LIVED EXPERIENCES OF MALE NURSING STUDENTS WITH CARING

DISSERTATION

Submitted to the College of Human Resources and Education

of

West Virginia University

In Partial Fulfillment of the Requirements for

The Degree of Doctorate of Education

by

Patricia Jean Hedrick Young, RN, C, MSN

Morgantown

West Virginia

1997

Acknowledgments

I am grateful to the many people who assisted me in this dissertation study. First, I want to express my heartfelt gratitude to Dr. Patricia Obenauf, the chairperson of my doctoral dissertation committee. In her patient, soft-spoken manner, she encouraged me to continue when I was discouraged and was a source of inspiration. Pat exemplifies caring and is a role model to emulate in all aspects of her life.

Thanks also to the other members of my committee. Dr. Mona M.Counts has been a supportive teacher, role model, and friend throughout my graduate and postgraduate education. She has struggled with me as the chairperson of my committee for my Master's thesis and now as a member of my dissertation committee. I was in several of Dr. Ron Iannone's C & I classes. In class and on this dissertation committee, he demanded much, but was always fair and willing to help. Dr. Scott Bower was always amenable to providing assistance. I greatly appreciate that Dr. John Paterson has remained an active member of the committee, even though he has retired. That's dedication! I thank all of you for the caring I received as a student in your classes and in the dissertation process. You were all role models in your own way. You encouraged me to expand my knowledge and life experiences, as well as opened my eyes to other realms and realities.

My dear friend and colleague, Brenda Lohri Posey, has been with me throughout this journey. As we traveled many miles to and from classes

throughout the entire doctoral program, we shared our knowledge, ideals, concerns, problems, and lives. This camaraderie sustained us as we survived the blessings and joys, as well as trials and tribulations of school, families, and work. In our quests for knowledge and self-growth, we have accomplished more than we ever dreamed we would. Other friends and colleagues who provided encouragement and ideas throughout this endeavor were Elaine McLeskey, Jennifer Robinson, Pauline Law, SueEllen Schwab-Kapty, and Becki Kurtz. Other colleagues, friends, fellow church members, and my large loving extended family also provided love and support throughout this entire educational process.

Most of all, I need to acknowledge the support and love I received from my family. David, my husband, has always been my anchor throughtout my many years as a "professional student." He was been the "wind beneath my wings." Georgia Lynn and Bill, our children, were both still in high school when I began this journey. They had to share their time and lives with my endeavors. Now they have entered their journeys of life into adulthood. Both of my parents, Mary Jean and Raymond Hedrick, were teachers and were the ones who helped instill the love of reading, the desire to achieve whatever I attempted, and the quest for knowledge. My parents have always been there when they were needed. A special thanks to my sister Kimberly Turner, who did an excellent job of transcribing all my audiotapes. That was a tremendous help! My other sisters, Beverly Kubachka and Sharon Tiano, and my brothers, Douglas and Ronald Hedrick, have been an important influences in my life and have provided much encouragement.

Finally, I want to thank the fifteen male students that participated in this study. Without their willingness to share their experiences with me, I would not have been able to do this study. I also appreciate the cooperation of the four nursing school that allowed the students to participate in the study.

Dedication

I dedicate this in loving memory of my brother-in-law, Michael Alan Kubachka, for all his strength, courage, and determination in his battle with cancer for almost four years. His struggle and suffering ended on April 5, 1997. As Vince Gill wrote in memory and honor of his own brother, so do I say to Michael, "Go rest high on that mountain, cause son, your work on earth is done, go to heaven a-shouting, Praise for the Father and the Son." Michael, may your journey to another life provide healing and peace. Michael is sadly missed by all who knew him, but we have our memories of love, joy, sharing both the good and the bad times, fun times, and his impact on our lives. We cherished our time with Michael, which was far too brief.

I also dedicate this to his wife, my sister, Beverly Ann Hedrick Kubachka. She has taken care of Michael, remained active in her church, community, and her job as a nursing instructor, and tried to keep life as normal as possible for their three children, Kevin, Lisa, and Matthew. She doesn't believe how strong and capable she has been. Beverly has been an inspiration for all of us as she has tried to be everything to everybody...and she has usually succeeded. Although she believes that Michael was "the wind beneath her wings", she truly was "the wind beneath the wings" of Michael, her children, and many in our family. I hope that she realizes how special she is and that she is also greatly loved as she continues her journey in life.

Table of Contents

CHAPTER ONE

Aims of the Study

Introduction

Nursing education, like nursing itself, has experienced tremendous changes in recent decades. One of the most profound changes has been in the student population. Historically, since the days of Florence Nightingale, nursing has been predominantly female (Vestal, 1983; Christman, 1988; Cyr, 1992). However, since the 1960's, the student population has evolved from a homogenous population of traditional female nursing students who were the "cream of the crop" academically, Caucasian, newly graduated from high school, and single, to the present heterogeneous population. This new student population contains members of both genders, who are culturally diverse, who have family responsibilities and obligations, who may be in job retraining for second or third careers, and who are viewed as "adult learners." These changes have resulted in challenges to all involved: the nurse educators, the students themselves, the healthcare system, and the patients and their families.

One of the most obvious changes is the increase in male nursing students, which results in a greater number of nurses who are male. Since nursing has been chiefly regarded as a female profession, there are both positive and negative issues inherent with males in nursing, as well as in the realm of caring, In this phenomenological study, the lived experiences of senior male nursing students in West Virginia were examined in relationship to caring.

Phenomena of Interest

The phenomena of interest were the lived experiences of male nursing students related to caring. Since nursing has been seen as intrinsically a female profession grounded in female values, morals, holistic worldview, and characteristics, the lived experiences of male nursing students with caring and caring behaviors needed to be examined. If caring is the essence of nursing, then all nurses, regardless of gender, need to have areas of commonality in theoretical and practice perspectives.

Several issues were explored in relation to male nursing students. The first area to be examined was why the male students entered nursing, as well as their perception of nursing prior to entering nursing education. Changes in their perceptions were identified. Next, caring was explored in various realms: (a) their definitions and examples of caring as both a care provider and a care recipient in their male nursing student role; (b) their focus on caring and/or technological aspects of nursing; and (c) their perceptions and experiences with gender differences and similarities in caring in nursing. Future career aspirations were also discussed.

Males in nursing and nursing education

In order to attain a sense of today's male nursing students and male nurses, the following areas were examined in this study: (a) history of males in nursing, (b) reasons for entering nursing, a non-traditional profession for men, (c) benefits attained with males in nursing, (d) specialization preferences, (e) stereotypes, discrimination, and role strain, and (f) privileged status and power issues.

Historically, there have always been male nurses. In Medieval times and prior to the time of Florence Nightingale, many men were nurses, especially during wartime (Bullough & Bullough, 1984; London, 1990; Kalisch & Kalish, 1978; Halloran & Welton, 1994; Vestal, 1983; Cyr, 1992; Villeneuve, 1994). However, most of the time, their numbers and visibility have been minimal in the United States. Kelly (1991) states that male students and nurses represented 7 percent of all nurses in 1910, and concomitantly, the number continued to drop to 2 percent in 1940. By 1960, males constituted 0.91 percent of the nursing workforce; however, since then the number has increased to 3.3 percent. Concurrently, the number of male students has increased from 6 percent in the 1971-1972 academic year to 7.3 percent in 1987 (Kelly, 1990). Squires (1995) asserts that the number of males in nursing school has risen to twelve percent, according to the latest figures published in 1992.

Although nursing has been predominantly a female profession, more males are entering nursing for various reasons, such as: intermittent unemployment, depression in manufacturing and government employment, loss of job security in recent economic cycles, improved salaries, desire to work in a humanistic area, and interest in biology (Halloran & Welton, 1994; Fagin & Maraldo, 1988). "History, economics, the military, and sex-role stereotyping have all weighed heavily against nursing as a career choice for American men" (Halloran & Welton, 1994, p. 683). "Existing barriers to the employment of men nurses appeared to be due more to sentiment and tradition than to any actual ineptitude based on sex," according to Kalisch and Kalisch (1978, p. 635). Male nurses and students, like females, vary from exceptionally competent to minimally competent, as well as contribute to

nursing both negative and positive characteristics of all humans. In his defense of males in nursing, Christman (1988) also acknowledges, "no one race, gender, or ethnic group has a monopoly on the qualities of intelligence, scientific competence, imagination, empathy, tenderness, concern for others, or motor skill ability" (p.75).

Caring

Characteristics of caring have been analyzed in many disciplines, including philosophy, anthropology, history, nursing, and education. Characteristics and definitions of caring are multifaceted and are based chiefly on moral, ethical, and philosophical foundations. Various terms used to describe and characterize caring are: a phenomena, a life force, nursing, a process, a behavior, an ideal, a principle, a virtue, therapeutic interactions, interpersonal interactions, moral imperatives, affects, human traits, and the central unifying domain of nursing's body of knowledge and practice (Fry, 1991; Morse, Solberg, Botoroff, & Johnson, 1990; Dietrich, 1992). Models and guides of caring have been developed to direct human action toward the means and the ends of the moral ideals that are intrinsic to human civilization. As Watson (1990) reiterates, "these values and views of women and caring are not just woman values, but values for all humanity" (p. 64).

Jean Watson has expanded the theory of human caring in nursing to be a humanistic science as opposed to a biological or formal science. Caring is defined by Watson (1994) as "it orients the practice of nursing toward a covenant that remains at the heart of the nursing profession: to develop with the other a trusting, caring-healing relationship that potentiates health and well-being, physical comfort, systems management, pain management, and provides meaning, growth, and harmony between the providers and others" (p. 1). The search for wholeness,

healing, integrity, and harmony are incorporated with the issues of health and quality of living (such as living, coping, growing, and dying) into our aspects of human "being" in caring-healing relationships. Bevis (1989) further asserts that "nursing has a unique social mission: to care for the vulnerable and to provide caring services in prevention, cure, and maintenance...it concerns itself with lived experiences of people who face health problems" (p. 350).

Caring, the essence of nursing, has been identified as a female trait. Traditionally, women have been seen as caregivers and nurturers, while men have been seen as providers, leaders, and doers. Unfortunately, as Gordon (1991) exhorts, "Women's caregiving work has become a negative standard against which we measure our progress. Our progress, that is, is charted in the distance women have traveled away from caregiving work, and toward traditional male activities and preoccupations" (p. 46).

Tremendous changes in nursing and nursing education have been based on major technological advances in nursing, medicine, and society in general. "American society has made great technological advances and-at the same time-has tacitly devalued the 'soft', feminine professions such as teaching, nursing, humanities, and the arts in deference to 'harder' quantitative professions" (Fagin & Maraldo, 1988, p. 365). The business world and marketplace have invaded the public, caring segments of society--the caring professions of education, nursing, social work-- and incorporated profit and performance as their bottomlines, while negating caring. Our society has sanctioned this invasion by the business world and promoted the fear of caring, which has denigrated caring into a scarce commodity. This reality has exacerbated the traditional low pay, poor working

conditions, and limited opportunities for advancement of the caring professions (Gordon, 1991).

In the care/cure dichotomy, caring has been denigrated with the increase in technology, economic constraints in health care, and subservience of female dominated nursing to male dominated medicine (Garden, 1992). Many nurses tend to focus on cure as a means of achieving status and recognition, rather than on caring and care, since they fear that others may see caring as demeaning and nonscientific (Belknap, 1991), Technological skills and knowledge are vital in today's society and health care agenda, but so are the caring, interpersonal aspects of nursing. Watson (1994) reiterates that nurses must move beyond nursing's functional and technological skills to embrace both the therapeutic use of self and deal with much greater dimensions and subjective meanings in the health-illness continuum.

Caring and Nursing Education

Care is the essence of nursing and must become an essential component of nursing curriculum (Leininger, 1984, 1988, 1991; Watson, 1985, 1988, 1994). However, since caring is difficult to measure with behavioral objectives, many educational programs have had difficulty incorporating caring into their curriculum. Leininger (1991) also acknowledges that specific teaching and practice opportunities about care are vital to ensure that graduates are cognizant about and will use caring in their practice.

There are implications for nursing educators in Beck's (1991) phenomenological study that describes how students perceive faculty caring. Students need to feel cared for and nurtured before they can nurture and care for

others. Thus, in order to foster nursing students' capacities to care, the nursing faculty need to promote a caring environment for students. It is also suggested that when faculty members know what students view as caring behaviors, these behaviors can then be incorporated into their daily interactions.

Student nurses need to be socialized and educated to view caring as a tangible concept, not just as an abstract ideal. This can be accomplished by teaching the physical, technical, and behavioral aspects of nursing via a caring framework (Gardner, 1992). .

Socialization of males and females

Socialization affects how we perceive our world. Bowers (1987) defines socialization as "the process of learning the habits, norms, and ways of thinking essential for fitting into society" (p. 33), while Chafetz (1983) describes socialization as a complex process in which each individual is instilled with culturally defined values, roles, and norms.

