country of origin in the inclusion

criteria. 182 articles were screened through reading the abstracts and a further 169 articles were discounted as they did not meet the inclusion criteria. The remaining thirteen articles were deemed suitable for inclusion and are included in this scoping review.

Quality appraisal

Studies which met the inclusion criteria were reviewed and read in full. Seven studies did not fit into an existing Critical Appraisal Skills Program (CASP) checklist and were therefore not appraised. The remaining six studies were measured against possible CASP checklists. The studies appraised were:

1) Potential for misinterpretation: An everyday problem male nurses encounter in inpatient rehabilitation
2) The experience of workplace gender discrimination for women registered nurses: A qualitative study
3) Men in nursing: Intention, intentionality, caring, and healing
4) The essence of helping: Significant others and nurses in action draw men into nursing
5) A comparative study of Australian and New Zealand male and female nurses' health: A sex comparison and gender analysis
6) Stressors and rewards experienced by men in nursing: A qualitative study

The CASP checklists are designed to assist the user to make an informed decision on the quality of an individual study (Dixon-Woods et al., 2007) and are recommended for novice qualitative researchers (Long et al., 2020). No study was excluded based on the determined quality of the information as the scoping review is intended to ascertain the scale of research available regardless of its quality (Pham et al., 2014). Peters et al. (2022) confirm this when they state critical appraisal is often omitted from scoping reviews as scoping reviews are descriptive and focuses on the characteristics of data found. One CASP checklist has been included as an example in appendix two, with the table below showing an overview of the findings of all six CASP appraised articles.

Table 1, overview of CASP appraised studies

Potential for misinterpretation: An everyday problem male nurses encounter in inpatient rehabilitation
Aims for the research were clearly stated with the methodology being appropriate. The recruitment strategy was appropriate, and the data was collected in a way that addressed the research issue. Relationship considerations between the researcher and the participants could have been more overt and the study does not address the researchers own bias or influence. Ethics and rigour considerations are satisfactory.
The experience of workplace discrimination for women registered nurses: A qualitative study
The aim and relevance of the study is clearly indicated, and the methodology is appropriate for the type of research aimed for. The recruitment process and data collection process were adequately justified with data saturation occurring after ten interviews. The relationship between the researcher and the participants was considered with researchers examining their own role and biases. Ethical considerations were strongly considered, and rigour was maintained through credibility, conformability, dependability, and transferability. The findings may contribute to discussions around recruitment and retention of nurses globally.
Men in nursing: Intention, intentionality, caring, and healing
The aims of the research were not clearly presented, and certain key terms were not defined. The methodology was not outlined nor was reasoning behind this mentioned. The recruitment strategy was vague with limited information behind how the data was collected and recorded. The researcher did not relay their own role within the data collection nor highlight any biases that may have occurred during the study. No follow up for participants was offered and ethical approval was not mentioned. Some themes were provided however there was no description of how these themes were gathered.
The essence of helping: Significant others and nurses in action draw men into nursing
The introduction was very brief with limited rationale provided on the relevance of the research. The methodology and research design was appropriate. Recruitment strategy and data collection was suitable and justified by the researcher. The relationship between the researcher and the participants was not considered yet ethical approval was received. Rigour was not sufficiently achieved as the researcher did not examine their own role or biases. The findings are somewhat relevant however they are limited by being focused on male nurses.

A comparative study of Australian and New Zealand male and female nurses' health: A sex comparison and gender analysis
This study clearly focused on the issue and recruitment occurred in an acceptable way. Both subjective and objective measurements were used to minimise bias and a reliable system was used to minimise bias. Confounding factors were suggested however there was no apparent follow up of participants. The results were believable with 95 per cent confidence intervals.
Stressors and rewards experienced by men in nursing: A qualitative study
The aims of the research are clearly identified, and the methodology is appropriate. The methodology is appropriate. The researcher may have known some of the participants after reaching out those on social media but this is not clarified. The researchers own biases have not been discussed and ethical approval was obtained. Rigour was maintained through thematic analysis and crosschecked by all authors. Follow up interviews with the participants may have enhanced the studies findings.

Determining themes

The extraction of themes from the included studies was guided by Braun and Clarke (2022) reflexive thematic analysis. The first phase involved reading and re-reading the articles included in this scoping review. Brief notes were initially taken and recorded on Post-It notes, with additions being made after each re-reading. Ideas and a deeper understanding of the topic started to be developed during this phase. Background research occurred to assist with a gaining a deeper understanding of the topic with an aim to become more analytical. Once phase one was nearing completion, notes were transcribed into Microsoft Word and started to become more formalised. During the second phase, the articles were re-read with a specific focus of starting to determine codes. Relevant data was becoming more apparent and meaningful. NVivo was used to store studies and aided with the initial development of codes. The initial codes were largely obvious while being inputted into NVivo and as this process developed, the coding became more concentrated and conceptual. NVivo was a useful tool to add in additional thoughts and reflections, and to link possible codes to segments of data in each study. Phase three involved identifying patterns across codes. The codes that were compiled are actively developed and additional notes were made during this process. Shared meanings within different codes were then consolidated to create a potential theme. Notes were always kept and revised as a way of informal journaling and reflection. This is appropriate

for a scoping review where the researcher is encouraged to be iterative, engaged and reflexive throughout the research process (Arksey & O'Malley, 2004). The fourth phase involved developing and reviewing themes. Additional re-reading of the articles occurred to make sure the initial themes made sense and fitted the overall topic. Thirteen early themes were proposed and as patterns continued to emerge and data was drafted then consolidated, some themes were able to be combined. As guided by Braun and Clarke (2022), the relationship between the themes was recognised and possible sub-themes were drafted which was aided by the background research that happened in phase one. During phase five, themes were established and were based on a main concept. Themes were then named, and an outline of the theme was drafted. Phase six involved a lengthy process of pulling together notes and the outline from phase five to write the theme up. Editing the writing that occurred was an ongoing process and notes were always kept ensuring nothing was forgotten and reflection could continue to happen. The research aim was continually re-read to ensure the themes were appropriately addressing the research question. Four final key themes were determined: (i) touch, (ii) money, (iii) glass elevator and glass ceiling, and (iv) gender identity and assumptions of nurses.

Conclusion

Scoping review was deemed the most appropriate methodology for this research due to gender bias being a broad and emerging subject, and a search from a large body of literature including grey literature was required to determine the extent of existing research. Data found within a scoping review may lead to additional research through a systematic review or can aid with ideas for future expansion. This scoping review is guided by the Joanna Briggs Institute Manual for Evidence Synthesis protocol and a literature review was undertaken as guided by PRISMA framework. Search terms were developed with assistance from a librarian and an inclusion and exclusion criteria set out with rationale. From 565 articles initially found, this was narrowed down to 13 articles being included in this scoping review. Limited quality appraisal happened using CASP forms. Four themes were determined after following guidance from Braun and Clarke (2022) use of thematic analysis.

Chapter Three Findings

Findings of the Review

This chapter outlines the findings derived from the search and consequent thirteen included articles. Themes and sub-themes will be outlined and supported with evidence from included articles. The themes discussed are touch, money, glass ceiling and glass elevator, and gender identity and assumptions of nurses with sub-themes of gender role strain, gender as active challenge to social norms, sexuality, and the need for muscle.

Six out of the thirteen articles are based on qualitative research with the remaining articles predominantly being survey studies. Six articles are based in the United States of America, five primarily from Australia, one from Canada, and one article is based on nurses from Australia and New Zealand. One article focused on female nurses whereas an additional six articles focused solely on male nurses. Six articles did not mention ethical approval, however five of these were survey studies where the information the study was based on is available to the public. The remaining article is a qualitative study which did not rate highly in the CASP assessment, partly due to the lack of transparency around ethical management of the participants.

Table 2 – overview of studies

	Methodology	***Methods***	***Sample***	***Location***	***Ethics***
Baker et al. (2021)	Constructivist grounded theory	Interviews and observation	23 male nurses, 15 patients	Australia	Ethical approval granted
Blackley et al. (2019)	Phenomenological design	Semi-structured interviews	6 male nurses	Australia	Ethics approval granted
Bumbach et al. (2020)	Survey study, secondary data analysis	Data from 2012 Survey of Nurse Practitioners	8978 Nurse Practitioners	United States of America	Not mentioned
Gauci et al. (2022)	Qualitative, exploratory design	Semi-structured interviews	10 female nurses	Australia	Ethical approval granted
Greene et al. (2017)	Survey study, secondary data analysis	Data from 2012 Survey of Nurse Practitioners	6591 Nurse Practitioners	United States of America	Not mentioned
Juliff et al. (2017)	Phenomenology	Interview	9 male nurses	Australia	Ethical approval granted
Munnich and Wozniak (2020)	Survey study	US Census and American Community Survey	2500 cohorts	United States of America	Not mentioned
Stanley et al. (2016)	Quantitative, survey	Online questionnaire via email	247 male nurses, 808 female nurses	Australia	Ethical approval granted
Tuckett et al. (2016)	Survey study	eCohort self-reported survey	342 male nurses, 342 female nurses	Australia and New Zealand	Ethical approval granted
Twomey and Meadus (2016)	Qualitative descriptive	Questionnaire	239 male nurses	Canada	Ethical approval granted
Wallen, Mor and Devine (2014)	Survey study	Web based survey	178 male nurses	United States of America	Not mentioned
Wilson et al. (2018)	Survey study	Data from American Community Survey	427,080 nurses, 965,878 teachers	United States of America	Not mentioned
Zahourek (2016)	Qualitative, grounded theory	Interviews	12 male nurses	United States of America	Not mentioned

Themes

The themes were developed through capturing patterns of meaning and shared topics within the data (Braun & Clarke, 2022). Once a pattern started to emerge or a shared topic was identified, further analysis would take place. This meant that upon further re-reading of the articles, concepts and topics that may have originally been discounted as irrelevant were unpacked and assisted the formation of four main themes from an initial draft of eleven main topics. Braun and Clarke (2022) recognise the importance of early clustering in the creation of codes which in turn assist with the formation of a theme. It was recognised that the themes of touch, money, and glass elevator and glass ceiling had clear boundaries however the theme of gender identity and assumptions of nurses had evolved and required additional sub-themes that underpinned the topic of gender identity and assumptions of nurses. Braun and Clarke (2022) advise sub-themes to be used sparingly as too many sub-themes may cause a lack in analytic depth and should only be used to tell the strongest story about the data.