In this study roles are of primary interest. Roles are sociological concepts that prescribe and proscribe behaviors and expectations for persons who hold a particular position in a particular social context (Kessler & McKenna, 1978). Each of us has multiple roles. Ascribed roles are roles over which one has no control, while achieved roles are roles that have been earned or accomplished. Roles are characterized by expectations and standards concerning behaviors that: (a) will be rewarded for conformity and performance, (b) will cause desired rewards to be withheld, or legal and social sanctions to occur, or (c) will result in enforcement of penalties if the individuals do not fit their proscribed behavioral patterns or if they are nonconformists. Dissonance between an individual and ascribed roles and

dissonance between achievement and achieved status can result in severe psychological consequences (Fields, 1985).

Gender roles are ascribed roles and encompass expectations concerning behaviors that are appropriate for members of each gender, including interests, activities, dress, skills, occupation, and sexual partner choices. Historically cultural roles of women and men have varied, but there have been different roles ascribed for each of them. Different historical contexts demonstrate that gender roles are not universally constructed over time and place. Butler (1990) reiterates that gender roles intersect racial, class, ethnic, sexual, and regional modalities of discursively constituted identities. Social conditioning, economic factors, and environmental factors also contributes to roles, especially gender roles.

There is often confusion between the terms gender roles and sex roles. Gender roles have been described as culturally constructed and as a process of historical context and culture; while sex roles are seen as the biological component (Butler, 1990; Lerner, 1989). Sex role theory, part of structural functional theory, proposes that social structures were developed to meet societal needs (Bunting, 1992). Thus, roles and relationships of individuals have specific purposes and functions necessary to maintain society. One of the chief issues with sex roles concerns whether or not they are based on natural, immutable biological facts. Conversely, inequality and discrimination that are based on biology are easier to maintain and justify than are those which have occurred as a result of socialization.

Sexual stereotypes are sets of beliefs about characteristics of roles, which are not necessarily based on facts or personal experiences, but that are applied to each role occupant, regardless of actual circumstances. The assumption is that

certain characteristics are more natural (based on biology) or desirable in members of one sex. Unfortunately, human capacities are dichotomized by sexual stereotyping, which mandate an "either/ or" prospective, rather than a "both/and" prospective. This false"either/or" dichotomy makes complimentary characteristics seem incompatible and unchangeable (Warren, 1982).

Males entering nursing have broken the stereotype of the ascribed role for males. Nursing has been considered women's work and has been delegated the role of care-giving, while the male dominated profession of medicine has assumed the "more important and certainly self-serving scientific work of curing patients" (Gardner, 1992, p. 248). Some aspects that have the potential to be problematic for the senior male nursing students might be the "sanctions" they receive for not remaining in their stereotyped sex role. These might include additional discrimination based on stereotype, lack of male role models and camaraderie, and being given "token" male status. On the other hand, they may be given privileged status and reverse discrimination may work in their favor. Since women, not men, have been socialized to become caregivers, one may wonder how males perceive and provide caring in comparison to females in nursing.

Phenomenology.

This study was done using phenomenological methodology, which is a type of qualitative research. Bergum (1989) contends that "phenomenological research is a human science which strives to 'interpret and understand' rather than to 'observe and explain'....phenomenology has to do with a description of experiences and hermeneutics with interpretations of experiences" (p. 43-44). The use of subjects' oral or written retrospective descriptions of lived experiences is

employed to elucidate the essence of the phenomenon being investigated through reflection and remembrance of situation or circumstances (Parse, Coyne, & Smith, 1985). Through the processes of bracketing, intuiting, analyzing, and describing, the researcher "dwells with" the subjects' descriptions to uncover meaning of each subject's lived experiences.

Nursing is a human science which assumes value from knowledge created in unique nursing situations from shared lived experiences. Nursing involves the interaction of meaningful behaviors and activities, not cause and effect ones (Bishop & Scudder, 1991). Human phenomena, such as caring and events of being, cannot be studied or examined as if they were inanimate beings or objects or neutral items. The human experience must acknowledge feelings, moods, and emotions. "Nursing and phenomenology share beliefs and values that people are whole and that they create their own particular meanings" (Taylor, 1992, p.184).

Implications for the Study

There has been minimal research done concerning males nurses and male students in nursing; consequently, there is little research about the caring essence of these two groups. Most articles and books give personal perspectives, historical accounts of males in nursing, and reviews of literature. Several studies relate more to recruiting males into nursing and perceptions of nursing by non-nursing males and students. Thus, this is an area which need further research.

In regard to educational implications, this study examined the lived experiences of male nursing students concerning caring and caring behaviors. There may be implications for curriculum related to caring, role of male students, and for nursing educators. Also, the number of male graduates from nursing

schools are substantially less than the number who are admitted, according to Halloran and Welton (1994), who posit that nursing schools may not provide a welcoming climate for male students. There may be implications for the nursing educators and institutions concerning an unwelcoming (or non-caring) academic environment and attrition rate if participants also identify this area as a problematic one.

Assumptions and Biases

There are several areas of biases and assumptions that need to be identified and "bracketed". First, I will bracket my biases. I acknowledge that I am a nurse and nursing educator who is a feminist. On the other hand, I have become increasingly aware of and committed to holism and cultural diversity. As a nursing educator for eight years, I have taught and dealt with many nontraditional and traditional nursing students, including many males. I am trying to reconcile my feminist beliefs with the diversity and perspectives that males bring to nursing, as well as to the fact that men in nursing are here to stay. The female/male dichotomies in nursing are relevant to the nursing profession, but so are the realities of male nurses (and students), with which the nursing profession and I have to deal with as a changing profession.

My theoretical and philosophical frame work for nursing is based on various caring theories, including Watson, Leininger, Noddings, Boykin & Schoenhofer, and Bevis. To me, caring is the essence of nursing. Technological aspects of care are also important; however, I believe there is too much emphasis on technology, and not enough on caring by many nurses. Another bias I have in

this realm is that many people enter nursing for the "high tech, glamorous aspects" of nursing as portrayed in the media, television, and movies.

Most of my assumptions are based on my biases and experiences. In my experiences, the percentage of male students in each class has averaged between one-third and one-fourth of the class. Many of the male students are in job retraining programs or are entering second, third, or more career. This may be more true in diploma programs, such as where I teach, rather than in baccalaureate programs. Male students have tended to assume the positions of "power", such as class and/or organizational presidents and class representatives. At times when the hospital hires few new graduates, they tend to hire the males first, regardless of their academic standing and faculty recommendations. Smaller numbers of males in the classes increase their visibility, both from positive and negative experiences in the classroom and clinical setting, and accentuate their presence to the faculty. I have seen more males than females show resentment and resistance toward the faculty as female educators and authority figures. This is particularly true of ones who have previously served in the military.

Also, many of the males that are in nursing education for job retraining have been factory union members and officials, who have a "blue-collar mentality" which is often at odds with the sense of professionalism and "mentality" of nurses and healthcare workers. For example, one can leave at the end of the shift in a factory, while one cannot always leave precisely at the end of the shift in a hospital where life and death situations may be occurring. The assumptions relevant in these instances are that male students have different life and career experiences than female nursing students and have different nursing educational experiences as

a minority due to socialization processes, as well as gender and sex roles differences.

The male students that I have dealt with seem to be more future and goal oriented than the female students. Many do not plan to remain "bedside nurses", but rather plan to go into higher technological areas, anesthesia school, nursing administration, or medical sales. Their focus tends to be "high-tech, glamorous nursing", like that often viewed in movies and television. Learning basic skills and interpersonal skills are viewed as impediments to "real" (technological) nursing. The medical model of technology and curing tend to be much more prevalent than the caring aspect of nursing with a majority of the male students that I have encountered. The assumption in this area is that males tend to focus on the technological and future career changes, rather than on the caring aspects of nursing.

In this study I hope to identify the differences and similarities of male students' experiences with and perceptions of caring, as compared with those identified in the caring literature, which is female oriented. Males in nursing are a reality, so as a caring, holistic profession, nursing must explore the relevant diversities.

CHAPTER TWO

Review of Literature

Introduction

This phenomenological research study examined the lived experiences of male nursing students in regard to caring. Since nursing has traditionally been viewed as a female profession grounded in female values, morals, holistic world view, and characteristics, there is a need to examine the male nursing student in relationship to these attributes. Caring has been identified as the essence of nursing and has been identified as a predominantly female gender role. If nursing is to become a genderless profession, then male perceptions and attributes need to become visible and given a voice. The implications for a caring curriculum need to be explored. Lived experiences of gender differences and perceptions were examined concerning the nursing profession and caring.

Areas examined in this review of literature were: (a) males in nursing; (b) caring; (c) caring and nursing education; (d) gender and socialization,: and (e) phenomenological research. Various subtopics were explored in relationship to the main topics. Potential implications for nursing and nursing education were also examined.

Males in nursing and nursing education

History

There is a paucity of actual research concerning males in nursing (Fagin & Maraldo, 1988; Villeneuve, 1994). Concurrently, there is minimal research about the caring essence of male nurses and male students, as well as how males perceive

caring in nursing. Most articles and books contain personal/individual perspectives and experiences, historical accounts of males in nursing, and reviews of literature about males in nursing. Historically, there always have always been male nurses. In Medieval times and prior to the time of Florence Nightingale, many men were nurses, especially during wartime (Bullough & Bullough, 1984; London, 1990; Kalisch & Kalisch, 1978; Halloran & Welton, 1994; Vestal, 1983; Cyr, 1992; and Villeneuve, 1994). However, their numbers and visibility have been minimal in the United States throughout its history. In the United States, male nurses were barred from the Army Nurses' Corps once the Army Nurses' Corps, Female, was established in 1901 (Kalisch & Kalisch, 1978). Male nurses received no official recognition or status, and were not used in the capacity of the nursing role. Multiple attempts by the American Nurses' Association and male nurses failed to change this discrimination in the military until 1966, when males were no longer mandated to remain in the enlisted ranks of the regular armed services, but were able to receive commissions in the Regular Nurses Corps (Halloran & Welton, 1994; Kelly, 1991; Kalisch & Kalisch, 1978).

Reasons Males Are Entering Nursing

The rate of men nursing entering has increased due to intermittent unemployment, depression in manufacturing and government employment, and loss of job security in recent economic cycles, as well as to improved salaries (Halloran & Welton, 1994). Fagin and Maraldo (1988) state that men enter nursing "for many of the same reasons that women do: job security, an interest in biology, and the desire to work in a humanistic setting" (p. 367). Cyr (1992) conducted an informal study of 25 males practicing in Massachusetts and Texas to

see if recent changes in nursing had changed male nurses' perceptions of the nursing profession. The chief reasons for choosing nursing as a career were: (a) helping others, (b) challenging career, (c) job security, (d) the work itself, (e) unsure, (f) advancement, and (g) job flexibility.

Villeneuve (1994) cites several studies that claim that comparisons between males and females entering nursing show that males are generally: "(a) older, (b) married, (c) more educated, and (d) choosing nursing as second or subsequent career" (p. 219). Men choosing atypical male careers, when compared with those in traditionally male careers, tend to: "(a) have come from working class (blue-collar) backgrounds, (b) have experienced a major family loss during their youth, (c) have been influenced in their career choices by women, and (d) be more tenderminded," according to Lemkau (1984, cited in Villeneuve, 1994).

Benefits Attained with Males in Nursing.

Some of the advantages for recruiting males into nursing are: (a) men tend to be more career oriented, (b) men are more likely to make an active lifetime commitment to the profession, (c) men are more flexible in mobility, and (d) men are willing to work longer hours. Conversely, females: (a) are generally more restricted in geographic mobility related to their husbands' careers, (b) leave work to have children and generally have little flexibilities in their schedules; and (c) are much more responsible for their families than men, so their familial concerns outweigh job concerns (London, 1990; Villeneuve, 1994). "Male nurses are entirely capable of performing their duties with the same professionalism, gentleness, and compassion as women," according to Villeneuve (1994, p. 219).

Other characteristics that have been attributed as benefits of having males in nursing are their "administrative abilities, supervisory skills, leadership qualities, drive, initiative, ambition, and independence of thought" (London, 1990, p 365). It has been further suggested that males could positively affect physicians' attitudes toward nurses since males are less likely to be intimidated by physicians than female nurses. Vestal (1983) goes as far as to say that once physicians become accustomed to male nurses performing nursing functions, physicians' attitudes toward the male nurse and nursing in general will become more positive.

Specialization Preferences.

Men tend to specialize as nurse anesthetists, psychiatric nurses, or nursing administrators, according to London (1990), since these areas require minimal physical intimacy and do not require wearing the traditional nurses' uniform, which identifies them as nurses. This is seen as a way to reduce uncomfortable role strain. These areas are also seen as a way to gravitate to realms of higher pay and economic benefits. Fagin and Maraldo (1988) assert that men tend to work in psychiatric nursing, male urology, and emergency care in order to minimize role strain, while Egeland and Brown (1989) describe male preferences congruent with male sex roles as: "administration, emergency, anesthesia, critical care, operating room, psychiatry, and occupational health" (p. 705).

Stereotyping and Role Strain

Stereotypes. Sexual stereotypes are sets of beliefs about characteristics of roles, which are not necessarily based on facts or personal experiences, but that are applied to each role occupant, regardless of actual circumstances. This assumption

is that certain characteristics are more natural, based on biology, or are more desirable in members of one sex. In our society, females are seen as nurturers and caregivers, while males are seen as leaders, doers, and protectors. Nursing, a predominantly female profession, has been delegated the role of caregiving, while medicine, a male dominated profession, has assumed the "more important and certainly self-serving work of curing patients" (Gardner, 1992, p. 248).

There are several sex role stereotypes have been detrimental to male nurses. The first stereotype is that by becoming nurses, males are acknowledging that they are not smart enough to become physicians (Groff, 1984; Cyr, 1992). Another negative stereotype is that males are not caring enough to be nurses (Groff, 1984). Also there is the stereotype that male nurses are homosexuals (Groff, 1984). Kelly (1991) also identifies that since male nurses have mistakenly been stereotyped as homosexuals, this has provided disincentives for males to become nurses, as well as provides role strain. Cyr (1992) acknowledges that the sexual stereotyping is the most prevalent negative factor concerning nursing, followed by: (a) lack of camaraderie, (b) low pay, (c) limited career opportunities, and (d) that female nurses view male nurses as brawn, not brain.

McPhee (1984) and Tomis (1986) rejects using the qualifier "male" with "nurse", as it delineates the two terms as mutually exclusive, rather than identifying a member of a profession that they believes is genderless. Christman (1988) posits that "no one race, gender, or ethnic group has a monopoly on the qualities of intelligence, scientific competence, imagination, empathy, concern for others, or motor skill abilities" (p. 75).

If a genderless profession is to exist, then the sex-role stereotyping of both female and male nurse must be destroyed (Tomis, 1986). Furthermore, both female and male nurses have to unite to change the current image of the "female sex symbol, physician-seeking nurse and non-masculine 'whimp' male nurse" (p. 17) to the image of a professional nurse. Female nurses need to acknowledge male sensitivities, as well as welcome men into the profession as colleagues and as a power source, not perceive them as a threat (Tomis, 1986). Both masculine and feminine characteristics are necessary in nursing. Sex roles are changing slowly, and sexual integration is possible when females and males learn to deal with each other as equals (London, 1990).

Role Strain. Role strain in nursing is defined as " the social pressure and accompanying difficulties associated with selecting a traditionally female profession (Fagin & Maraldo, 1988, p.367). The mistaken sex-role stereotyping of male nurses as homosexual provides role strain for some individuals, according to Kelly (1991). Many of the other forms of stereotyping also contribute to role strain. The lack of male nurses may be a reflection that men refuse to accept the perceived working conditions of nursing, and suggest that the job title and perceived images of nurses are significant barriers to nursing, not to the practice of nursing,

Another form of role conflict and strain is that some males are threatened by having female authority figures (Kelly, 1991). Since most nurses are female, most nursing educators and authority figures are females. Bland (1985) concurs that men are not used to taking orders from women, especially when previous bosses and authority figures have been male.

Discrimination, Privileged Status and Power Issues.

Discrimination or Privileged Status? There are those who believe that discrimination exists for male nurses. Kelly (1991) asserts that "men suffered the same discrimination in nursing that women encountered in male-dominated fields, although this was not always the fault of nursing" (p.230).

On the other hand, there are those who see males as the privileged few and the saviors of nursing. London (1990) purports that even though male nurses are definitely a minority, they do not generally suffer the social isolation, role entrapment, and performance pressure associated with "token status" and powerlessness. "Token" dynamics are not seen as applicable when the "tokens" are socially dominant Caucasian males, according to a study by Snavely and Fairhurst (cited in London, 1990). Men are not treated as powerless 'tokens', but conversely have been view by some as the saviors of nursing.

In a study by Johnson (1989), some respondents claim that male nurses receive privileged status due to their gender and are viewed as having greater chances for professional advancement. The respondents also mentioned that the general public is likely to view male nurses as physicians (based on gender role assumptions), thus investing them with more status, and as more qualified and trained than female nurses. The male nurse's attitudes, efficiency, and work habits, not gender or the stereotypical idea of homosexuality, were determining factors in the acceptance of individual male nurses.

Others see the effects of male nurses on the profession as a panacea, which may foster increased wages, benefits, status, and increased recognition for the profession (London, 1990; Vestal, 1983). Some have even suggested that most of

nursing's problems are a result of being a predominantly female profession which is plagued by low wages and status, as well as lack of leadership and unity related to sexism and oppression. Furthermore, it has been suggested that these problems could be resolved through active recruitment of males into nursing, which would relieve the causative factors of the problem (London, 1990).

Conversely, McPhee (1984) acknowledges that misconception that male nurses have sweeping powers to change the profession and the benefits, such as salaries. This misconception is erroneous in two areas: first, that the small group of males nurses are seen as having incredible powers; secondly, this also discredits the efforts of female nurses who have been working to improve nursing salaries, benefits, and status for many years. London (1990) asserts that research has demonstrated that male nurses are no more likely than female nurses to be a unifying factor. Christman (1988) also reiterates that male students and nurses, like females, bring to nursing both positive and negative characteristics indigenous to all human, running the gamut from borderline to exceptionally competent.

Unfortunately, these stereotypical ideas about the superiority of male attributes and characteristics epitomize further the dichotomization of socially ascribed gender roles. This does not promote a sense of a genderless profession, but rather denigrates the contributions, attributes, and characteristics that female have always contributed to nursing.

Power issues. The fear that men will dominate the higher echelons of nursing is one that exists not only for American nurses, but nurses in other countries (Kelly, 1991). Ryan and Porter (1993) examined the increased entry of men into nursing in the United Kingdom, and found that the entry of men into

nursing was chiefly of benefit to the male nurses. They purport that there does not need to be an overwhelming number of male nurses to control the occupation in their favor. In 1987, less than 10% of nurses in Britain were male, yet over 50% of chief nurses and directors of nursing education were male. This was seen as a result of the 1966 Salmon Report to the Nation Health Service, which abandoned the female dominated matron system for a "rational, masculine system of management" (Ryan & Porter, 1993. p. 262). This report ignored the women's employment trajectories and was openly sexist as evidenced by the statement regarding "feminine qualities of nurses as a hindrance to efficient administration because they lead to excessive concentration on minutiae" (Ryan & Porter, 1993, p. 262). Concerning the continuation of the present nursing power structure in the United Kingdom, "it would seem that the marginalization of women from power in an occupation overwhelmingly staffed by women will continue (Ryan & Porter, 1993, p. 264).

There is evidence that demonstrates that when the percentage of males in a female dominated profession reaches 20%, the male majority tends to assume administrative control of the profession. As London (1990) reiterates, "the male power base is so strong that when males are introduced into a predominantly female profession, they tend to raise to executive positions" (p.367). This assumption is exemplified through the previous example of nursing in the United Kingdom, as well as how the American elementary and secondary educational system is chiefly comprised of females educators, yet the administration and control of the profession is male dominated.

Another concern is that a large proportion of male executives would be self-perpetuating, and would make it difficult for women to regain lost leadership roles. This has potential to severely limit women's growth potential, to minimize the political effectiveness of female nurses, and to reinforce the oppressed group behaviors which are keeping nursing in its submissive role (London, 1990). Factors which London (1990) views as contributing to these problems are:

> (a) the sexist hiring criteria that pervades society dictates that the more demanding the job, the more males are preferred over females for the position; (b) men refer other male associates to jobs; (c) fewer women may become interested in leadership positions because of a loss of female role models; and (d) men at the top may not choose to mentor women, consequently limiting female nurses' opportunity to have this critical developmental relationship (p. 368).

Paradoxically, Christman (1988) states that "women, when they are in power, are just as reluctant to share power with men as men have been accused of doing in their relationship with women" (p. 75). The issue of power is difficult for feminists and women. "Power is the energy and control that gets things done" (Baym, 1990, p. 66) and is a requisite dimension of any situation. Even though power is often seen as oppressive by feminists, even feminists require power.

Caring and Nursing

Definitions and Characteristics of Caring.

Caring is viewed as the essence or core component in nursing practice (Leininger, 1984, 1988, 1991, 1993; Watson, 1985, 1988, 1994). Therapeutic interventions, interpersonal interactions, moral imperatives, affects, and human traits are some of the descriptions of caring (Morse, Solberg, Neander, Botoroff,

& Johnson, 1990; Dietrich, 1992). In addition, caring has been characterized as : a phenomenon, a life force, nursing science, a process, a behavior, an ideal, a value, a principle, a virtue, and the central unifying domain for nursing's body of knowledge and practices (Fry, 1991).

"True caring in not a form of behavior, not a feeling, or a state. It is an ontology, a way of living. It is not enough to be there to share--it is the way--the spirit in which it is done" (Ericksson, 1992, p. 209). Gardner (1992) describes caring as "those processes and activities in nursing directed at meeting patient needs through individualized services" (p. 241), by nurses "caring for, caring about, and caring with persons, as well as assisting in the curing of persons" (p. 242). Boykin and Schoenhofer (1993) describe caring related to nursing:

> As an expression of nursing, caring is the intentional and authentic presence of the nurse with another who is recognized as a person living caring and growing in caring. Here, the nurse endeavors to come to know the other as caring person and seeks to understand how that person might be supported, sustained, and strengthened in their unique process of living caring and growing in caring (p. 25).

Nursing provides services of an intimate nature to those whose life, family unity, and independence has been threatened, as well as to people trying to survive amid the disaster of our present healthcare system. As Bevis (1989) further ascertains, "nursing has a unique social mission: to care for the vulnerable and to provide caring services in prevention, cure, and maintenance...it concerns itself with lived experiences of people who have to face health problems" (p. 350). A social mandate for nursing has also been expressed by Bevis (1989) which is "to give compassionate, humane care by helping people with their lived experiences

within an ineffective healthcare system that continually denies the individual's personhood both during and in the aftermath of medical 'miracles' technology" (p. 350).

Caring theory has no one correct expression, but has necessary requisites. "Caring is a social creation, not an individual achievement....as part of a larger team or network when providing care (Montgomery, 1994, p. 40). For authentic caring to be maintained, one must transcend one's own ego and superficial self to find greater meaning and significance in one's interactions with clients. This spiritual transcendence reaches to the person's spirit and the core of one's being.

Caring begins with emotional abilities, ethical motives, and willingness to do something special. Warmth, presence, rest, respect, frankness, and tolerance are cultural characteristics of caring communion (Ericksson, 1992). The basis of caring is faith, hope, and love, which are disseminated through caring, playing, and learning that occurs in the context of everyday nursing. Suffering is the beginning point of caring (Ericksson, 1992); thus, the very heart of caring is the alleviation of human suffering. When the nurse feels the responsibility to do all that can be done for the patient, caring becomes a natural behavior.

Compassion, competence, confidence, conscience, and commitment are five characteristics of caring identified by Roach (1984). Compassion encompasses sensitivity and participation in another person's experiences, including their joys, pains, achievements, and sorrows. Competence maintains that professional responsibilities and demands are met through requisite skills and accumulated knowledge of the professional caregiver. Confidence incorporates the attributes of mutual trust and respect in caring relationships. Conscience

entails the convergence of an individual's desires, obligations, and time invested in a person, task, or career. Commitment describes what one wants to do and what one is supposed to do. This entails the convergence of an individual's desires and obligations into a task, relationship, or career.

There is an asymmetrical relationship between the two modes of subjectivity, which are "the one caring" and the "one cared for" (Schweikart, 1990). Caring is more than a feeling, it requires a dual perspective for "the one caring" which is derived from the viewpoints of both "the one caring" and "the one cared for" (Noddings, 1984; Schweikart, 1990). Characteristics displayed by "the one caring" are engrossment and motivational displacement. The person who is "the one cared for" is defined by that individual's vulnerabilities and needs, while "the one caring" has the position of caring by the authorization to help or instruct and has the power to give or withhold care.

Watson (1994) and Boykin and Schoenhofer (1993) described carative factors of caring. Watson (1994, p. 6), in her human caring theory, identifies the following ten carative factors that provide a theoretical and conceptual guide:

1. A humanistic-altruistic system of values.
2. The instilling of faith-hope.
3. Sensitivity to self and others.
4. Helping-trusting human care relationship.
5. Expressing positive and negative feelings.
6. Creative problem-solving caring process.
7. Transpersonal teaching-learning.

8. Supportive, protective, and/or corrective mental, physical, societal, and spiritual environmental.
9. Human needs assistance.
10. Existential-phenomenological-spiritual forces.

To believe that all persons are caring, one must be committed to the belief that one must know self and others as caring persons. Ongoing opportunities for knowing self as a caring person exists throughout one's lifetime of experiences. Transformation of relationships occur through caring, which is living in the context of responsibilities of relationships between and among persons.

A perspective of the meaning of being human is "valuing and celebrating human wholeness, the person as living and growing in caring, and active personal engagement with others" (Boykin & Schoenhofer, 1993, p.10). They also reiterate that caring "is the foundation for understanding nursing as a human endeavor, a person-to-person science, a human social institution, and a human science (p. 10). In 1993, Boykin and Schoenhofer proposed "A Theory of Nursing as Caring: A Model for Transforming Practice," which contained the following assumptions:

1. Persons are caring by virtue of their humanness.
2. Persons are caring, moment to moment.
3. Persons are whole or complete in the moment.
4. Personhood is the process of living grounded in caring.
5. Personhood is enhanced through participating in nurturing relationships with caring others.
6. Nursing is both a discipline and profession (p. 21).