The themes are presented in table 3. Eleven out of thirteen articles exhibited information on gender identity and assumptions about nurses, with the theme of touch following closely with ten articles. Gender identity and assumptions of nurses did not appear in articles by Greene et al. (2017) and Bumbach et al. (2020); these were survey studies and focused on gender differences in nurse practitioners. The touch theme did not show up in three articles as two of the articles focused on salary and the other focused on male nurses' gender professional identity integration. The theme of money was shown in eight articles with four of the articles this theme was excluded from having solely men as participants in the research. The remaining article studied men and women but focused on their overall health. The theme that appeared in the fewest articles was the theme of glass elevator and glass ceiling. Out of the eight research articles that do not exhibit information on the glass ceiling or glass elevator, six of these articles focus on men in nursing and the remaining two articles focus on nurse practitioners. All four themes are identified in two out of thirteen studies by Gauci et al. (2022) and Stanley et al. (2016). The article by Gauci et al. (2022) rated highly in the CASP assessment and although the article by Stanley et al. (2016) did not fit into an existing CASP assessment tool, it was deemed to have nil or few flaws in a more recent study by Gauci et al. (2023).

Table 3, Sources and themes	**Touch**	**Money**	**Glass elevator and glass ceiling**	**Gender Identity and Assumptions of Nurses:**
Baker et al (2021)	X			X
Blackley et al (2019)	X		X	X
Bumbach et al (2020)	X	X		
Gauci et al (2022)	X	X	X	X
Greene et al (2017)		X		
Juliff et al (2017)	X	X		X
Munnich and Wozniak (2020)	X	X		X
Stanley et al (2016)	X	X	X	X
Tuckett et al (2016)	X		X	X
Twomey and Meadus (2016)	X	X		X
Wallen, Mor and Devine (2014)				X
Wilson et al (2018)		X	X	X
Zahourek (2016)	X			X

Touch

The theme of touch appears in ten out of thirteen articles which indicates there is consensus in the literature that there is heightened awareness of the professional touch provided by male nurses, and the touch received by male nurses. In the qualitative grounded theory design study by Baker et al. (2022), female patients assumed their male nurse is heterosexual, yet male patients assumed their male nurse is homosexual; both genders of patients indicated touch by their male nurse may have been sexually motivated. In Zahourek's (2016) qualitative grounded theory study, they explained that male nurses have heightened sense to ask for permission from patients of any gender for instrumental touch tasks such as obtaining a blood pressure and will readily ask for a chaperone while attending to female patients. Zahourek (2016) stated that touch for men in nursing may be taken as seductive. Studies by Baker et al. (2022), Blackley et al. (2019), Stanley et al. (2016) and Zahourek (2016) determined male nurses are much more likely to have their care declined by female patients and are more likely to be accused of alleged sexual misconduct and are more likely to manage the resulting emotions by working in areas such the intensive care unit, where physical touch is less necessary. Tuckett et al. (2016) explained from their survey study that male nurses are more focused on the technical aspects of nursing such as taking a blood pressure and are more likely to work in intensive care units and emergency departments where they are more likely to gain respect from others. This may reinforce the stereotypical gender behaviours within masculinity and does not assist with breaking down gender stereotypes within the nursing profession. Bumbach et al. (2020) identified in their survey study that fewer male nurse practitioners in the United States perform physical examinations on their patients compared with their female colleagues, preferring to

provide education and preventative care. The historical association of nursing as women's work may cause patients to harmfully question the care provided by a male nurse especially when intimate touch is involved.

Male nurses appear to be aware of the tension when providing touch and may consciously choose the area they work in based on the type of touch or personal care required. Munnich and Wozniak (2020) also undertook a survey study and reported 70 per cent of male Registered Nurses worked in hospitals in 2013 and were more likely to work in lower touch areas such as surgery or the intensive care unit instead of areas like primary care. Stanley et al. (2016) used "a non-experimental, comparative, descriptive research design" (p. 1155) using an online survey and found that male nurses in their study were more commonly working in critical or emergency care, mental health, and management, and were underrepresented in certain areas such as midwifery and aged care. Juliff et al., (2017) used interpretive phenomenological analysis to underpin their qualitative research approach and found male nurses are more likely to avoid the female focused areas of nursing due to issues around intimate touch, and based on data published in 2012, found one-third of male nurses in Australia work in low-touch areas. Juliff et al. (2017) interestingly pointed out that males may be more drawn to nursing as a career due to the prominence of bedside technology in healthcare which may contribute to male nurses decreasing the moments of touch to their patients. Male nurses consciously choosing low touch areas of nursing may continue to underpin gender role stereotypes and gender expectations within nursing.

Zahourek (2016) suggested male nurses may also choose what type of touch is used based on the gender of the patient: male patients may be more likely to be offered a handshake or a rough pat on the shoulder than female patients and touch toward female patients is typically less 'touchy feely'. Blackley et al. (2019) phenomenological qualitative research found male nurses often feel apprehensive when providing personal cares to female patients and it is this elicited fear that these nurse's may be accused of sexual misconduct has caused some male nurses to reconsider their suitability for the nursing profession. Juliff et al. (2017) note a network group for male nurses seeking support due to challenges faced in their career would be beneficial for job retention and satisfaction. Zahourek (2016) illustrated that male nurses do not feel supported by their female colleagues when the issue of discomfort from touch was raised and suggest how men in nursing deal with touch needs further investigation. In contrast,

Gauci et al. (2021) found in their qualitative exploratory design study that female nurses feel excluded from male social cliques in and out of the workplace which further reinforces traditional gender hierarchies in patriarchal healthcare systems. Despite the male social cliques that were identified, Zahourek (2016) stated the isolation and lack of support for men in nursing is a major stressor and links failures within nursing education through not providing male students with tactics for dealing with intimate touch and possible false accusations.

Touch may be used as part of a de-escalation strategy toward patients. Gauci et al. (2021) and Blackley et al. (2019) highlighted that male nurses are typically designated or will designate themselves to assist in de-escalation techniques which causes female nurses to feel undermined, invisible, and undervalued as a result. Tuckett et al. (2016) and Twomey and Meadus (2016) reported from their quantitative questionnaire study that male nurses are more likely to be called upon for security reasons due to the perception that male nurses are physically powerful and have the strength to protect others. Blackley et al. (2019) follow on and stated this may be viewed as a trade-off for female nurses who generally take on more of the intimate care roles for patients. The overt way men are chosen for certain tasks within nursing continue to reinforce the feminine stereotype of women being submissive with little power and who lack the skills that male nurses have.

Money

Globally, women continue to earn less money than men which is multi-faceted in nature behind why the gender pay gap exists. Jobs that are usually associated with men tend to pay better than historically female-dominated jobs even when these jobs require the same level of skill. Gauci et al. (2022) recognised that men are promoted more readily within nursing partly because it may be considered out of place for them to be engaging in care work. Stanley et al. (2016) also acknowledged the faster rate men progress in their nursing career compared with women and note financial reasons underpinning misperceptions of men in nursing, selling points to attract men into nursing, and reasons why men are not attracted to a nursing career. Twomey and Meadus (2016) explained that historically nursing is of low economic status and is devalued when compared with male occupations. Greene et al. (2017) utilised data from the American National Sample Survey of Nurse Practitioners and stated that within nursing in the United States, male nurses earn noticeably more than female nurses with the gender pay gap having not considerably changed since 1988. Munnich and Wozniak (2020) suggested that

since 1980, pay for Registered Nurses in the United States has strengthened considerably when compared with jobs that do not require a high proportion of university education. Ironically Twomey and Meadus (2016) and Stanley et al. (2016) pointed out that pay is a reason why men may leave the nursing profession yet also state with Juliff et al. (2017) that salary is a reason behind why men entered nursing to begin with. Stanley et al. (2016) noted a very small percentage of both men and women from their study chose a high salary as a reason why they entered nursing, with salary being the least significant reason why men would choose nursing. Greene et al. (2017) acknowledged that male nurses are more willing to change jobs for a higher salary yet do not expand further to explain why.