Caring is a means of humanizing all people. Although caring is deemed as a female characteristic, it has the potential to cross gender barriers. As Gordon (1991) reiterates:

> Caring is also a fundamental human imperative that must be obeyed by all humanity, not just half of it. Thus, we hope to teach men to value caring, to share in women's caring work in home and workplace, to support truly care-centered programs in the political arena (p. 45-46).

Historical Aspects of Caring and Nursing.

To explore the meaning of caring, it is necessary to delve into the relationship between nursing and womanhood (Reverby, 1987). Cultural and structural circumstances that create caring cannot be severed from caring as an element in female identity or as a human quality, as many disciplines have done. Caring is a historically created experience, as well as a subjective and material one. "Particular circumstances, ideologies, and power relations thus create the conditions under which caring can occur, the forms it will take, the consequences it will have for those who do it" (Reverby, 1987, p. 5).

Historically, nurses as women, were expected to care as an obligation and duty to all family members and all in need. Altruism, which is assumed to be the basis of caring, did not permit autonomy of practice, but demanded a sense of selflessness. Religious tenets also maintained that caring was a female virtue. Caring was to be an unpaid labor of love, not a job or means of financial restitution. Later, the duty of caring became merely the demand to follow physicians' orders. Today, nursing still struggles to determine the basis for and

value of caring, what count as nursing skills, and whether educational criteria can measure nursing characteristics such as caring (Reverby, 1987).

Although women's experiences are the basis of the ethic of care and intersubjectivity of care, Schweickart (1990) believes that these are a means to understand and evaluate all human actions, not just female experiences. Unfortunately, in adult relationships between women and men, the caring role has been thrust upon women, which generally results in greater vulnerability and less power for women. Although the women's movement has strived to change the traditional female traits of dependence, nurturance, helplessness, these characteristics, as well as the emphasis on physical attractiveness and finding a mate, continue to be exhibited by women as part of their gender role.

Models of Caring.

Caring has been analyzed in multiple disciplines. It has been analyzed historically, anthropologically, culturally, and philosophically. Some of the nursing models of caring are: cultural, feminist, humanist, obligation-oriented, and covenant-oriented (Fry, 1991).

The cultural model of caring evolved from the tenet that cultural beliefs, practices, and human survival are related to caring. This caring phenomenon is described as the unique and central focus of nursing. In the feminist model of caring, both moral and cultural practices are based on feminist perspectives. Human caring is described as both a phenomenon and an attitude which acknowledges and expresses the earliest memories of being cared for (Noddings, 1984; Fry, 1991). Feminist theory applied to nursing gives rise to the basis of caring that supports individual discretion and values, while acknowledging that

nurses' right to care should be considered to have equal value as curing by physicians.

Obligation-oriented and covenant-oriented models are based on moral dimensions of caring. Morality is as "active virtue" which is based on two aspects: (a) the relation of natural caring from love or natural inclination and the perception of "good" and (b) the desire to maintain, recapture, or enhance this "good" which motivates us to be moral (Noddings, 1984)

Caring as a Humanistic Science

Caring science is a humanistic discipline based on all aspects of human life and death (Ericksson, 1992). The protection of human dignity and preservation of humanity are the characteristics of the humanistic model of caring, which is a philosophy of moral caring (Fry, 1991). Human caring is described as both a phenomenon and an attitude which acknowledges and expresses the earliest memories of being cared for (Noddings, 1984; Fry, 1991). Thus, caring can be described as a will, a commitment, an ideal, and an action related to the moral dimensions of a specific role (such as nursing) toward another person. Watson (1994) expands the theory of human caring for nursing to provide a moral, ethical, and philosophical foundation for practice and commitment. Watson (1994) also views nursing as a humanistic science, as opposed to a formal or biological science:

> It orients the practice of nursing toward a covenant that remains at the heart of the nursing profession: to develop with the other a trusting, caring-healing relationship that potentiates health and well-being, physical comfort, symptoms management, pain control, and

> promotes meaning, growth, and harmony between provider and others (p. 1).

Caring involves the nurses' humanity, expands to incorporate other's humanity, and attempts to preserve the process of mutuality and trust in the intersubjective human-to-human contact between nurses and others. This also includes the search for wholeness, healing, integrity, and harmony, which are components of this transpersonal relationship. Health and quality of living issues, such as living, coping, growing, and dying, are aspects of human "being" in caring-healing relationships (Watson, 1994). There must be a move beyond nursing's functional skills to encompass therapeutic use of self and to deal with much greater human dimensions and subjective meanings in the continuum of health-illness. Through the "mindbodyspirit" and human field integration, caring can be acknowledged as "a special way of being human that requires specific consciousness and intentionality in relation to the preservation of dignity, humanity, and wholeness of self and other within the greater universe" (Watson, 1994, p. 4). In addition to restoration of a spiritual reverence concerning life, humanity, and unknown mysteries, Watson's theory attempts to promote restoration of the sense of reverence concerning caring-healing relationships and practices in nursing through integration of traditional and nontraditional healing modalities, competencies of our complex medical technologies, and advanced caring-healing concepts derived from both humanities and arts. "As the heart of nursing, caring involves a deep level of commitment to patients, families, communities, societies, and to planet Earth" (Watson, 1994, p. 3).

Care versus Cure Dichotomy

The conflict expressed in the care/cure dichotomy exacerbates when the two dimensions of nursing, science and humanistic caring, fail to coexist (Gardner, 1992). As Watson (1994) purports, both biomedicalization and technologizing health care have minimized the impact of caring to nurses and others. Through "rediscovery" of the mind-body connection and the "soft" caring modalities, nurses "affect longevity, meaningful living in the midst of suffering, and healing responses at the psychoneuroimmune level" (Watson, 1994, p. 3). A curing focus took precedence over a caring focus because: (a) nursing has been primarily controlled and supervised by male physicians whose focus was cure, (b) nurses were educated in hospitals (and later in colleges and universities) with medically-oriented, male dominated curriculum, and (c) nurses practiced in institutions that denigrated caring while promoting curing. Also humanitarian needs have been overshadowed by the economics of the health care system.

The advent of major technological advances in nursing, medicine, and society in general also promoted curing as opposed to caring. The caring professions of our society--nursing, teaching, and social work-- have been invaded by the business world and marketplace. Caring has been negated as our society sanctioned this invasion of the business world with profits and performance being the bottomline, increase in technology, economic constraints in health care, bureaucratic institutions and constraints, and subservience of female dominated nursing to male dominated medicine (Gordon, 1991; Gardner, 1992). "American society has made great technological advances and---at the same time--has tacitly devalued the 'soft, feminine' professions such as teaching, nursing, and social work,

and the arts in deference to 'harder' qualitative professions," (Fagin & Maraldo, 1988, p. 365). The reality that caring has become a scarce commodity has further exacerbated the traditional low pay, poor working conditions, and limited opportunities for advancement of the caring professions (Gordon, 1991).

Technology can either benefit or hinder human welfare and well-being, depending who controls it and whose interests it serves (Segal, 1987). Similarly, Watson (1990) states:

> Women's caring work is invisible, and somehow subsumed under the important work of men (medicine) in the patriarchal health care system...caring is either women's work and therefore invisible and not valued, or it is something to fear because it can threaten human power, oppose control and domination, and make one vulnerable to human dilemmas one cannot change. It reminds us that we are all equally human, equally in the need of others, and equally vulnerable to forces we cannot always control, no matter how deeply we are socialized to accept the male-oriented view of the world (p. 63).

Montgomery (1994) acknowledges that caregivers have been socialized to not get involved with patients, because it has been seen as unprofessional, as well as a threat to medicine's objective, value-neutral position. This has caused many to suppress their caring instincts. Many nurses have tended to focus on cure as a means to achieve status and recognition, rather than on care and caring, fearing that caring may be seen as demeaning and nonscientific (Belknap, 1991).

Men have traditionally been seen as providers, leaders, and doers, while women have been viewed as the caregivers and nurturers. "Women's caregiving work has become a negative standard against which we measure our progress. Our progress, that is, is charted in the distance women have traveled away from

caregiving work, and toward traditional male activities and preoccupations" (Gordon, 1991, p. 46).

Technological skills and knowledge are vital in today's world and health care agenda, but so are the caring, interpersonal aspects of nursing. As Watson (1994) reiterates, nurses must move beyond nursing's functional and technological skills to embrace both the therapeutic use of self and deal with much greater dimensions and subjective meanings in the health-illness continuum.

Caring fosters independence through empowerment of the patient, but does not promote over-involvement which may result in unnecessary dependency, overtreatment, or usurping another's pains and experiences. Therapeutic perspective is achieved through our access to broader perspectives assimilated through our "knowledge base, life experiences, and experiences with other clients that serve as a source of hope and optimism" (Montgomery, 1994, p. 40). This therapeutic perspective can prevent caregivers from the downfall of therapeutic objectivity, where the focus is the patient's pathology, despair, and hopelessness. Clinical and technological knowledge, expertise, and power are vital to help heal, solve, or remove problems, but these curing functions should be used in a caring relationship to alleviate vulnerability, not just as a means to an end.

Caring and Nursing Education

Caring curriculum

Leininger (1991) believes that caring concepts need to be incorporated into nursing curriculum from the beginning. Caring behaviors can be learned and nurtured in the educational process (Leininger, 1991; Fry, 1991). Specific

teaching and practice opportunities concerning care are vital to ensure that graduates know and practice caring.

The paradox of caring as a concept is that caring can be learned but not taught, according to Hughes (1992). Learning about caring will probably not occur in the classrooms, but rather through interaction with others, where one experiences being the recipient of caring in a caring environment. Students are socialized to the attitudes and normative values about nursing through faculty interaction. In Hughes' (1992) qualitative study, the climate for caring perceived by the students was described as one where the faculty both acknowledge and respond to the stress and anxieties of the students by meeting students' needs and providing opportunities for students to express their concerns and opinions without fears of reprisal and retribution. This study was consistent with Noddings' conceptualization of moral education, and the same four characteristics were: modeling, dialogue, practice, and confirmation. Educators need to promote a climate where students are the recipients of caring and the teacher is the care provider (Noddings, 1984).

Educational institutions have the opportunity to "provide the tools with which one can become wise and mature" (Bevis, 1989, p. 67). Unfortunately, when caring is relegated to the hidden or illegitimate curriculum this opportunity is lost, since there is actual teaching of the caring concepts but there is no written acknowledgment since caring is difficult to measure with behavioral objectives. The teaching of caring is left to each individual instructor's abilities and priorities. Bevis (1989) proposes to use a curriculum development model which is designed to promote insight and skills through building on lived experiences of nurses,

students, and patients/clients. Boykin and Schoenhofer (1993) suggest that the transmission of caring knowledge to nursing students is vital for them "to be presented the opportunity to know themselves ontologically as caring persons and professionals and to understand how caring orders their lives" (p. 154).

Concurrently, the ability of students to care for others is grounded in their personal experiences of being cared for themselves. Ira (1992) proposes that caring is essential in education. Inherent in the transmission of caring knowledge are the following assumptions:

> (1) care is essential for human growth and development; (2) care is the moral imperative of nursing and nursing education; (3) care knowledge can be transmitted; (4) a caring teacher student interaction is a prerequisite for caring student-patient interaction; and (5) the culture of the nursing education institution influences the students' perceptions of the value of caring (p. 261).

The caring ways practiced by students are influenced by the caring ways faculty members teach. Learning to become a nurse occurs concurrently with learning to be a person committed to the care of others (Berman, 1988). The core of nursing education is related to the personhood of the nurse-to-be. Berman (1988) also acknowledges that the dualities of commonalities and differences concerning personhood: "strengths and weaknesses, assets and liabilities, possibilities and probabilities, certainties and uncertainties" (p.14) are vital attributes needed in nursing education.

Gender Based Teaching/Learning Processes. Men and women take learned values and behavior into the classroom where gender affects both how they learn and all aspects of their lives. Smithton (1990) also acknowledges that it is likely

that men and women read, speak, think, and learn differently, yet she admits that it is difficult to identify the differences in learning styles and to develop gender-based learning styles. Different classroom interactional patterns are partially related to the different societal privileges and constraints experienced by women and men (Kramarae & Treichler, 1990). Women tend to favor collaborative learning, to be concerned with the teaching-learning process, and to participate in classroom interactions on a personal level with other students and faculty. Openness, supportiveness, not imposing their views on students, and attempts by the faculty to ensure positive relationships with class members are the characteristics women prefer in teachers. Women are often silenced and discouraged by the different perceptions of the male teachers. Conversely, men are more interested in the content of the learning, rather than the personal and cognitive aspects that women prefer. Teachers who control the classroom discussions, have organized lectures, and who encourage individual questions and comments are preferred by most males. The amount and kind of classroom interaction is attributed to the males' interests and ideas, rather than on the teacher's behaviors.