Wilson et al. (2018) compared nurses gender wage differences to teachers in the United States using data in the American Community Survey and found men in nursing have preferential wages more so than for men in teaching. Wilson et al. (2018) noted that further education is not effective against the gender pay gap and that at every level of academic achievement, men earn more than women. According to Wilson et al. (2018) and Greene et al. (2017) earnings disparity may be partly explained by racial and ethnic bias; other differences cannot yet be fully explained but can highly likely be linked to gender discrimination. Interestingly in the study by Greene et al. (2017) it is determined that non-white and Hispanic nurse practitioners earned more than white nurse practitioners. Greene et al. (2017) focused on gender differences in nurse practitioner salaries and conclude that male nurse practitioners earn significantly more than their female colleagues however also highlight that despite all nurse practitioners holding a Master's level qualification, more men held doctorates than their female colleagues (Bumbach et al., 2020). Neither article expanded on reasons behind this difference. Further, Greene et al. (2017) recommended that nursing schools should offer education in negotiation skills as in the United States, as nurse practitioners are required to negotiate their own salary and employment terms. Greene et al. (2017) also hoped their findings will provide stimulus for female nurse practitioners to learn to negotiate their salaries effectively. Wilson et al. (2017) stated it is disheartening that women continue to earn less than men in female dominated professions and links the gender pay gap to people's occupation choices. Gauci et al. (2022) acknowledged the implication found within their own study that female nurses are responsible for their own lack of career progression; women may demonstrate passive acceptance of gender discrimination. There appears to be an assumption within the research found that women adhere to traditional gender stereotypes and lack assertiveness and certain skills that

men may fundamentally hold with Gauci et al. (2022) recognising that patriarchy is often so entrenched that it has become the norm.

Glass elevator and glass ceiling

Professionally, men and women in nursing are treated differently with men experiencing career progression at a faster rate than females. Women are more likely to need to balance childcare, unpaid domestic labour, and work, and are less likely to be promoted as readily as their male colleagues. This obstructive glass ceiling effect is confirmed by Wilson et al. (2018) who describes the effect as discriminatory and highlights the financial impact a lack of career progression has on women.

Tuckett et al. (2016) focused on the health of nurses by gender and recognises traditional gender stereotypes and the impact this has on nurses, especially their mental health. Tuckett et al. (2016) outlined that female nurses feel tired and worn out because of the feminine norm of taking on the greater part of household and unpaid labour. In contrast, male nurses may be swayed by masculine norms of stoicism and report elevated feelings of calmness and peace (Tuckett et al., 2016). Blackley et al. (2019) also recognised that male nurses tend to go through less physical and mental health related issues than female nurses. The reported wellness male nurses feel compared with their female colleagues assists with understanding a small part of the glass ceiling effect in nursing. The traits described may form the assumption that male nurses are more desirable candidates for employment as they fit the mould of an employee who may take less sick leave and be flexible with their working hours. According to Stanley et al. (2016), men are more likely to get into nursing as a career later in life whereas females are more likely to enter nursing around the age of 20. This may indicate that career diversity options for men are more prominent yet may also suggest that nursing is not heavily promoted as an option for men throughout their schooling years. The lack of exposure to diverse career options for females is another factor underpinning the glass ceiling effect. Along with improved mental health, Stanley et al. (2016) confirmed the presence of a glass elevator for men in nursing whereby male nurses have a professional advantage which raises their position as a nurse. The care provided by a male nurse is deemed to be of a higher value than if it was provided by a female based on behavioural assumptions based on gender. It is also assumed that behaviours traditionally held by men such as assertiveness are more appropriate for higher level nursing jobs. Stanley et al. (2016) and Wilson et al. (2018) explains although women in nursing are prominent in healthcare management their male colleagues

advance past them on an invisible elevator and are more likely to obtain senior nurse positions despite being a minority within the nursing profession. Gauci et al. (2022) stated the pursuing of men into leadership positions within nursing has been described as overt, transparent, and common knowledge across organisations which results in reduced job satisfaction and job retention within the profession. Gauci et al. (2022) also stated male nurses may be specifically targeted for leadership positions within nursing through having applications to attend conferences or undertake study more readily suggested to and approved. There continues to be an outdated idea that men are more appropriate for senior nurse or managerial positions within healthcare based on gender role stereotypes and traditional gender behaviours. Unconscious bias may occur in the recruitment process and training on this may assist hiring managers in being reflective on their candidate choice.

Gender Identity and Assumptions of Nurses

Gender role conflict occurs when stereotypical gender roles and norms have adverse outcomes or a negative effect on the individual or others. Further, Wallen et al. (2014) used a sample from the American Assembly for Men in Nursing and through their survey it was recognised that identity integration can occur when a person has seemingly incompatible gender and professional roles, but also acknowledged the intersectionality culture has on an individual's identity. Men who work in female-dominated professions may experience gender role conflict and conflicting identity integration due to societal expectations of how a man should behave. According to Tuckett et al. (2016, p. 451), "student attrition and burnout rates among men in nursing have been linked to gender role conflict fuelled by the female-dominated nature of nursing, prevalent stereotypes, and gender bias in nursing education". Men who work in female-dominated professions will likely encounter challenges that women have traditionally faced in working in professions dominated by men (Twomey & Meadus, 2016).

Although gender norms can change over time, historically it is the norm that women are caring and nurturing, and men are expected to be assertive and strong. Tuckett et al. (2016) advised that while male nurses both reject and rely on masculine norms, the reliance on masculine ideals can negatively impact their own wellness. Gender role strain is fed by media representations of nurses, men, and women. Stanley et al. (2016) stated the media plays an important role in further stigmatising male nurses through demonstrating male nurses as often being morally corrupt, effeminate, or incompetent. Wallen et al. (2014) highlighted the film 'Meet the Parents' and Zahourek (2016) mentions it's offshoot 'Meet the Fockers' as

mainstream examples of the media portraying male nurses as effeminate with the main character – a male nurse – having his career choice joked about in a comical manner. Stanley et al. (2016) recognised the wider impact this has on the public perception of male nurses which may negatively impact the recruitment of men into nursing.

Care work is typically undervalued in society as it is largely performed by women. Nursing is inexplicably connected to the act of caring which is largely linked to the female gender role. Tuckett et al. (2016) recognised that feminine standards are equal to caring for oneself and others whereas masculine ideals correlate to toughness, competitiveness, and avoidance of health services. This may lead to poorer health outcomes for men and a focus on men's health which can lead to a reinforcement of gender stereotypes and behaviour (Tuckett et al., 2016). According to Stanley et al. (2016) men see the issue of negative stereotypes as an important reason why men may be turned off a nursing career. Stanley et al. (2016) and Baker et al. (2021) recognised the word nurse has many feminine connotations (breastfeeding, for example) and as a result men may struggle to situate themselves within a modern interpretation of nursing. Baker et al. (2021) highlighted the need for nursing, motherhood, and domesticity to become 'uncoupled' from each other to challenge gender ideology and suggests changing the name of the nursing profession may assist with this. Gauci et al. (2022) and Stanley et al. (2016) recognised that men in nursing progress their careers at a faster rate because men and the qualities associated with men are valued higher than qualities associated with women. Gauci et al. (2022) acknowledged that gender stereotypes can result in the presumption that women lack competence which may result in lower performance expectations and decreased opportunities for women in nursing.

In the articles there are stereotypical assumptions of men and the areas in which they are suitable to work in to strengthen a man's gender role as a masculine person. Wilson et al. (2018) recognised the financial impact organisational biases have on women, which results in the gender pay gap and inequalities in income and status. Gauci et al. (2022) also recognised the negative impact patriarchal systems in healthcare has on female nurses often due to the inconsistencies in requirements for career progression between men and women, and the invisibility female nurses often feel in comparison to their male counterparts. Gauci et al. (2022) acknowledged that patriarchal oppression towards women is perpetuated by other women with some female senior nurses being overly friendly to their male colleagues and male nurses using this to their advantage to be allocated more favourable workloads.

Male nurses find it important to see other men working as nurses. Juliff et al. (2017) recognised the value male nurses hold on having exposure to male educators despite participants in the study claiming they see nursing as a gender-neutral profession. Women may feel pushed into certain speciality areas of nursing due to the preclusion of men. Juliff et al. (2017) advised men are more likely to choose certain nursing specialities such as mental health and critical care as they are regarded as more fitting for men due to the assumed need for physical strength and the higher use of technology. Juliff et al. (2017) confirmed that men are more likely to enter these areas as male nurses perceive these areas to be more acceptable or more masculine and thus not requiring additional gender role strain or identity integration conflict.

Gender role strain

Blackley et al. (2019) stated gender role strain may bias public perceptions of the nursing profession and is likely to dissuade some men from pursuing nursing as a career. Blackley et al. (2019) followed on from this and highlight male participants in their study were aware that by becoming nurses they might be perceived by others to have not complied with standard gender roles. In contrast, Twomey and Meadus (2016) explained men who choose nursing as a career test contemporary notions of gender and masculinity which may ultimately challenge the cycle of bias that confines the role of men in nursing. Juliff et al. (2017) highlighted the importance of exposure to male nurses in action to assist with male nurse's consolidation of their identity as a nurse and state that male nurse role models "bring a sense of maleness to the role" (p. 163). According to Gauci et al. (2022), female nurses are very aware of their perceived subordinate role as 'just a nurse on the floor' and feel conflicted with the knowledge of traditional gender stereotypes yet are unsure of how to gain the same level of value for their work as their male colleagues are provided.

Gender as active challenge to social norms

Juliff et al. (2017) found it may be that the strengthening of a man's identity as a nurse occurs through contact to other male nurses in action within a workplace. According to Gauci et al. (2022), female nurses speak positively about their male colleagues despite knowing that nursing has a patriarchal culture and is undervalued as a profession. Stanley et al. (2016) acknowledged that female patients are more likely to decline care from male nurses which can make the nurse feel marginalised or victimised. Yet, Gauci et al. (2022) stated that nursing

performed by men is valued much more highly than the same work done by women. Munnich and Wozniak (2020) identified if a state within the United States has higher levels of public gender tolerant attitudes, higher rates of men appear in nursing with white men being more likely to enter nursing than black men. Munnich and Wozniak (2020) expanded to say that changing gender roles is a predictor of men choosing historically female dominated careers. Wilson et al. (2018) noted that in the United States, healthcare employers prefer to hire white male nurses, followed by minorities, then internationally qualified nurses and lastly white female nurses educated in the United States.

According to Gauci et al. (2022) female nurses choose not to challenge gender stereotypes or gender discrimination as it is viewed as pervasive, systemic, and culturally ingrained. Gauci et al. (2022) have stated it is too difficult for female nurses to challenge such a broad norm and will often lose confidence over time. Further to this, Gauci et al. (2022) stated female nurses are disadvantaged after having a baby as it is assumed their job performance will decrease which stems from devalued social status associated with being a mother. It is easier for women to take career breaks or work time than challenge the assumptions faced when attempting to return to work after childbirth.

Sexuality

Baker et al. (2022) highlighted the belief that some patients deem the care male nurses provide to be sexually motivated regardless of the patient's gender and the assumption the patient holds about the male nurse's sexual orientation. Stanley et al. (2016) found societal assumptions exist around a male nurse's sexuality because of his career choice and additional stereotypes related to the inappropriateness of nursing as a career for men. Baker et al. (2022) also found male patients are more likely to use homophobic language to describe male nurses which can cause emotional distress due to their gender role conflict. Twomey and Meadus (2016) and Stanley et al. (2016) stated assumptions are made about a man's sexuality based on his career choice which is one reason why male nurses consider leaving the profession altogether. Zahourek (2016) and Blackley et al. (2019) validate that sexist attitudes and stereotypes exist with male nurses often feeling the need to justify their decision to become a nurse rather than a doctor and are more inclined to wear their name badge that clearly states their role to avoid assumptions made by patients and colleagues.

Tuckett et al. (2016) suggested that by providing men-centred group-based programs at work

that foster friendly competition will engage men and assist with delinking femininities from self-care. It could however be argued that by encouraging 'friendly competition' reinforces traditional masculine gender roles and further isolates women from their male colleagues. Only one article included in this review by Gauci et al. (2022) focused on female nurses with no mention of sexuality-based assumptions toward female nurses by patients. Twomey and Meadus (2016) recognised there has been little change in societal attitudes toward female nursing stereotypes however do not elaborate to state exactly what these stereotypes are.

The need for muscle

Male nurses are often assumed to be the best person for the job in certain situations and particularly around de-escalation and needing to be used as 'muscle'. Twomey and Meadus (2016) stated male nurses are identified as physically and emotionally strong and as a result will be asked to perform tasks that female nurses may not be routinely asked to do based on the females perceived lack of physical strength and the males assumed leadership skills and physical ability particularly in times where a patient may be deemed a security risk. Stanley et al. (2016) found in their study that male nurses find it a common and challenging issue to be seen as muscle by their female colleagues. Blackley et al. (2019) reported male nurses sometimes stay away from certain patient rooms to avoid being asked to provide physical assistance and find this a stressor in the job. Gauci et al. (2022) highlighted that men are generally rated highly on agentic qualities such as assertiveness, competence, and self-confidence whereas women rate highly on kindness, sensitivity, and emotional expression. Gauci et al. (2022) followed and stated that stereotype-based gender assumptions can result in women being perceived as lacking in competence and physical aptitude which results in lower performance expectations for women and decreased skill development. This occurs particularly after a woman has had a child, with their male peers being seen as more committed to their work when requesting flexible working arrangements than women (Gauci et al., 2022).

Conclusion

Four main themes of touch, money, glass ceiling and glass elevator, and gender identity and assumptions of nurses have been discussed as per the findings from thirteen included research articles. The theme of touch highlights the experiences that male nurses face when they are required to provide personal care or touch a patient to complete certain tasks within their job. Male nurses experience bias as there may be an assumption that their touch is sexually

motivated and are more likely to have care declined by patients when compared with their female peers. They are more likely to be accused of sexual misconduct than their female colleagues. Male nurses are aware of this which may impact where a male nurse is more inclined to work and can also influence the type of touch a male nurse deems to be appropriate depending on the patient. There are calls to support men through these experiences with professional network groups however this may further exclude and alienate female nurses who battle traditional gender hierarchies and patriarchal healthcare systems.

Nursing salaries are historically lower than male dominated professions partly due to the low value that is placed on caring professions. This, and the fact that men are more readily promoted within nursing are factors that contribute to the gender pay gap in nursing. It is disappointing to note that further education does not protect women against the gender pay gap. Ethnicity is not often mentioned in the included studies, but racial and ethnic bias can also intersect gender bias. Studies based in the United States of America highlight the need for nurse practitioners to negotiate their own salary and encourages nurses to effectively negotiate their own salary. In contrast, this may imply that nurses – and especially female nurses – may lack the assertiveness required to adequately negotiate their salary which reinforces traditional gender stereotypes and assumptions.

Slower career progression by women in nursing is also highlighted in the 'glass ceiling and glass elevator' theme. This glass ceiling effect impacts a woman's ability to earn higher wages and can be detrimental to a woman's mental and physical health. Men in nursing do not experience the same negative impact on their mental and physical wellbeing than their female colleagues. Men in nursing experience the presence of a glass elevator and are more likely to be sought out for leadership positions due to underlying gender assumptions that men are more suited to leadership and management positions due to their presumed assertiveness and dominance.

Chapter Four Discussion

In this chapter, the aim of the scoping review will be revisited, and research findings will be summarised. Strengths, limitations, and gaps within the literature will be explored. Also, this section will provide suggestions for future research to aid with reducing gender bias within the nursing profession. The aim of this review was to examine definitions and conceptualisations of gender in nursing, and critically evaluate research to report on gender dynamics within the profession, with a particular focus on Aotearoa New Zealand. The research found for this scoping review has interesting findings yet many limitations as it focused heavily on the experiences of cisgendered male nurses and includes very little on the experiences of the female majority group of nurses. Although men in nursing face gender bias and discrimination within the workplace, they also experience benefits that their female peers are not afforded through the glass elevator effect. Women in nursing continue to experience the glass ceiling effect and the gender pay gap is just one factor evidencing this. Gender non-binary people were absent within the research found and there was very little intersectionality focus on ethnicity, culture, and religion. The research was determined to be sexist itself with such a substantial focus on male nurses. Nursing continues to be positioned as women's work and as a result, the nursing profession continues to be undervalued, poorly financially compensated and the victim of patriarchal organisational structures.

The lack of wider intersectionality within this scoping review is clear through the absence of recognition that personal identities such as sexuality, ethnicity, religion, and age interlink in a professional context. Aspinall et al. (2023) recent integrative review is believed to be the first article focusing on intersectionality within nursing leadership which is suggestive of the recent acknowledgment of the importance of the concept within nursing. It is evident within this scoping review that gender bias occurs at a recruitment level with men – especially white men – being favoured for horizontal job opportunities over women and particularly over women of colour. Aspinall et al. (2023) reported although men in nursing are disproportionately represented in positions of power, male nurses from ethnic minority groups are limited. Further, Aspinall's et al. (2023) study spanned 11 countries and demonstrates that ethnicity "can impede career progression, particularly for minority groups" (p. 2478). Given the numbers of internationally qualified nurses have decreased in recent years due to Covid-19 related border restrictions in New Zealand (Nursing Council of New Zealand, 2023), it will be revealing

to discover how this number changes in the next few years. It was identified within this scoping review that male nurses gravitate to certain low-touch, high-technology areas to maintain their masculine gender norm, yet it has been suggested this also occurs, so they have close working relationships with doctors, a strategy adopted to raise their status in the profession and progress their career (Ammann et al., 2021).

This scoping review demonstrates that gender roles and traditional gender behavioural norms continue to be evident in the nursing workplace. Gender role conflict does occur in nursing and is identified in O'Neill's (1981) seminal work as "a psychological state in which gender roles have negative consequences or impact on the person or others" (p. 203). It is the gender norm that women are caring and nurturing, and men are not, which reflects a broader hierarchy where masculinity is superior to femininity and those who identify as anything other than cisgender experience discrimination and social sanctioning (Heise et al., 2019). The act of caring is largely undervalued and marginalised which is consistent with the disproportionate amount of unpaid work women undertake (Ministry of Women, 2023). There is an apparent incongruence between masculinity and caring which may be due to how different genders are socialised from a young age, and a possible reason behind men being such a minority in nursing (Loughrey, 2008). Patriarchal systems such as those in healthcare shape certain assumptions regarding the type of nursing men are suitable for and benefit those men who prescribe to conformity (O'Lynn et al., 2020). This was evident in this review as men are hyperaware of how they may be perceived by others and as a result are more likely to work in areas that require less physical touch toward patients. Men may experience gender bias and stereotyping in nursing education programmes as these facilities are often comprised mostly of women and may experience discrimination during maternity or gynaecology focused clinical placements (Kouta & Kaite, 2011). It is recognised by O'Neill (1981) that some men have been socialised to be sexist due to their attitudes never having been challenged before. Members of the public may devalue those who stray from traditional gender role behaviours and is one form of sexism between people (O'Neill, 1981). Men may feel oppressed or confined by inflexible gender role socialisation which limits their potential to be wholly human and can cause men difficulty integrating new roles into their lives (O'Neill, 1981) which may discourage men from entering nursing. Although not mentioned in articles included in this review, gender bias and assumptions can also occur within the interprofessional relationship in healthcare. Males attribute negative interprofessional interactions to personality differences whereas females identify gender as the reason behind negative interprofessional interactions (Cleveland

Manchanda et al., 2021). Further, in a study not included in this review, it was noted that male nurses highlighted negative stereotypes of women which the author suggests needs additional action before nursing becomes gender-neutral (Martinez-Morato et al., 2021). If a person does not identify as either male or female, there is no space or acknowledgement for gender neutral or gender non-binary people within the profession.