Sexism in the classroom exists at all levels of education (Sadker & Sadker, 1990). Male students are given more active teacher attention than females. Research has shown that elementary and secondary teachers talked to, listened to, counseled, criticized and praised, asked questions, and gave more extended directions to male students than to female ones. This pattern has continued into post secondary education. Female students are often "invisible" in the class and often have difficulty interacting with the male professors. When they do interact in class they are more likely to be interrupted and less likely than males to be

accepted and praised. Research has shown that female and male students receive evaluative feedback differently. Girls generally receive praise based on the attractiveness of their work and general appearance, while boys receive praise for the intellectual quality of their work. Criticism for females are usually related to their intellectual abilities, while criticism for males are more likely to be related to their lack of neatness and not following rules and forms. Another significant difference in evaluation concerns academic abilities. Inadequate academic performance in males is attributed to lack of effort, while for females they are not.

Weiler (1988) compares the similarities of feminist teachers and vocational educators by asserting that many of the injustices of our society can be approached by using feminist theory to analyze the multiple social and economic problems, which are the same issues relevant to both the clientele and the purpose of vocational education. Further, Weiler posits that feminist teachers "challenge sexist assumptions and call into question accepted definitions of gender...They challenge sexist notions of appropriate behavior and work for women and men" (p. 125). In the struggle to eliminate sexism and promote equity in vocational education, equity should be available to both females and males.

Socialization and Gender Roles

Socialization

Some of the terms to be explored are socialization, role, gender, gender role/sex role, gender attribution, gender identity, and stereotypes. Socialization is a complex process that reflects instilling culturally defined values, roles, and norms to each individual (Chafetz, 1983). Socialization is also seen as "the process of learning the habits, norms, and ways of thinking essential for fitting into society"

(Bowers, 1987, p. 33). Doyle (1989) views socialization as a process by which individuals learn what is expected of them through interaction with others, as well as the process where everybody learns the lessons that others deem necessary for them to fit into their social group. Socializing agents are any person or social institution that shapes a person's values, beliefs, and behaviors.

Berger and Luckman (1966) claim that "socialization is never total and never finished" (p. 137). There are two types of socialization: primary and secondary. Primary socialization involves learning sequences that are socially defined. The individual is not born a member of society, but is born with a social predisposition and becomes a member through socialization. Significant others in the social structure (including families) are the socializers for the individual. Primary socialization is further affected by the requirement of the overall societal order. Secondary socialization, according to Berger and Luckman (1966, p. 138) is "internalization of institutional or institution-based 'subworlds'. Its extent and character are therefore determined by the complexity of the division of labor and the concomitant social distribution of knowledge." Secondary socialization has the presupposition of the preceding primary socialization process, which includes an already formed self and internalized world. Role specific knowledge is also incorporated as part of secondary socialization. Role performance and expectations "are established institutionally to enhance the prestige of the roles in question or to meet other ideological interests" (Berger & Luckman, 1966, p. 141).

Roles

Roles are seen as necessary and essential in any society as a basis for freedom and opportunity. Kessler and McKenna (1978) define role as a sociological concept that proscribes and prescribes behaviors and expectations for a person holding a particular position in a particular social context, while Moulton and Rainone (1982) state that roles encompass nearly any pattern of behavior or function in a group or system and provide information for informed choices related to expectations of the role. A role is characterized by expectations or standards about behaviors that will be rewarded for conformity and performance. Roles can be classified as ascribed and achieved (Doyle, 1989). Ascribed roles are roles over which one has no control, while achieved roles are roles that have been earned or accomplished.

Legal and social sanctions, penalties, and withholding desired rewards may result for individuals not fitting the proscribed patterns of behavior and also for nonconformity. Dissonance between an individual and ascribed roles, as well as dissonance between achievement and achieved status can lead to severe psychological consequences (Fields, 1985). Conversely, roles can constitute restrictions, and limit freedom of choices and options. Although role restrictions are often justified, restrictions of one group's freedoms should not be used to further subordinate that group (Kessler & McKenna, 1978). Provision of future-oriented information, including expected behaviors, how behaviors are related, and expected treatment for conforming or nonconforming to the roles have been identified by Moulton and Rainone (1982) as additional components of role restrictions.

Gender Roles/ Sex Roles

Gender roles, which pervade our everyday life, are ascribed roles and are a set of expectations about what behaviors are appropriate for members of one gender, including interests, activities, dress, skills, and sexual partner choice. Gender is only one of the multiple factors that constitute an individual's life, according to Baym (1990). It is seen as an assumption, rather than a certainty that gender is the greatest factor. As a social norm and concept, gender is transmitted imperfectly and partially to both men and women, as well as varies across class, ethnic, and national lines. Feminism does not equate gender as the prime factor, but is a practical decision to make a livable world by directing one's limited energies and powers.

Historically, cultural roles of women and men have varied, but there have been different roles for females and males. Men and women continue to receive different messages that dictate their "proper" role in their specific cultural environment (Gabriel, 1990). Thus, gender roles are not universally constructed over time and place, nor are they constructed coherently and consistently in different historical contexts (Butler, 1990; Kessler & McKenna, 1978; Moulton & Rainone, 1982; Doyle, 1989).

Gender roles intersect racial, class, ethnic, sexual, and regional modalities of discursively constituted identities (Butler, 1990; Segal, 1987). Jackson (1987) asserts that no human sexual behavior or practice can be divorced from the sociopolitical context in which it takes place and the social relation in which it is embedded. Sexual identities are encoded in complex social practices, including legal, pedagogic, moral, and personal ones, that cannot be willed away (Weeks,

1987). Doyle (1989) elucidates that there are many presumed gender differences where really few exist. Certain roles are seen as biologically unchangeable, since gender, as feminine and masculine, is an ascribed role (Kessler & McKenna, 1978). "Gender is repeated stylizations of a body, a set of repeated acts within a highly rigid regulatory frame that congeals over time to produce an appearance of substance, of a natural sort of being," according to Butler (1990, p. 33). Feminine and masculine roles are the gender roles. Women and men relate to social definitions of feminine and masculine with varying degrees of acceptance, ambivalence, tension, conflict, and antagonism.

Gender role identity is described as how much a person approves of and participates in the feelings and behaviors that are deemed appropriate for that society, as well as self-attribution of gender (Kessler & McKenna, 1978). Culture plays an important role in shaping the gender identity role (Doyle, 1989).

Chodorow (1978) accentuates that feminine identification processes are more relational based, while the denial of relationship tends to permeate the male identification processes. She states:

> Women and men grow up with differently constructed and experienced inner object worlds and are preoccupied with different relational issues....Masculine personality, then comes to be defined more in terms of denial of relations and connections (and denial of femininity), whereas feminine personality comes to include a fundamental definition of self in relationships (p. 169).

The distinct patterns of male and female differentiations are related to the fact that women provide the caretaking in the child's earliest development, not due to anatomy. Males and females differ both in their developmental processes and in

interactions with others (Flynn, 1990; Gilligan, 1982). This impacts on the interpersonal dynamics of gender identification formation in both boys and girls. According to Gilligan (1982),

> females' identify formation takes place in a context of ongoing relationships...girls, identifying themselves as females, experiencing themselves as like their mothers...Boys, in defining themselves as masculine, separate their mothers from themselves, thus curtailing their primary love and sense of empathic ties (p. 7-8).

Weeks (1987) claims that identity is a choice, not destiny. As Woods (1994) reiterates:

> Gender is not merely a quality of individuals....it entails social expectations that define meaning of sex and that are systematically taught to individuals....individual's positions within a society influence how they see social life and how they define their roles, activities, priorities, and feelings....women and men typically occupy different standpoints, which profoundly influence how they understand and act in the world as well as how they define themselves (p. 53).

There are some disagreements concerning gender roles and sex roles, based on theoretical perspectives. The chief philosophical differences are differentiated as: (a) whether biological differences between women and men are subject to change, whether mutated or eliminated, or (b) are biologically caused psychological changes eternal and universal? (Vetterling-Braggin, 1982). There is a link between sex and gender, but Vetterling-Braggin (1982) disagrees that biology controls the person's gender and claims that sex and gender are universally correlated with environmental, economic, and social conditioning factors which all

have an impact. Blau and Ferber (1989) concur that biology can constrain but not determine gender roles.

Sex is the most decisive determinant of personal identity; it is the first thing noted about an individual and the last thing forgotten (Goldberg, 1983). Sex is defined as biological (female and male), while gender is defined as psychological (feminine and masculine), according to Trebilcot (1982). Lerner (1989) also views gender as a process of historical context and culture, while Oakley (cited in Segal, 1987) reiterates that the role of biology in determining gender is minimal and may be overridden by cultural learning. Sex roles are described as roles performed only or primarily by persons of a particular sex, which are promoted by societal factors. Sex designates the biological components of women and men (Kessler & McKenna, 1978; Lerner, 1989; Butler, 1990). Sex role systems are deeply entrenched in most human societies, which cause some people to believe that these roles are natural, immutable facts (Fields, 1985). Dobson (1989) views sex roles as determined by reproduction, with the sexes being innate, biologically determined, relatively resistant to changes, and instilled with innate biases and preferences.

Others have interpreted the biological components as natural in both the religious and moral sense, and have used this to justify exploitation of certain groups, especially women. Moulton and Rainone (1982) declare that sex roles are morally objectionable when sexual divisions of labor are used to perpetuate women's submission to men.

Sex roles are the various ways that girls and boys, women and men take their place in the world. Three factors in sex roles are: (a) that assignment is made

on the basis of ascribed personality traits according to sex, (b) that allocation of appropriate work and activities are based on sex, and (c) the assumption that male and masculine aspects are more valuable and important than females (Fields, 1985).

Neither behavioral nor physiological characteristics are "always and without exception" for only one gender, as Kessler & McKenna (1978) demonstrate in their examples of studies concerning gender ambiguous individuals, such as transsexuals and hermorphodites. Sex roles are not universal but are deeply rooted in the social context, where different qualities and attributes are expected of females and males in different societies. Change in sex roles can cause confusion and anguish; however, adapting to inappropriate sex roles can cause pain, frustration, and social and economic oppression for women (Fields, 1985). Any fundamental change in sex roles requires changing social, economic, institutional, individual, and societal attitudes. Kaschak (1992) further reiterates the impact of anatomy:

> Destiny is inherent not in biological anatomy but in anatomy gendered and meaningfully contextualized. Anatomy given meaning in our society becomes destiny, for this is the meaning that it is given. One of the most existentially profound and psychologically meaningful issues with which each of us must contend is the arbitrariness of anatomy and its assigned meanings, which then determine every individual's life to an extraordinary extent. Once assigned, it is gender, as the basic psychological organizing principle in the family (along with age) and in larger society (along with race and class), that determines and organizes development and identity (p. 42).

Conversely, basing biological roles on sweeping generalization of non-human species, including primates, is erroneous because humans are distinguishable from animals due to human socialization to norms, expectations, and intellectual abilities, rather than to blind instincts of animals (Blau & Ferber, 1989).

Technology and Sex Roles.

Roles and social rules are not determined by biology alone, but by the interaction of biology with the technology of production (the way goods and services are produced in given circumstances) and economics (Blau and Ferber, 1989). Gender roles were developed as a rational response to conditions at a particular time in economic development, but have not relinquished their hold after they have ceased to be functional and mechanization has occurred.

Technology has superseded many of the previous physical demands that necessitated different work qualifications. Qualities that were necessary for survival in prehistoric times are no longer required of modern people. No longer must a man be a hunter to provide food for his family, since technology and industrialization have assumed the task of providing food for a price. Lerner (1989) debunks "biological determinism" as a theory that selectively ignores the fact that humans have distanced themselves from nature by inventing and attempting to perfect culture and technology. Changes in our life spans and life cycles have greatly impacted our lifestyles, yet these changes have been ignored concerning gender and sex roles. Cultural and technological advancements have freed men from much hard physical labor which is now done by machines, yet women are still doomed to service of our species through biology or "nature".

Although breast feeding is still a viable option, prepared formula can be used to feed infants, which means that the mother and her activities are no longer constrained by breast feeding. Lerner (1989) also criticizes the absurdity that most human activities have changed with time, except female nurturance, which is used to consign over half the population to a lower state of existence, using "nature" as the excuse.

"Men and women do not just have different experiences; they have unequal experiences that is used...to perpetuate that inequality by inhibiting women's career progression and reinforcing the practices of women being primarily responsible for childrearing" (Allen, Allman, & Powers, 1991, p. 54). Held (1982) decries that women have routinely had to choose between parenthood and having an occupation, while men can enjoy both parenthood and have another occupation.

Sexual Stereotypes

Stereotypes are sets of beliefs about characteristics of roles, which are not necessarily based on facts or personal experiences, but that are applied to each role occupant, regardless of actual circumstance. The stereotypes also have an evaluative component (Kessler & McKenna, 1978). Soble (1982) asserts that the component terms of masculine and feminine are strongly evaluative because judgment value is embodied in any claim using them. Sexual stereotyping tends to be based on assumptions that certain characteristics are more natural or desirable in members of one sex. Mead's view of gender stereotyping is described as specific clusters of personality traits that are ascribed to each gender, rather than by tasks actually performed (cited in Duran, 1982). These stereotypes are chiefly due to social conditioning and nurturance.