Patriarchal power structures that favour men operate in organisations across the world and may be one reason why women continue to experience a gap in pay and salary due to their gender (Stojmenovska, 2018). The World Health Organisation and International Labour Organisation (2022) have recently published a lengthy report which focuses on the large gender pay gap in the health and care sector. The report is global and has found women earn around 20 per cent less than men in the health and care sector which is a wider pay gap when compared with other non-health sectors. The International Council of Nurses (2022) recognised the chronic worldwide undervaluing and underfunding of feminised work such as nursing and demands equal pay for equal work within the nursing sector. In Aotearoa New Zealand, the government has agreed on a nursing pay equity deal to "recognise the significance and importance of a group that has been historically undervalued based on gender" (Beehive, 2023, para.6). While two articles included in this scoping review focused specifically on nurses salary, other articles indirectly touched on reasons underpinning the gender pay gap within nursing yet did not openly link the two together. The survey study by Greene et al. (2017) was based on data from the United States where nurses have a different salary structure compared with New Zealand, Australia, and Canada. Nurse practitioners in the United States are more likely to be able to negotiate a salary compared with nurse practitioners in other countries where access to healthcare is largely funded by the government. There is a lack of data within this scoping review providing background on why more women choose nursing as a profession; a possible lack of career diversity options in secondary school may indicate one reason why so many females enter nursing. Women may also be aware that nursing offers flexible shift options and the possibility for part-time employment which may be attractive given women are more likely to need this if they become a mother. Maurud et al. (2022) reported that women in nursing express higher family-related values and are more likely to be motivated by altruism which demonstrates gender-norm behaviour. The small number of articles found on gender-focused career choices within nursing centered on men in nursing. The survey study by Stanley et al. (2016) indicated men are more likely to get into nursing later in life whereas female

nurses had started to consider a career in nursing before their 20th birthday. While this same study indicates this may be due to a failure on the nursing profession or universities to market nursing towards men, they make no mention of the possible lack of career diversity aimed at females. Men who get into nursing later in life may be more financially stable and feasibly having taken no time off work for parental leave, they may be less inclined to look for a job with competitive wages but more inclined to look for job satisfaction. Greene et al. (2017) noted that male nurse practitioners are more likely to be educated at a doctoral level than their female peers yet do not expand on reasons why. Aspinall et al. (2023) confirmed that women are generally only able to engage in further study at the discretion of their partners and family and are more likely to choose their family over their career – another example of a patriarchal structure present in everyday life.

Traditional gender stereotypes can impact how touch performed by a nurse is perceived by the patient. Touch is a significant part of nursing care and can demonstrate compassion and empathy and can be used to create a bond between nurse and patient. Touch can be comforting or procedural, therapeutic, or diagnostic. However, within healthcare, touch may be placed in relation to power and may be involved in abuse (Twigg et al., 2011). Touch can have a physiological calming effect on a person through lowering a person's blood pressure and heart rate (While, 2021). Given the essential nature of touch within the nursing profession, a nurse's touch can have profound inferences for both nurse and patient as there is the potential for touch to cause uneasiness or apprehension, and in nursing the emotional outcome of any touch-based procedure may be influenced by the nurse's gender (Lemermeyer, 2022; Whiteside & Butcher, 2015). Patients prefer firm but not rough touch and would favour touch that is not too fast but not too slow; a subjective determination and one which highlights the importance of the nurse asking for feedback while delivering care (O'Lynn & Krautscheid, 2011). Male nurses are more inclined to ask for consent to touch a patient whereas female nurses are less likely to ask for permission (O'Lynn & Krautscheid, 2011) due to the assumption that male nurses touch may be sexually motivated as shown in this review. Male nurses may be more inclined to use humour to comfort their patients to decrease the possibility of their touch being misconstrued especially in areas such as paediatrics (Martinez-Morato et al., 2021). In contrast, due to doctor's social class and authority, touch by a doctor is more readily accepted regardless of the doctor's gender, yet doctors are less likely to touch their patients and will more likely use 'distancing' techniques such as the use of surgical gowns (Twigg et al., 2011). Touch can cause psychological discomfort for both parties when it occurs by a man because people are often

conditioned from childhood to only expect touch from females (Harding, 2008). In the Western culture the masculine norm is often perceived as a male who is white, heterosexual, and middleclass, and who has likely been discouraged from showing sensitivity and empathy and may construct men as possible sexual predators (Ronald, 2001, Twigg et al., 2011). Research suggests the assumption that male nurses may be homosexual stems from a discourse that suggests an opposition with otherness and a way to rationalise normal gender roles (Harding, 2008; Mao et al., 2021). Historically, male nurses may have been separated from female patients and children, further solidifying the idea of otherness.

While male nurses may experience fear or anxiety when they are required to touch patients, female nurses continue to endure recurrent sexual harassment by male patients, doctors, patient's family, or other co-workers. Given the nature of the literature found for this scoping review is heavily weighted toward the experience of male nurses, female nurses experience of touch has not been acknowledged. The experience of touch within this review has not been intersected with culture, ethnicity, or religion. As this review was aimed at countries that have indigenous populations, this is a significant limitation of the research found. A recent systematic review confirms the distinct lack of quantitative research regarding sexual harassment and female nurses, instead the focus has been qualitative research on nurses in general (Kahsay, et al., 2020). Parke et al. (2023) believed their study is the first report of bullying and sexual harassment experienced by Intensive Care Unit nurses in Australia and New Zealand and recognise the protections that Te Tiriti o Waitangi should afford in the workplace yet highlight Indigenous people in Australia do not have a treaty to protect their rights. Parke et al. (2023) reported sexual harassment is largely unreported in the nursing profession with this unacceptable behaviour being displayed by other nurses, doctors, patients, or orderlies. From a religious perspective, the orthodox Jewish religion prohibits touch between unrelated men and women, and Muslim female nurses feel conflicted when needing to provide intimate care to male patients (Yellon & Yellon, 2022).

Nurses are being asked to be more aware that therapeutic touch is part of holistic healing and may assist with enhancing cultural safety (Nuku, 2020). Body work and deep tissue massage (mirimiri/romiromi) is used as an element of Rongoā Māori (traditional Māori healing), yet this is not offered in the New Zealand public hospital system and this marginalisation of Māori people leads to negative experiences, slower rate of healing and a higher rate of self-discharges

(Wilson & Barton, 2012, Graham & Masters-Awatere, 2020, & Mark et al., 2022). Other indigenous or First Nation people also believe holistic healing is the most appropriate way to view health and wellbeing, and incorporate aspects such as massage, prayer, and herbal medicines into the care of patients however this is usually undertaken by traditional healers (Mark & Lyons, 2010). Pacific people may be more inclined to use traditional masseurs and complimentary healers to assist with illness however there is a gap in the literature regarding touch provided by nurses to Pacific people (Ministry of Health, 2008). Māori and Pacific people with a cervix are less likely to obtain cervical checks than Pakeha people for multiple reasons: invasive touch is required, there is possible exposure to a male doctor and people experience a lack of cultural responsiveness during the procedure (Ministry of Health, 2008, Adcock et al., 2021). This informs a failure to detect cervical abnormalities and can lead to a higher rate of mortality from cervical cancers (Foliaki & Matheson, 2015). A qualitative systematic review from a 20-year period showed Māori people are more likely to experience racism and feel dehumanised in New Zealand's healthcare system due to a lack of cultural and spiritual safety and a focus on a biomedical model of health (Graham & Masters-Awatere, 2020). A search was undertaken to determine the experiences of Māori and Pasifika people and touch by nurses, but limited research was found on the topic. This was a discouraging finding given the importance of cultural safety within nursing particularly for indigenous populations and minority ethnic groups. While there is a clear message found in the research for this review that nursing recruitment needs to focus on recruiting and retaining men in nursing, there is no mention of the importance of recruiting Māori or Indigenous nurses to assist with improving Indigenous peoples' health outcomes as it has been proven that Māori patients prefer care from Māori nurses (Komene et al., 2023).

This scoping review is within a minority of other research attempting to extract reasons behind gender bias within nursing. There are limitations to this review, with the core limitation being most of the research is from the perspective of men. Despite an initial search occurring and a subsequent broader search across multiple databases, very few papers were found that demonstrate gender bias from the perspective of female nurses. As previously discussed, intersectionality is extremely limited within the research included. Studies were limited to four countries due to their Indigenous/First Nation population and it was revealing the lack of intersectionality with ethnicity based on the studies found. This scoping review is limited as it did not include developing countries which may have provided a different lens to the review. During reflexive thematic analysis, there is always the possibility for researcher bias (Braun &

Clarke, 2022) which was acknowledged during regular meetings and reflective discussions with a university supervisor. Scoping reviews are limited in themselves, due to the quantity of research found in a search and their inappropriateness to inform clinical guidelines or recommendations (Arksey & O'Malley, 2005, Pollock et al., 2021).