Warren (1982) posits that we are all born unique but that sexual stereotyping diminishes our individual uniqueness, while Fields (1985) concurs that stereotyping does not take into account the differences between individuals. Freeing individuals from rigid sexual stereotypes allows more androgynous and more flexible alternatives to adapt to new situations, while providing less restrictions concerning what one can do and how one can express oneself "I have come to believe that we need a new standard psychological health for the sexes, one that removes the burden of stereotypes and allows people to feel free to express the best traits of men and women (Bem, 1983, p. 31).

Part of the injustices in sexism and racism is that stereotypes do not fit (Grim, 1982). Social injustice occurs when differences between individuals and groups, whether real or imagined, are considered fundamental rather than social differences. Some of the differences are social differences that rely on the construction of the social order, such as interests, needs, and desires. If the gender issue differences are a reflection of our social order, they can be changed rather than remain invariable dictators of social change. Instead of being exploited, these differences can be corrected and be compensated.

Behavioral characteristics, such as aggression, are interpreted differently when demonstrated by women and men. These observed social differences can be avoided, at least in theory, if they truly are not fundamental differences (Grim, 1982). According to Smithton (1990), "Males and females are obviously raised differently in American society" (p. 6). Some of these differences are: (a) women tend to value connections with others while men tend to value autonomy; (b) men tend to be much more comfortable with professional power than women; (c) anger

and violence are more acceptable in men than women; and (d) more men are college professors and more women are elementary teachers. There are multitudes of obvious ways that demonstrate the fact that American society offers women different roles, aspirations, and estimates of worth than men receive. Feminist research and theory emphasize that an imbalance of the social order where males have dominance over females further contributes to these male/female differences (Flynn, 1990).

Virtues and vices must be seen as human attributes, not as sex-linked ones. Problems with basing characteristic traits on gender are: (a) a lack of acknowledgment about how traits are mixed, (b) the desired proportions if all traits are equal, (c) whether a variety of mixtures are possible, or (d) if these traits are psychological, behavioral, or physiological, or a combination of all three (Pielke, 1982).

Stereotyping dichotomizes human capacities, making complimentary characteristics seem incompatible. These false dichotomies mandate an "either/or" perspective, rather than a "both/and" one (Warren, 1982). Hare-Mustin (1988) asserts that isolating or dichotomizing phenomena is customary method of research analysis, which can lead to false assumptions. An example is the emphasis of female and male differences, rather than on their commonalities, which may be overlooked. Allen, Allman, and Powers (1991) acknowledge that "our self concepts, the categories we use to create and evaluate our lives, are influenced by the technology of research" (p. 50). Discourse concerning sex/gender questions relative to women have been divided into two groups: (a) those that were attributed to women's competencies and performances relative to their biology,

including sex and nature, and (b) those that were attributed to socialization, such as gender and nurturing. Inequality that is attributed to biology is easier to maintain and justify than is inequality which results from socialization and social arrangement. "Men and women become different through a long, arduous process involving distinct social experiences" (Allen, Allman, & Powers, 1991, p. 54).

Examples of false dichotomies will be examined. Reason and emotion, as well as reason and intuition, are viewed as separate entities, rather than as having complimentary aspects of knowledge. Men have been viewed as having higher levels of intellect because they are seen as using reason in decision-making, while women have been denigrated for incorporating emotion and intuition (Caplan, 1987; Warren, 1982), Since the Enlightenment period in the 17th century, rationality has been equated with knowledge and masculine identity, while emotions, feelings, and intuition have been denied as a source of knowledge and has been seen as a female weakness (Seidler, 1987).

It is not enough to look to science to end sexual stereotyping. Allen (1992) asserts that " the role of science in sustaining social injustice is too significant to ignore...women and people of color have a long, terrible history of having their explanations supplanted by those of white, male scientists" (p. 31). Examples to substantiate this claim includes how medical science has provided scientific "truths" about supposed inferiority of women due to left brain attributes and hormonal problems, as well as that African-Americans are more susceptible to AIDS due to their genetic predisposition to impassivity and aggression. Allen further reiterates that "supposedly neutral or universalizing claims are shaped by the social position of scientists (among other aspects)," and that these former

"truths" have been "relativized" (p. 3). Men have chronicled women's historical narratives and defined our fields of inquiry, which has resulted in the suppression, marginalization, omission, and silencing of women's perspectives. Flynn (1990) further states that in the attempt to universalize, our differences have been erased and men have become "the standard against which women are judged" (p. 114).

Conversely, Martin (1982) acknowledges that male biases and their transmission occur when education involves initiating both males and females in male biased fields of knowledge. Scientist and medical physicians have usurped sexuality and gender into the scientific realm by defining certain kinds of sexual institutions and practices as natural, rather than as social, political, or economic issues. It is also difficult for women to achieve equality with men within the scientific and medical establishment, without internalizing male values of these professions in the process (Jackson, 1987).

Phenomenology

Qualitative Research

Phenomenology is one of the forms of qualitative research. Qualitative research, according to Benoliel (1984) is described as "modes of systematic inquiry concerned with understanding human beings and the nature of their transactions with themselves and with their environment'" (p. 3). Polit and Hungler (1989) posit that the use of qualitative research is based on the philosophical assumption of holism, which incorporates concern for humans and their complex environment. Knowledge about humans is viewed as possible if the lived human experiences are described and defined by the participants. Morse (1989) states that the strength of qualitative research is the induction process, which promotes the emergence of

data to provide theory, not the reverse. Parse, Coyne, and Smith (1985, p. 3) state that:

> Qualitative research identifies the characteristics and the significance of human experiences as described by subjects and interpreted by the researcher at various levels of abstraction....the researcher's interpretations are intersubjective, that is, given to researcher's frame of reference, another person can come to a similar interpretation. Qualitative data are processed through the creative abstraction of the researcher as the subjects' descriptions are studied to uncover the meaning of human experience.

Qualitative nursing research was introduced in the 1960's, but did not receive acceptance until the 1970's. Some nurses felt that quantitative research was too constraining, so phenomenological research was embraced by some to study the lived experiences of patients and families (Anderson, 1989).

Phenomenology

Phenomenologists have diverse philosophical perspectives, yet agree on the method of inquiry. Philosopher Frantz Brentano, in the late nineteenth century, was the first writer to use the phenomenological method of inquiry. Edmund Husserl, Martin Heidigger, Gabriel Marcel, Jean Paul Sartre, Maurice Merleau-Ponty, Alfred Schutz, Paul Ricoeur, and Richard Zaner are all pre-eminent phenomenologists (Parse et al, 1985; Anderson, 1989).

Phenomenology is a "distinctive philosophy, theory, and method for studying the world of everyday life," although there is diversity in the usage of phenomenology (Anderson, 1989, p. 16). Bergum (1989) further reiterates that "phenomenological research is a human science which strives to 'interpret and understand' rather than to 'observe and explain', which is normally found in natural

science....phenomenology has to do with a description of experience and hermeneutics with interpretation of experience" (p. 43-44).

Phenomenology is appropriate for sciences that focus on humanness and connection with the world as the point of inquiry. "Sound human science research... helps those who partake in it to produce action sensitive knowledge" (van Manen, 1990, p. 21). Knowledge about experience is not based on the prescriptions of quantitative methodologies, but rather is expanded through the use of the subjects' oral or written descriptions of the experience as the raw data. This is a deliberate move away from hypotheses testing, causal relationships, and quantification of data. Phenomenology as a human science is a western research method used to acquire understanding of concrete lived experiences by means of language, and is not to be confused with eastern philosophy. Problem solving is not the emphasis of phenomenology (van Manen, 1990).

The major task of phenomenology is to elucidate the essences of the phenomenon being investigated, including the context of the situation through asking the meaning and significance of certain phenomenon (Parse et al., 1985; van Manen, 1990). Retrospective descriptions of lived experiences encompass reflection and description of the situations or circumstances in which the experiences occurred and how it is presently remembered. Phenomenological description is only interpretation and no single interpretation of human experiences will ever exhaust all the possibilities of complementary or richer experiences (van Manen, 1990). Bergum (1989, p. 43) describes phenomenological research as a:

> drama, an interactive involvement of both the 'researcher' and the 'researched'. For the researcher, the research drama is experienced

> as a dialectic between the inner commitment (the interest, the passion), and the outer activities (stating the question, establishing the approach, operationalizing the tasks, writing, and rewriting.

As "action-sensitive-understanding" method, phenomenological research has its beginning and end based "in the practical acting of everyday life and leads to a practical knowledge of thoughtful action (van Manen, Bergum, Smith, Ford, & Maeda, 1987). In order to understand the lived experience, one must surpass the taken-for-granted aspects of life (Bergum, 1989). Benner (1985) maintains that to understand the lived experience the researcher must "uncover meanings in every day practices in such a way that they are not destroyed, distorted, decontextualized, trivialized, or sentimentalized" (p. 6).

Phenomenology and Nursing

A phenomenological study of lived experiences can be representative of a nursing situation, in which nursing can be known through understanding of the new meanings derived from the nurse's and the nursed person's shared lived experiences (Boykin & Schoenhofer, 1993). Limitations of phenomenology can occur when the phenomena is removed or abstracted from the nursing situation, which can be mistaken for nursing knowledge. When returned to the full context of the nursing situation, this knowledge can be used to illuminate the study of nursing. "Nursing...is not a normative science that stands outside a situation to evaluate current observations against empirically derived and tested normative standards" (Boykin & Schoenhofer, 1993, p. 16). Nursing is a human science which assumes value from knowledge created in unique nursing situations from shared lived experiences. A key concept of this concept is the nursing situation,

which is "a lived experience in which the caring between the nurse and the nursed enhances personhood" (Boykin & Schoenhofer, 1993, p. 24). This nursing situation is the locus concerning all that is known and done in nursing, and the study of the nursing situation provides the content and structure of nursing knowledge. Thus, generation, development, and conservation of the content of nursing knowledge occur through lived experiences of nursing situations.

Watson (1988) describes phenomenology as a method that attempts "to describe and understand human experiences as they appear in awareness" (p. 80). The subject matter concerns the types and structures of the human experiences, as well as the subjective meanings, relationships, and essences. Human phenomena, such as caring and events of being, cannot be studied or inspected as if they were objects, neutral items, or inanimate beings. Feelings, moods, and emotions of experiences are how the human experiences are acknowledged. Phenomenology maintains that human existence is only meaningful and of interest when there is consciousness of something (Boyd, 1993).

> Human behavior occurs in the context of relationships to things, people, events, and situations, in which Merleau-Ponty refers to as embodiment. People, in all their subjectivity, are inseparably caught up in the physical world in such a way that the truth we search for in nursing research efforts will be grasped only by attending to the realities constituted in individual experiencing. Lived experience is, however, layered with meanings that brought to the relation of being-in-the-world. This occurs through the attention to life taken up in experience, which is to take up a perspective of the world (p. 104).

According to Bishop and Scudder (1991), nursing involves meaningful behaviors and activities, not cause and effect. Looking for meanings, not causality,

is necessary to find the essence of nursing. The interpretation of lived experience as a totality is an advantage of using the phenomenological methodology). The researcher is able to understand an experience from the perspective of the individuals being studied. "Nursing and phenomenological methodology share the beliefs and values that people are whole and that they create their own particular meanings" (Taylor, 1992, p.184).

Phenomenological Methodology

In the phenomenological method, the researcher can study the whole configuration of people's lived experiences through the emergence of patterns and can participate in uncovering meanings of these experiences (Parse et al., 1985). Meanings of lived experiences are generally hidden or veiled (van Manen, 1990). A true reflection about a lived experiences is thoughtful, yet reflexive, grasping of what in particular renders an experience as significant. Phenomenological research "consists of reflectively bringing into nearness that which tends to be obscure, that which tends to evade the intelligibility of our everyday life" (van Manen, 1990),

This human science method takes into account the participant's experiences with a situation. The subject describes the experiences, while the researcher studies the descriptions and analyzes the information to develop a final description of the lived experiences being studied. The researcher "dwells with" the subjects' descriptions through the processes of intuiting, analyzing, and describing to uncover the meaning of each subject's lived experience. Themes, or common elements, surface and are identified and synthesized into structural definition of the lived experiences. Adequacy of the sample is achieved when there is redundancy or repetition in descriptions and statements concerning the phenomenon being

studied. Then conclusions are drawn relative to the research question being studied (Parse et al., 1985).

Bracketing, analyzing, intuiting, and describing are the four basic strategies in phenomenological research (Swanson-Kauffman & Schonwald, 1989). These strategies are also related to the four ways of knowing in nursing: ethical, esthetic, empirical, and personal knowledge. These strategies will be further described in Chapter Three, the methodology chapter.

Summary

This focused literature review was conducted to provide fundamental background for this study. Various areas were explored to provide an awareness of the current and past information relevant to this study. Also, this was another way to bring additional biases and assumptions into my awareness prior to beginning the data collection. This facilitated the bracketing process. After the data was collected and analyzed, it was necessary to return to the literature review to compare this information with the descriptions in my data. This process helped provide external validation. Findings of this study are described in Chapter 4. Correlation of the literature review information and the data collected in this study are identified in Chapter 5.

The first topic in the literature review related to males in nursing. The following subtopics were: (a) the history of males in nursing, (b) reasons males enter nursing, (c) benefits attained with males in nursing, (d) specialization preferences, (e) stereotyping, discrimination, and role strain, and (f) privileged status and power issues.