Conclusion

This scoping review provided an overview of the emerging topic of gender bias among nurses. This review has sought to clarify certain definitions of gender bias, explore nurse's experiences of gender bias in the workplace and determine any relationship between gender bias and inequalities in nurse's career. Key data from thirteen examined articles informed the generation of four key themes and four sub-themes in relation to the aims of the scoping review. A few key points were discovered through the generation of themes and the resulting discussion. It was found that gender stereotypes are engrained as evidenced through the small amount of research available that focuses on the experiences of female nurses; most of the research found focuses on male nurses and their experiences of gender bias. The topic of gender bias in nursing has demonstrated the unconscious bias that occurs from a recruitment level and patient perceptions of nurses. It was also found there is a lack of intersectionality within the research which necessitates additional research. People who do not identify as cisgendered do not feature in the research which indicates an additional gap in existing research and scope for future research to be undertaken. There appears to be plenty of opportunity for further research into the topic of gender bias in nursing to assist with narrowing inequities faced by women, ethnic minority groups and non-cisgendered people.

Chapter Five Conclusion and Recommendations

This scoping review exploring gender bias in nursing has found that to date, most research focuses on the experiences of men in nursing. This review has highlighted that men experience gender bias within nursing and are subject to questions regarding their sexuality and career choice due to not conforming to traditional masculine gender stereotypes. Although this is problematic, men in nursing also benefit from adhering to these traditional masculine gender stereotypes and will progress their careers at a faster rate than their women peers. The absence of research from female nurse's perspective is disappointing and reinforces the gender norm of masculinity being valued at a higher level than femininity. There is a distinct lack of intersectionality within the research found which demonstrates a dearth of visibility on the significance of the interlinking of other personal factors such as ethnicity, religion, and age. Considering the global shortage of nurses, the scarcity of females in nursing leadership positions, and the need to increase the numbers of Indigenous nurses, the focus may need to be taken off men and placed on making nursing better for females and minority groups. It is timely to challenge traditional gender stereotypes to take steps in making the nursing profession less biased in the hopes this will improve job satisfaction and job retention.

Gender assumptions and stereotypes need to be challenged, particularly in the nursing workforce where most employees are female. Hiring managers need to be aware and accountable for their recruitment decisions, ensuring their decision is based on capability and not gender. Organisations should provide professional development opportunities that challenge hiring managers unconscious bias and stereotypes around gender and ethnicity to assure equal opportunity. Additional transparency and reasoning within the recruitment or career promotion process may be warranted to assist with reducing possible gender bias. Organisations, and especially those in countries with an indigenous population, need to provide additional education to ensure that indigenous or First Nation nurses are not being burdened with additional tasks which supports underlying institutional racism.

Touch within nursing remains a complicated area of focus due to its context dependent nature. Patients will have varying degrees of comfort around being touched and may have differing perspectives based on whether touch is being offered by a male or female nurse and where touch is required. There is emerging research regarding touch from a nurse's perspective and

the extent culture and religion plays on a nurse's willingness to touch certain patients. Consent from both nurse and patient is required for touch to occur. Tertiary institutions and healthcare organisations may need to consider how touch is taught and discussed, which may prompt nursing students and nurses in general to reflect on how they approach providing touch to their patients. This may also assist with supporting a nurse who is not comfortable with touching a particular patient to ask their colleague to step in without judgement. Being informed by trauma informed care and culturally safe care is an important feature of contemporary healthcare. In healthcare organisations, chaperones should be routinely offered to patients regardless of their gender. Additional research on this topic is recommended from an intersectional approach, and from both patients and nurses' perspectives.

Pay equity within nursing in New Zealand is occurring and is a positive step in the right direction however additional research needs to occur to identify the extent of both the gender pay gap and ethnic pay gap. Human resources within organisations may want to consider undergoing a gender and ethnicity analysis, particularly of nursing leadership roles to monitor the gender and ethnicity mix of certain senior nursing positions. Organisations could create policies to see a range of ethnicities in leadership positions to improve equity within a workplace. Reasons behind women not applying for or accepting senior nursing positions should be acknowledged and strategies such as flexible working hours, subsidised day care, and working from home options should be considered by organisations to attract and retain employees.

Recognition that nursing work is highly skilled and should be valued as highly as male-dominated professions can be started by breaking down assumptions that nursing is women's work is vital to reduce gender biases within the profession. These discussions could be started at a school level, followed by universities or polytechnics offering a nursing qualification promoting a gender-neutral environment. Creating conversation on this important topic is likely to challenge nurses (regardless of gender) to perhaps start to question their own assumptions and stereotypes of gender as a way of starting to break down subtleties.

Challenging patriarchal culture through the recognition and deeper understanding of gender stereotypes and assumptions is difficult due to the often-unconscious nature of these beliefs. Nurses engaging in post-graduate study or internal education on gender bias and unconscious

bias may contribute to conversations or even further research on this emerging topic. Recruitment processes could include the removal of names and pronouns before sending job applications through to the hiring manager as a way of reducing gender and ethnic unconscious biases that may occur. Human resource policies and process should be critically reviewed and supported by a gender analysis of the company or organisation, including genders other than male and female. These policies include diversity initiatives and family friendly policies. Open reporting of the gender of new employees or transferring employees should be encouraged to provide transparency of the gender mix within a workplace. An organisation will be able to monitor gender mix of employees and the proportion of all genders in leadership and management positions. Professional development training days where employees – especially hiring managers – can be educated about unconscious and subconscious biases in the hiring process. Education should be provided to challenge gender and ethnic stereotypes in a supportive and non-judgemental forum. Leaders and managers should have heightened awareness of the impact of any additional cultural safety related tasks asked of indigenous or First Nation individuals as a way of minimising institutional racism or stereotypes.

The findings of this scoping review indicate a gap in the literature on the experiences of gender bias in the nursing workplace from the viewpoint of women. Future research on this topic is vital to continue to create conversations and to assist with nurses rejecting traditional gender stereotypes. Once additional research has happened, organisational gender equality policies may be able to be founded and become commonplace in healthcare structures.

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Appendices

Appendix One

Possible articles for inclusion:

Authors and date	Title	Methodology	Sample	Finding 1	Finding 2	Finding 3	Limitations	Notes
Golden, S.E. 2018.	Strategies to Overcome Gender Bias in Maternity Nursing	Editorial/opinion Literature Review		Male students were not welcomed by staff onto maternity wards for their placement, felt rejection as male caregivers	Male students/nurses on maternity wards worried about the appropriateness of personal touch/worried about how touch would be perceived on maternity wards		Editorial/opinion based. Focused on nursing students, unable to include.	
Gauci, P., Elmir, R., O'Reilly, K., & Peters, K. 2021.	Women's experiences of workplace gender discrimination in nursing: An integrative review	Integrative review, guided by PRISMA framework	Databases: CINAHL, PubMed, Scopus, SocINDEX and PsycINFO. 11 studies included.	Female nurses need to be supported to return to the workplace following a period of absence rather than feel excluded and not worthy of progressing their careers.	The nursing workforce culture needs to change but this will only be possible when we accept women make valuable contributions to nursing that need to be equally accounted for.	The gender pay gap exists		One recommendation to fill the shortage of nurses is the recruitment of more men into the profession. Whilst a more inclusive and

								sustainable workforce is critical, it is important to ensure that the recruitment of more men in nursing does not disadvantage women already in the profession. Male RN's more geographicall y mobile than female RN's. Career progression linked to motherhood. Unable to include as is an integrative review.

Jamieson, I., Harding, T., Withington, J., & Hudson, D. (2019).	Men entering nursing: Has anything changed?	Qualitative descriptive. Thematic analysis.	Male student nurses – exclude from review.	Two predominant gender scripts: nursing as women's work and the stereotyping of men who are nurses as homosexual	Male student nurses have their career choice negatively characterised due to resistance to normative masculinity	Barriers to men's engagement in nursing remain potent	Only 8 students studied from one nursing school in NZ.	
Sasa, R.I. (2019).	Male nurse: A concept analysis	Walker and Avant's methodology. Concept analysis.		Seven attributes of the male nurse were identified: perceived as male, credentialed as a nurse, increased visibility, nonconformist as to career choice, cautious caregivers, stereotyped/stigmatist, and increased role strain.	First concept analysis review on "male nurse"	Men in nursing tend to gravitate toward certain areas of the hospital, get quickly promoted	Slanted toward Western value systems. Systematic review not conducted.	"Why do we say male nurses, but not female doctors?" Degendering nursing profession must translate to increasing the proportion of men in nursing to remove their token status. Unable to include as is a concept analysis.

Nickitas, D.M. (2018).	Editorial. Equal pay for equal work, not in nursing. Why?	Editorial.	U.S based, 2018 national salary research report	The gender pay gap exists in nursing. Men change jobs more often than women, resulting in the ability to negotiate their wages on a more frequent basis – females less likely to negotiate their wage, will more readily accept what is offered to them		One page editorial.		
Eliason, M.J. (2017).	The gender binary in nursing.	Invited commentary.		'Gender non-conforming' are hurt by not fitting into a traditional gender category and suffer more violence, discrimination, and harassment than almost any other group.	'Affirmative action' type programmes exist to recruit men into nursing	LGBQTI people challenge gender stereotypes, increasing awareness of the need for LGBQTI education in nursing	Second-wave feminism	I very much enjoyed reading this article! Lots of excellent points. Thought provoking.
Association of Women's Health, Obstetric, and	Gender bias in women's health, obstetric, and neonatal nursing.	An official statement of the Association of Women's Health, Obstetric, and Neonatal Nurses.		All women, newborns, and their families have the right to quality care	Gender is not a qualification to practice as a nurse, and gender discrimination in employment			Probably not worth including, doesn't add much. Only a few

Neonatal Nursing (2016).				provided by a clinically competent, professional nurse. The Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN) maintains that nurses, regardless of gender, should be employed in nursing based on their ability to provide such care.	in unlawful			paragraphs long.
Baker, M.J., Fisher, M.J., & Pryor, J. (2021).	Potential for misinterpretation: An everyday problem male nurses encounter in inpatient rehabilitation.	Constructivist grounded theory using semi-structured interviews and observation of practice of male nurses	38 participants comprising of 23 male nurses and 15 patients	Patients perceived nursing to be womens work and that male nurses are sexual threats (heterosexual and homosexual threat)	Male nurses mindful that on a daily basis that misinterpretation of their actions/inactions could happen at any time which influenced their ability to practice nursing		Findings reported are only one interpretation and not representative of every reality. There were silences in the data from other members of MDT, in particular	

							women nurses.	
Mele, et al. (2021).	Healthcare workers' perception of gender and work roles during the COVID-19 pandemic: a mixed-methods study.	Mixed methods. Phase One was an anonymous, internet-based survey, Phase Two was semi-structured interviews offered to all respondents upon survey completion.	2058 Canadian healthcare workers (87% women, 11% men, 1% transgender) survey respondent, 46 healthcare workers interviewed.	Men are more likely to hold pandemic leadership roles compared with women.	Women were more likely to report increased domestic responsibilities than men.	Women and those with dependent under the age of 10 years reported the greatest levels of anxiety during the pandemic.	Only captures perceptions of healthcare workers during a specific period of time. Healthcare workers who were too burdened by work demands due to Covid-19 may not have been captured. Canadian based study: may not be representative of those of the global healthcare workforce.	Nurses were included in this study however as the study does not solely focus on nurses, unsure whether to include.
Bumbach, M.D., et al. (2020).	Gender differences in nurse	2012 National Sample Survey of	8,978 NP's met the	Overall job satisfaction was not shown to be	Of the 11 measured patterns of care,		Only male/female option	

	practitioners: job satisfaction and patterns of care.	Nurse Practitioners.	inclusion criteria, 92.8% were female.	significantly different between genders.	six were significantly different between genders with a female majority indicating that they performed these services most often.		included for gender. Survey response rate 61%. Survey was from the 2012-2013 period.	
Wilson, B., Butler, M.J., Butler, R.J., & Johnson, W.G. (2018).	Nursing gender pay differentials in the new millennium.	Data taken from the American Community Survey was used; a U.S random representative sample of RN's and primary or secondary school teachers from 2000 to 2013 using fixed-effects regression analysis	427,080 RN sample vs 965,878 teacher sample.	Nurses are paid more than teachers – male nurses then female nurses then male teachers then female teachers.	Increased disparity between nurse pay by gender than in teacher pay by gender.	The glass ceiling is experienced by women and is one of the ways discriminatio n is manifested in the workplace.	Employment history incomplete – unable to determine if interruptions in the employment of women relative to men played any role in the measured disparities.	
Bohanon, M. (2019).	Men in nursing: a crucial profession continues to lack gender diversity.	Editorial.		Raising awareness about the nursing profession to male high school students needed to encourage more men to join the profession	Small percentage of nursing education faculty members are men which may mean male students feel more isolated	Male nurses can be powerful advocates in combating the WHO's 'mens health gap'.	Editorial.	

Gauci, P., Peters, K., O'Reilly, K., & Elmir, R. (2021).	The experience of workplace gender discrimination for women registered nurses: a qualitative study.	Qualitative exploratory design informed by feminist perspectives and underpinned by social constructionism.	10 women RN's, semi-structured interviews. Thematic analysis.	Five themes: It's a man's world; gender stereotypes; being a woman and nurse; reluctance to call out gender discrimination; the status quo.	Participants believed men's career progression in nursing were favoured over women.	Constructed gender norms continue to form the basis of inequality for women in the workplace. Fundamental that workplaces do not discriminate against women and ensuring support for family and work life balance.	Participants represented a small geographical area in Sydney, most worked in an acute area.	Limited research on women's experience of discrimination in the nursing professions. Australia.
Brandford, A., & Brandford-Stevenson, A. (2021).	Going Up! Exploring the phenomenon of the glass escalator in nursing.	Exploration/discussion.		Males represent 10% of the nursing workforce yet hold close to half of top leadership positions in nursing	The impact of the glass elevator is clear for white males, it does not appear to apply to minority males or persons of colour equally or equitably	A strategic plan to slow the glass escalator is to promote participation in mentorship and networking programs.		U.S.

Speer, J. (2019).	Where the girls are: examining and explaining the gender gap in the nursing major.	Uses data from the American Community Survey's 2009-2016 waves and Baccalaureate and Beyond (US Department of Education).	Female nursing students	Nursing yields high initial earnings but low earnings growth – women may put more weight on the initial salary due to possibly needing to take time off at a later date to have children	Females who are generally less risk averse than men may want a clear job outcome at the end of their degree	Strong relationship between 'helping' and 'people' and the female share may be why females are more attracted to nursing	Heavily quantified	Focuses on nursing in university - ?not to include. U.S.
Smith, B.W., Rojo, J., Everett, B., Montayre, J., Sierra, J., & Salamonson, Y. (2021)	Professional success of men in the nursing workforce: An integrative review	Integrative review	Studies from seven databases – 12 studies published between 1987 and 2021 were included.	Higher numbers of men occupy senior leadership positions compared with their overall percentage in nursing	Gender is not a predictor of job satisfaction however there may be a link to men being granted more opportunities for advancement which may lead to increased job satisfaction	Men in nursing experience negative attitudes, stereotypes and discrimination in nursing – multiple specific examples given, but article states black men who were nurses are more likely to be mistaken for janitors or	Only focuses on male nurses, data from 80's/90's may not be as relevant today	Australia

						orderlies; white men who were nurses get mistaken for doctors		
Munnich, E., & Wozniak, A. (2020).	What explains the rising share of US men in registered nursing?	Data taken from the US Census and the annual American Community Survey	Male registered nurses – US	Men and women both become more likely to report a nursing occupation as they age through their 20s and early 30s (job retention)	Poor early labour market conditions in a cohorts birth state is associated with less movement of men into nursing – possibly indicating credit constraints as a factor to move into nursing	Men do respond to market-level changes in the rewards to non-traditional occupation	Heavily quantified.	
Burton, C. (2020).	Paying the caring tax. The detrimental influences of gender expectations on the development of nursing education and science.	Discussion.		"Pink collar" Socially constructed gender expectation that female-identified individuals will by nature engage in certain types of caring behaviours. Conflict between 'masculine' behaviour of career progression, independence,	Hegemonic femininity within nursing might best be identified as the enforcement of feminine-associated behavioural norms regardless of environment, often resulting in horizontal oppression.	"Caring tax" This added burden of situational caring expectations for nurses regardless of work environment can lead to exceptionally disparate workloads both in the physical and	Recognising how the centrality of caring to the work of nursing can be co-opted to reinforce and substantiate binary gender divisions is critical to the development	Worth looking more into: the caring tax?

				autonomy, and 'feminine' behaviour of caring, cooperation, dependence.		emotional realms—a "caring tax," in that it is implicitly required as an addition to the nurse's academic and professional activities.	of the profession and to its growth among a diverse population.	
Greene, J., El-Banna, M.M., Briggs, L.A., & Park, J. (2017).	Gender differences in nurse practitioner salaries.	Analysed the relationship between gender and salary among NP's using the National Sample Survey of NP's.	2011 pre-tax earnings, 6591 NP's	Male NP's earn more than female NP's, the gap grows over time	Non-white and Hispanic NP's earned more than white NP's – this difference was noted in women NP's but not in men NP's – reasons unclear		Salary is self-reported. Some variables have response category combined to preserve confidentiality. Certain factors that may influence the gender pay gap was not collected by the sample survey.	

Zahourek, R.P. (2016).	Men in nursing: Intention, intentionality, caring and healing.	Follow-up to an interview and observation grounded theory study from 2001 (all female participants). Second grounded theory study.	12 men nurses.	Men encounter stereotyping and pressures that may minimise their contributions to the profession.	Understanding of intention/intentionality from both genders perspective		Small sample size.	
Twomey, J.C., & Meadus, R. (2016).	Men nurses in Atlantic Canada: Career choice, barriers, and satisfaction.	Descriptive design.	240 men nurses from Atlantic Canada.	The majority of men nurses are satisfied or very satisfied with their career choice.	Main reasons for men to choose nursing as a career include helping people, job security and having a challenging and responsible profession.	Barriers to men in nursing practice include: being seen as muscle, sexual stereotypes, lack of exposure to male role models	No means to determine whether bias has occurred. Recall bias may have occurred. Convenience sample used.	
Stanley, D., Beament, T., Falconer, D., Haigh, M., Saunders, R., Stanley, K., Wall,	The male of the species: a profile of men in nursing.	Non-experimental, comparative, descriptive research design focused on quantitative methodology, using an online survey in 2014.	1055 Registered and Enrolled Nurses and midwives from Western Australia.	Male nurses enter nursing at an older age than their female colleagues	Two main reasons for leaving the nursing profession include a poor salary and negative stereotypes.	Misperception of male nurses sexuality; reinforced by the media.	Convenience sample used. Limited numbers of younger and older aged respondents replied to survey.	