Caring was explored in the realms of both nursing and education. The second relevent topic, which was relevant to caring and nursing included the following subtopics: (a) definitions and characteristics of caring, (b) historical aspects of caring and nursing, (c) models of caring, (d) caring as a humanistic science, and (e) the care versus cure dichotomy. The third major topic was caring and nursing education topics. Caring curriculum and gender based teaching/ learning processes were the subtopics explored in this section.

Socialization and Gender Roles, the fourth topic, incorporated the subtopics of (a) socialization, (b) roles, (c) gender, (d) gender attribution, (e) gender identity, and (f) sexual stereotypes. In the fifth topic, phenomenology was explored through the use of the subtopics of (a) qualitative research and phenomenology, (b) phenomenology and nursing, and (c) phenomenological methodology.

CHAPTER THREE

Methodology

This chapter describes the actual methods and procedures utilized in this study. The methodology encompassed the phenomenological method as described by Swanson-Kauffman and Schonwald. Descriptions of the phenomena of interest studied, the methodology of the four step process of the Swanson-Kauffman and Schonwald method, the process of data collection, and the analysis of the data procedure are also included in this chapter.

Phenomena of Interest

The phenomena of interest in this study were the lived experiences of male students related to caring. I wanted to uncover the meanings that male student nurses were forming and experiencing related to caring in their nursing educational experiences and their personal lives. By encompassing their experiences of "being-in-the-world" of nursing, this allowed the participants to find meanings relative to caring and their feelings in their journey to becoming a health care professional.

Participants

This study was conducted with volunteer participants who were male nursing students in baccalaureate nursing programs in West Virginia. In January, 1996, my doctoral committee met and approved my dissertation proposal. Permission was also granted by the Institutional Review Board (IRB) of West Virginia University to conduct the study. Four baccalaureate nursing schools were each sent a letter which explained the proposed research study, as well as requested information concerning the requirements for allowing students to

voluntarily participate in research studies and how to recruit volunteers at their institutions. All schools gave their permission for the researcher to seek volunteer participants and to conduct the study. .

Following the letters of approval from the schools and the IRB, I began recruiting participants in March, 1996. All the potential participant were in their final semester of their senior year. I visited a class at one of the schools, where I discussed the study and requested volunteer participants. The other participants were informed of the study by members of their faculties and that I would be contacting them. After I called them on the telephone and discussed the study with the all potential participants, I then sent them a follow-up letter and a cover letter, which re-explained the study, through the United States Postal Service mail. Appointments for fourteen interviews were scheduled during March, April, and May. The interviews were scheduled and held on the campuses of the participants' schools, at sites of their choosing. Fourteen interviews were then completed by May, 1996. One of the fifteen potential participants had verbally told a faculty member at his school that he was willing to participate; however, he never returned my telephone calls nor responded to the letters sent to him. This necessitated the need to find another participant in order to fulfill the number of participants needed for the study. In September, 1996, another participant was recruited from one of the schools used previously. This participant was a first semester senior. Thus there were fifteen participants recruited to participate in this study.

All participants were told that they had the right to withdraw from the study at any time and that all information obtained would be kept confidential.

The participants were informed that to maintain confidentiality the data was only handled by the investigator, the hired transcriptionist who transcribed the audiotapes verbatim, and a fellow doctoral student who assisted in verification of the emerging themes.

Design of the Study

Rationale for Using Phenomenology

This study was conducted utilizing the qualitative research methodology of phenomenology. Watson (1988) describes phenomenology as a method that attempts "to describe and understand human experiences as they appear in awareness" (p. 80). The subject matter concerns the types and structures of the human experiences, as well as the subjective meanings, relationships, and essences. Human phenomena, such as caring and events of being, cannot be studied or inspected as if they were objects, neutral items, or inanimate beings. The participants and phenomenon under investigations must be approached by the researcher with empathy, appreciation, and a sense of awe. Feelings, moods, and emotions of experiences are how the human experiences are acknowledged. Phenomenological theory maintains that human existence is only meaningful and of interest when there is consciousness of something (Boyd, 1993). Lived experiences can never be grasped in the immediate manifestations, but can only be reflected relative to the past presence (van Manen, 1990).

As van Manen (1990) posits " The only generalization allowed by phenomenology is this: Never generalize!" (p. 22). One's tendency to generalize can deter the focus on and understanding of the uniqueness of human experiences. However, any phenomenon is a possible experience, since ones' own experiences

are potential experiences of other and other's experiences are potential experiences of oneself. "The point of phenomenological research is to 'borrow' other people's experience and their reflections in order to better be able to come to an understanding of the deeper meaning or significance of an aspect of human experience, in the context of the whole of human experiences" (van Manen, 1990, p. 62). Data in human science research are human experiences, which are collected based on other's experiences because they allow us to become more experienced ourselves.

> Human behavior occurs in the context of relationships to things, people, events, and situations, in which Merleau-Ponty refers to as embodiment. People, in all their subjectivity, are inseparably caught up in the physical world in such a way that the truth we search for in nursing research efforts will be grasped only by attending to the realities constituted in individual experiencing. Lived experience is, however, layered with meanings that are brought to the relation of being-in-the-world. This occurs through the attention to life taken up in the experience, which is to take up a perspective of the world (Boyd, 1993, p. 104).

According to Bishop and Scudder (1991), nursing involves meaningful behaviors and activities, not cause and effect. Looking for meanings, not causality, is necessary to find the essence of nursing. The interpretation of lived experience as a totality is the advantage of using the phenomenological methodology (Taylor, 1992). The researcher is able to understand an experience from the perspective of the individual being studied. "Nursing and phenomenological methodology share the beliefs and values that people are whole and that they create their own particular meanings" (Taylor, 1992, p.184). Nursing knowledge can be communicated through sharing of stories.

Strategies in Phenomenological Methodology

Swanson-Kauffman and Schonwald (1989) summarized four basic strategies in phenomenological methodology: bracketing, analyzing, intuiting, and describing. These strategies were also related to the four ways of knowing in nursing: ethical, esthetic, empirical, and personal knowledge. These steps are not followed in a progressive or linear manner, but may be experienced simultaneously or may fluctuate between the four strategies.

Prior to intitiating this study, a pilot study was done to obtain information relevant to improve the dissertation study. In the pilot study, 2 recently graduated male students from a diploma program were interviewed. Changes in some of the semistructured interview questions were the main revisions needed in the study. The changes pertained to simplifying the questions and making them more open-ended. Some of the changes were relevant because of the differences in the participants of the two studies. In the pilot study, the participants were both older, nontraditional students in a non-degree nursing program, while the participants in this study were more traditional college students in a baccalaureate degree program. Also since the participants in the pilot study had been employed as nurses in a hospital setting for several months, they acknowledged that some of the questions were not easily answered since their educational experiences were no longer fresh in their mind. Finally, the participants in the pilot study had been students of mine and were aware of some of my biases and opinions, while the participants in this study were not known to me or previously exposed to my biases and opinions.

Bracketing. Bracketing is a methodological attempt to accurately interpret the participant's lived experiences, by reducing and setting aside the researcher's assumptions concerning the phenomenon, both prior to and during the actual interview. Bracketing can be viewed as the ethics of phenomenology. Also, there are three assumptions related to bracketing that we as researchers need to acknowledge: (a) that even though our experiences and knowledge are valid, they may not describe the reality of the informant(s); (b) that we have the capabilities to elicit and hear our informant's reality; and (c) that we believe that our informants will relate a unique or cohesive reality through their personal stories, thus negating our own a priori assumptions in interpretation of the stories (Swanson-Kauffman & Schonwald, 1989). These articulations of personal assumptions can replace the conceptual framework of a research study.

There are two layers in the bracketing process, according to Swanson-Kauffman and Schonwald (1989). In the first layer, our conscious assumptions concerning the phenomenon under investigation, the beliefs held about the answers to the research question, and the theories or studies deemed salient to the question are clearly identified and stated. Selected and focused literature reviews are conducted to provide a foundation for the study, as well as may bring into the researcher's awareness of additional biases and assumptions.

In the second layer, the assumptions and biases are set aside both prior to and during each interview in an attempt to more accurately "hear" the participant's realities. In this realm, it is necessary for the researcher to suspends both personal beliefs and the influences of all the information from previous participants during every new interview. Thus, the researcher is able to fully "attend to" each

participant's experiences and accept the participant as the "expert" in the phenomena being studied. This requires "being-in-the-moment" with the participant.

In this study, I described assumptions and biases prior to beginning the study. A review of literature was conducted which focused on historical and research contexts of the key concepts. The key concepts that were investigated included: (a) males in nursing and nursing education, (b) caring, (c) caring and nursing education, (d) gender and socialization, and (e) phenomenological research. These concepts were further delineated into relevent subtopics of research. The first research context, which included studies of: males in nursing and nursing education were: (a) reasons males are entering nursing, (b) benefits attained with males in nursing, (c) specialization preferences, (d) stereotyping, discrimination, and role strain, and (e) privileged status and power issues. Concepts of caring included: (a) definition and characteristics of caring, (b) models of caring, (c) caring as a humanistic science, and (d) care versus cure dichotomy. The review of the literature relevant to caring and nursing education focused on caring curriculum and gender based teaching/learning processes. In the realm of socialization and gender roles, subtopics included (a) roles, (b) gender roles/sex roles, (c) technology and sex roles, and (d) sexual stereotypes. Phenomenological research was investigated in the realm of its relevance to nursing and this study, as well as for the methodological components.

After the various reviews of literature were completed, I reviewed the original assumptions and biases to determine if additional ones might be brought to my attention as appropriate to include in the bracketing process. Bracketing was

then done prior to and during each interview by suspending all assumptions and beliefs, while "attending to" each individual's story. Thus, throughout the interviewing process I approached each interview as if it was the beginning one.

Analyzing. Analyzing, the empirics of phenomenology, consists of establishing the plan to locate, gather, record, sort, retrieve, condense, and verify accounts of lived experiences of the phenomenon being investigated (Swanson-Kauffman & Schonwald, 1989). Data collection may include (a) narrative, written descriptions of observations and the interview; (b) verbatim transcripts from audiotaped or videotaped inteviews; (c) entries included in the researcher's diary that detailed the dynamics of the setting; and (d) notes taken while reading written documents (Burns & Grove, 1993). Internal and external verification is then sought. Internal verification consists of having a second interview with the participants who critique the credibility of the emerging theoretical model. The subject's transcripts are reanalyzed through critiquing the applicability of each category to each subject. To determine external verification the researcher reviews the original assumptions and correlates them with other descriptions of the experience (Swanson-Kauffman & Schonwald, 1989). .

As the researcher reflects on the lived experiences, the structural or thematic aspects of the experiences are being reflectively analyzed. The meanings or essences are multidimensional and multilayered. Themes are elements that occur frequently throughout the text and are instrumental in structuring and giving meaning to the phenomena one is attempting to understand (van Manen, 1990). The process of theme analysis is recovering themes that are embodied and dramatized as the meanings evolve. This process gives control, structure, and

order to the research process through insightful invention, discovery, and/or disclosure. The thematic phrases point to, allude to, and hint at aspects of the phenomena. Approaches to uncovering or isolating thematic aspects of the phenomena are: (a) wholistic or sententious; (b) selective or highlighting; or (c) the detailed or line-by-line.

In this step of the study, I began the actual data collection. A plan was developed to locate, gather, record, sort, retrieve, condense, and verify the data. After I received approval from my doctoral committee, the IRB of West Virginia University, and the four baccalaureate nursing schools, I recruited fifteen participants and scheduled all the interviews.

At the interview, the participants were interviewed using a semi-structured interview format and were asked demographic information. Each participant was reminded that there were no correct or incorrect answers and that each individual's experiences concerning the phenomena were the focus of the the interview. The following semistructured interview was the basis of all the interviews.

Semistructured Interview

Demographic Information

Age

Marital status

Number of children

Residence location (rural vs. urban)

Previous educational experiences

Previous work/military experience

Previous experiences as caretaker (child, parent, etc).

Interview Questions

(1) Tell me about your decision to become a nurse.

(2) Describe your perceptions of nursing prior to entering nursing school.

(3) How did you learn about caring?

(4) How has being in nursing changed how you view nursing?

(5) How do you see caring in nursing? Give examples of experiences where you provided caring.

(6) Is the caring you give different than caring given by female students? Is the caring you receive different than the caring received by female students? If so, what are the differences?

(7) Tell me about a situation in which you experienced caring from a faculty member.

(8) What do you see yourself doing in the next 20 years?

All of the interviews were audiotaped. Interviews lasted from thirty minutes to one hour and a half hour, which allowed ample time for the participants to tell their stories. A journal was kept by the researcher concerning notes made prior to, during, and after the interviews. After each inteview was completed, the audiotape was stored in a file cabinet in my home. The tapes were coded by number for confidentiality reasons, so only I knew the participants' identities. I personally delivered the audiotapes to the hired transcriptionist at various intervals. The transcriptionist transcribed each audiotape verbatim. Some of the tapes and transcripts were returned to me by mail via the United States Postal Service and others were hand delivered by the transcriptionist.