P., & Nielson, S. (2016).								
Juliff, D., Russell, K., & Bulsara, C. (2017).	The essence of helping: significant others and nurses in action draw men into nursing.	Qualitative methodological approach using interpretive phenomenological analysis.	Nine participants, male nurses newly graduated. Purposive sampling.	The positive influence to enter nursing came from family and friends. Importance of positive support and other men to relate to during undergraduate years is noted.	Career choice triggers include previous employment, nurses working in the environment and specific encounters of other male nurses.	Exposure to their family in roles of helping assisted with the formation of the participant intention to enter nursing.	Snowballing technique for sampling. Unable to be replicated or generalised.	
Blackley, L.S., Morda, R., & Gill, P.R. (2019).	Stressors and rewards experienced by men in nursing: A qualitative study.	Phenomenological qualitative. Semi-structured open-ended interviews.	Six male nurses – purposive selection. Thematic analysis.	Gender role conflict: an awareness that by becoming nurses they may be perceived by others to have transgressed traditional gender roles. Less prominent in this study compared with older studies.	Feelings of exclusion in the workplace and apprehension when providing personal care to female patients.	Disproportionate assignment of 'masculine' tasks.	Convenience, snowballing and purposive sampling. No follow-up interview with participants. Small sample size.	
Wallen, A.S., Mor, S., & Devine,	It's about respect: Gender-professional identity integration	Quantitative.	178 male nurses, surveyed through the	Gender professional identity integration is positively related	Male nurses' perceived overlap between professional and gender		Single survey – common method bias may occur. Sample not	

B.A. (2014).	affects male nurses' job attitudes.		American Assembly for Men in Nursing organisation.	to job satisfaction and affective commitment. As integration increased, job satisfaction and affective commitment increased.	boundaries correlate with affective commitment.		truly random due to having membership to this organisation.	
Rotenberg, L., Silva-Costa, A., & Griep, R.H. (2014).	Mental health and poor recovery in female nursing workers: a contribution to the study of gender inequities.							Brazilian study.
Tuckett, A., Henwood, T., Oliffe, J.L., Kolbe-Alexander, T.L., & Kim, J.R. (2015).	A comparative study of Australian and New Zealand male and female nurses' health: a sex comparison and gender analysis.	Observation study. Self-reported survey. 108 questions. Australian and New Zealand Nurses and Midwives e-Cohort study. N=3968.	Practising nurses and midwives.	Male nurses had significantly higher BMI than women, with greater presence of cardiovascular disease symptoms and risk factors.	Men were twice as likely to be categorised as having high sitting time, more likely to be a current smoker and report sleeping less than female nurses.	Men were 3 times more likely than female nurses to report feeling full of life, calm and peaceful 'all of the time', whereas women nurses were more likely to report	Self-reported study, so participants can over- or underrepresent their actual health and wellbeing. Small sample size when compared to total number of Australian	

						feeling worn out and tired 'all of the time'.	and NZ nurses.	
20/06/2022 Articles found from reference lists:								
Bacon, D.R., & Stewart, K.A. 2015.	Results of the 2015 AORN Salary and Compensation Survey.	Survey - quantitative	3641 individuals, 7.2% net response rate. AORN members and non-members.	12% of respondents reported working in an environment with a union or collective bargaining unit - *different to other countries?	Women (but not men) with children in the home earned $900 less than other nurses. Nurses with fewer commitments outside of work received a higher base wage. Men have significantly out earned women in four of the past five years.			Will not add a lot to the review.
Hegewisch, A., & DuMonthier, A. (2015).	The Gender Wage Gap: 2015. Earnings Difference by Race and Ethnicity.							Not nursing related.

Ferguson, H., & Anderson, J. 2021.	Professional dominance and the oppression of the nurse: the health system hierarchy.							Not for inclusion – viewpoint. Interesting read.
	Gender equality: flying blind in a time of crisis. 2021 Global Health 50/50 report.							Not for inclusion – generalised, not specific to nursing. Useful for background.
Hader, R. (2010).	Nurse Leaders: A Coser Look							Doesn't meet inclusion criteria – survey using US, Saudi Arabia, Canada, China, and NZ data. Useful for background.
Muench, U., & Dietrich, H. 2019.	The male-female earnings gap for nurses in Germany: A pooled cross-sectional study of the years 2006 and 2012.							Doesn't meet inclusion criteria as data from Germany.

Munsch, C. 2016.	Flexible work, flexible penalties: The effect of gender, childcare, and type of request on the flexibility bias.	Controlled online experiment. 656 adults who reside in the USA found via Mechanical Turk (MTurk) and paid $2 each for their participation.						Not suitable for inclusion – not nursing specific. May be useful for background.
Porter, S. 1992.	Women in a women's job: the gendered experience of nurses.							Not suitable for inclusion due to year of research. May be used for background.
Punshon, G., Maclaine, K., Trevatt, P., Radford, M., Shanley, O., & Leary, A. 2019.	Nursing pay by gender distribution in the UK – does the glass escalator still exist?							Not suitable for inclusion due to country of origin (UK). May be used in background.
Williams, C. 1992.	The Glass Escalator: Hidden Advantages for Men in the							Not suitable for inclusion due to age of study.

	'Female' Professions.							
Flinkman, M., Leino-Kilpi, H., & Salantera, S. 2010.	Nurses' intention to leave the profession: integrative review.							Not suitable for inclusion as is an integrative review.

Appendix 2 CASP

CASP Checklist: 10 questions to help you make sense of a Qualitative research

How to use this appraisal tool: Three broad issues need to be considered when appraising a qualitative study:

Are the results of the study valid?
What are the results?
Will the results help locally?

The 10 questions on the following pages are designed to help you think about these issues systematically. The first two questions are screening questions and can be answered quickly. If the answer to both is "yes", it is worth proceeding with the remaining questions. There is some degree of overlap between the questions, you are asked to record a "yes", "no" or "can't tell" to most of the questions. A number of italicised prompts are given after each question. These are designed to remind you why the question is important. Record your reasons for your answers in the spaces provided.

About: These checklists were designed to be used as educational pedagogic tools, as part of a workshop setting, therefore we do not suggest a scoring system. The core CASP checklists (randomised controlled trial & systematic review) were based on JAMA 'Users' guides to the medical literature 1994 (adapted from Guyatt GH, Sackett DL, and Cook DJ), and piloted with health care practitioners.
For each new checklist, a group of experts were assembled to develop and pilot the checklist and the workshop format with which it would be used. Over the years overall adjustments have been made to the format, but a recent survey of checklist users reiterated that the basic format continues to be useful and appropriate.
Referencing: we recommend using the Harvard style citation, i.e.: *Critical Appraisal Skills Programme (2018). CASP (insert name of checklist i.e. Qualitative) Checklist. [online] Available at: URL. Accessed: Date Accessed.*

Critical Appraisal Skills Programme

Paper for appraisal and reference: Potential for misinterpretation: An everyday problem male nurses encounter in inpatient rehabilitation

Section A: Are the results valid?

1. Was there a clear statement of the aims of the research?

Yes

Aim of the research is clearly written. Goal and relevance of research is stated.

2. Is a qualitative methodology appropriate?

Yes

The methodology is appropriate for the aim of the research. The topic is subjective.

Is it worth continuing?

3. Was the research design appropriate to address the aims of the research?

Yes

The research design is explained and justified. Constructivist grounded theory approach justified as little is known about the topic.

4. Was the recruitment strategy appropriate to the aims of the research?

Yes

Purposive sampling including 23 male nurses and 15 patients. Inclusion and exclusion criteria is outlined. Some theoretical sampling occurred (some participants were interviewed more than once) to illuminate and expand data. There was no discussion around recruitment and reasons behind why some people chose not to take part.

5. Was the data collected in a way that addressed the research issue?

Yes

Phase one involved semi-structured interviews with nurses only. Phase two involved observation of patients and formal and semi-structured interviews with both nurses and patients. Field notes were taken during observation. The study does not identify how interviews were conducted or recorded. No information regarding possible saturation of data.

6. Has the relationship between researcher and participants been adequately considered?

No

The study identifies the constructivist position may be a limitation but does not address the researchers own bias or influence, nor how they responded to events during the study.

Section B: What are the results?

7. Have ethical issues been taken into consideration?

Yes

There is a very brief ethical consideration paragraph. The study was approved by an ethics committee. Written consent was obtained, and participants identified with a unique code for confidentiality. No acknowledgement of any effect of the study on the participant.

8. Was the data analysis sufficiently rigorous?

Yes

Constant comparison methods occurred to strengthen rigour. Rigour was maintained through prolonged engagement with the data and data collection points to build relationships with participants. Analytic process briefly outlined. Researcher did not critically examine their own role for bias or influence.

9. Is there a clear statement of findings?

Yes

Themes are outlined with findings explicit. Findings are limited due to the focus on rehabilitation setting.

Section C: Will the results help locally?

10. How valuable is the research?

Valuable – emerging topic however restricted due to the setting the research was based in.