Analysis of the transcripts was begun. Each interview was read and notes were made in the margins. Next, I copied key words and phrases from each

interview onto individual index cards, along with the number of the participant and the page number of the transcript. This helped to facilitate information retrieval at later times. The index cards were sorted into various piles at multiple times to attempt to find the essences and themes from the meanings. Interview transcripts were reread multiple times to correlate the essences arising from the sorting of the index cards and to assure the sorting was occurring in the correct context.

Attempts to derive themes from the essences were ongoing. A fellow doctoral student independently searched for essences and themes, then collaborated several times with the researcher to elicit essences and themes. Whenever there was disagreement or dissonance, there was much discussion and then a consensus was reached.

Internal validation was provided by contacting the participants concerning the emerging themes and essences. Each was sent a letter through the United States Postal Service that included a list of the emerging themes and essences. I enclosed a stamped, self addressed envelope to encourage them to respond to the letter. In the letter they were asked to review the themes and essences, then to make any comments concerning the emerging data, and return the letter to me. I also asked that if they agreed with the themes and essences or had no comments, to please sign the letter and return it to me. Six of the participants responded and returned their letters and comments. Of the six who responded, all agreed that the emerging themes and essences were representative of their experiences and the interview.

External validation occurred as I continually reviewed the original assumptions and information in the literature concerning similar descriptions of the

experiences. Prior to the study, my assumption was that caring was the essence of nursing and an ethical, moral imperative. Since nursing had predominantly been a female profession, and caring had deemed a female characteristic and attribute, I felt the need to examine the difference in caring between male and female nursing students. Assumptions and biases were bracketed prior to and during the interviews and were not conveyed to the participants during the interview or through the open-ended questions in the semi-structured interview. Thus, the participants were not given direction in explaining their lived experiences, but were given great latitude of freedom to express the re-telling of their stories and experiences. The participants did acknowledge difference in caring given and received based on gender. Other differences and similarities between male and female nursing student were described in their experiences. Correlations between the themes and essence and the literature are identified in Chapter 5.

Intuiting. In phenomenology, intuiting can be correlated with the esthetic aspect of the ways of knowing in nursing. Expressiveness, subjective acquaintance, individual perceptions, and empathy comprise the esthetic patterns of knowing relevant to the art of nursing (Boyd & Munhall, 1993). Intuiting is the process where "the researcher remains open to the meanings attributed to the phenomenon by those who have experienced it" (Polit & Hungler, 1995, p. 198). In this step, the researcher's openness to the other's reality is necessary in order to delve into the participant's thoughts that are not in everyday awareness. Seeking this data requires that the researcher: (a) be hyperattentive to the verbal and nonverbal communication of the participant; (b) believe that the participant, through the process of re-telling their lived experiences, is the expert on the

phenomenon being investigated; and (c) maintain spontaneous creativity to help the participant reflect on the meaning of the phenomenon and events as they are unfolding in the telling. Continuous critical reflection and discussions of emerging concepts of the multiple informants' reality promotes intuiting of the concepts. Categories and processes are identified, which enhances understanding of the phenomenon.

During this step of the study, I encouraged the participants to delve into their own personal experiences with the phenomena of interest. This intuiting process was occurring concurrently while obtaining the data collection in the interview process during the analysis step. I used open-ended, semistructured interview questions, as well as hyperattentiveness to the verbal and nonverbal communication styles of the participants. Various interviewing and communication techniques, such as restating, seeking clarification, focusing, giving broad openings, and giving information, were used to elucidate meanings and delve into the phenomena. Often silence occurred which allowed the participants to compose their thoughts without pressure from me. Silences and gestures were noted and included in the transcripts and journal.

I reinforced throughout the interviews that the participants were the experts pertaining to their own reality and experiences. Participants elaborated on their experiences as male nursing students and caring. At this point, I examined each participant's reality through being open to identify with the self of the participant and to consider this reality as a possible reality for my own self.

Intuiting continued after the completion of the interview. Continual critical reflection and internal contemplation were required in the continuing analysis

process of identifying meanings, essences, and themes. Frequent rereadings of the transcripts and resorting the index cards were ongoing processes.

Describing. The descriptive stage as the researcher develops understanding and can define the phenomenon (Polit & Hungler, 1995). Reporting the reality of the participants' lived experiences promotes development of the model derived from the study. Each participant's story adds to the richness of the model. If the components of the phenomena have been correctly identified, each individual that has experienced this same phenomena should be able to use the identified components to analyze the experience and personal realities.

The final step in this study was describing. The analysis of the phenomena, as well as the internal and external validation of the information, were utilized to derive a model. By grouping the identified 12 essences into 5 major themes the model was then delineated and described. These major themes of the model were the major concepts that described the lived experiences of senior male nursing students with caring. The findings of the study are provided in Chapter 4.

CHAPTER FOUR

Findings of the Study

The phenomenon of interest in this study was investigated through interviews with fifteen participants. The analysis of the demographic information and of the essences and themes are described to delineate the findings.

Demographic Information of the Student Nurse Participants

The participants for this research investigation included fifteen senior male nursing students in baccalaureate nursing programs in West Virginia. Ages of the participants ranged from twenty-one to thirty-seven, with thirteen of the participants in the twenty-one to twenty-five age group. The other two were ages thirty-four and thirty-seven. All were Caucasian. Marital status included eleven that were unmarried, three that were married, and one that was divorced. Thirteen participants had no children, one had two children, and one had four children. Six participants grew up in rural areas and six in suburban areas, while three lived in both locations (rural and suburban) throughout their growing up years.

Prior to entering their present nursing program, ten of the participants had no further educational experiences other than high school. Two of the participants had received another degree prior to entering nursing: one had received a Bachelor of Science degree in Business, while the other one had received an Associate Degree in Electrical Engineering Technology. One of the participants had spent time at three different educational facilities, while another one had previously attended one other university. Another participant had additional educational

courses while in the Army. Three participants had served time in the military, while twelve had not.

Previous or present employment included thirteen participants who have had various jobs in the past, including eleven of them who, at some point in time, have had jobs that were related to the health care field. These jobs included nurses' aides, assistants, or technicians, EMT, pharmaceutical representative, and medics in the service. Only two of thirteen had not been employed in some type of health care field, including one participant that counted his military service as employment, but who did not have any relationship to health care in the service. Four stated they had never been employed, but later in their interviews one talked about experiences as a lifeguard, while another participant that stated he had no previous work experience mentioned he had caretaking experience as a trained youth counselor.

Eight of the participants stated that they had had previous experiences as caregivers. Carl described his caregiving experience as being a trained youth counselor who worked with underprivileged youth ages 8-18. Nick stated that his previous experience as a caregiver was taking care of his children. Interestingly, Jake did not mention taking care of his children, but mentioned taking care of his stepmother's mother. Both Glen and Ray had each helped take care of an ill grandparent until their deaths. Two participants, Dennis and Kris, listed taking care of a sibling as their caregiving experiences. Baby-sitting and taking care of nieces and nephews composed the previous caregiving experience of Adam. It was interesting that Phil mentioned that he watched his nephews as his previous

caregiving experience, while his twin, Bill, stated he had no previous caregiving experiences. Seven participants said they had no previous caregiving experiences.

A Brief Synopsis of the Participants

In order to maintain anonymity yet provide an individual sense of flavor to each of the participants, each participant has been given a fictitious name. A brief synopsis about each one will be provided.

Bill, Participant 1, was single and 22 years old. He had no previous employment and no other college educational experiences, prior to this program. Both he and his twin brother (Participant 2) were raised in a suburb of Pittsburgh. Phil, Participant 2, was single, age 22, and had no health care experience until he entered nursing school. Immediately after high school, both of them entered their present educational facility.

Participant 3, who was raised in a rural area, was 22 years old and single. Adam had no previous or present employment and no educational experiences post-high school except this nursing program.

Carl, Participant 4, was age 22 and single. His early childhood until age 12 was spent in a rural area, then until age 18 he lived in a suburban area. Religion was mentioned as a big influence in his life. He had stated he had not been employed when asked, then later in the interview he stated he was a trained youth counselor for underprivileged children.

Dennis was Participant 5. He was 24 years old and the only participant who was divorced. He grew up in a rural area. After having been in the military for six years, spending time in the Gulf War, and having taken additional special leadership courses, he decided to become a nurse.

Participant 6, was single and 23 years old. Evan had been raised in both rural and suburban areas. This was his only post-high school educational experience. His previous work and health care experience was working as a nursing technician.

Frank, Participant 7, was 23 years old and single. He was presently employed as a nursing assistant during his educational experience.

Glen, single and 24 years old, was Participant 8. He had an Associate Degree in Electrical Engineering Technology. Prior to entering nursing, he worked in a titanium refinery and battery manufacturer. This previous summer he worked in an Emergency Department as a technician.

Ray had been working as a nurses' aide at a geriatric center for the last four years. He was Participant 9, and was 24, single, and entered college immediately after high school. He described the most personal dealings with his own illness, and the illnesses and deaths of family members.

Married and the father of four children, Jake, Participant 10 was 34 years old. He had lived in both rural and suburban areas as he was growing up, which included eighteen states and three foreign countries. In the military he worked as an operating room technician and at other medical related activities. He had no prior college education before entering the present nursing program.

Participant 11, Kris, was recently married. He was 23 year old and was raised in a rural area. He previously worked at various jobs unrelated to nursing, but at the present is employed as nurses' aide in a psychiatric unit. Kris had no previous higher education experiences except the present one.

Lance, as Participant 12 was single, 24 years old, and had attended three other universities before attending the present college. He took a semester off and worked at a rehabilitation center.

At age 37, Participant 13 had received a BS degree in General Business, was certified to teach health and social studies, and earned a National Registry of Emergency Medical Technician permit and certification. Also, Michael had spent one semester in law school, but stated that he didn't care for it. He had applied to medical school, but was not accepted. Presently, he was single and worked as a grounds crew laborer for a cemetery.

Married with two children, Participant 14 was a medic in the service. Nick was 25 years old and was raised in a rural area. At the present, he was in the National Guard.

Paul, Participant 15, was single and 21 years old. Before entering this college, he previously attended a university in another state where he was majoring in pre-physical therapy. Concurrent with his educational experience, he was working on weekends as a patient care assistant in a suburban hospital near his home.

The Primacy of Caring

The primacy of caring was the first theme of the study. Caring was an obvious theme, since it was a major aspect of the study. The primacy of caring contained four essences. These included the characteristics of caring, the origins of caring, the lived experiences of caring as male student nurses, and the caring versus technology dichotomy.

Characteristics of Caring

Caring was seen as a holistic focus on patients and their families. The two main characteristics of caring identified in this study were relationships and communications. Other characteristics were identified as being an advocate for patients, getting things they need, making the patient and family comfortable, being non-judgmental, and having respect for patients and families.

Caring and communication. Communication was seen as a major components of caring. Phil voiced that "communication with the patient is the key." Evan described his view of caring in the following:

> Caring is going into the room, talking to the patient, getting them things they need...time should be spent just talking to patients. I think more can be learned from the patient telling you what's going on and how they feel than from reading an MRI...or what the doctor's written in his notes.

Michael described how he cared about the patients. He also focused more on communication:

> I get along pretty well with most patients. I can remember instances of just sitting there and talking about life in general with some patients and talking to them about their interests and their experiences of being sick and some of their fears.

Communication was also the aspect of caring that Paul perceived as crucial. He explained his definition of caring as,

> I care because I always take time to talk to the patient...I just at least can take a few minutes and talk to them and just kind of get to know them, and let them know that maybe they can trust me, and on a friendly level...I'm pretty easy to get along with and I think my

> personality maybe helps me give off, to let them know that I care, the way I talk to them.

Caring and relationships. Characteristics of a caring relationship were also identified. Bill stated that caring included basic relationships with patients. Caring, according to Dennis was, "I see caring in nursing like doing little nicer things for people...just going out of your way to do things for them...just the little things...It's probably something you do in order to make someone else comfortable." A description of caring provided by Adam included, "Having a genuine concern about another person, and wanting to intervene in some way to help them." Jake elucidated on his perception of caring:

> I do believe that yes, just being with somebody, touching somebody and being there for them is potentially more important than, I'm not going to say that it's more important than checking their medications to make sure they're OK, but you have to take into it the psychosocial aspects of people. When you stop doing that then I think you stop caring.

Interestingly, five participants mentioned the concept of treating others as one would like to be treated. Dennis focused on the treatment of others. He remarked that, "I always try to put myself in the other person's shoes...I treat them just like my family." According to Michael, "I try to empathize with patients. Some of their experiences are similar to ones I had." Referring to a cancer patient he had cared for, Evan stated, "I wanted to treat him similar to how I treat a member of my family. I wanted to make his last days comfortable." Frank further elaborated on the relational aspects of caring. He focused more on feelings and emotions.

> Caring is having feelings for someone. Form like an empathy for someone, you know, being in their shoes, how would you want to be treated, treat others the way you would want to be. Helping them get to a point where they were, where they're not at now, but where they were at one point. Trying to get them on their feet. Showing respect for somebody. Doing for others. Showing true concern for people.

Aspects of caring were reiterated by Kris who described necessary requisites of a caring relationship. He stated:.

> As far as caring goes, I always give the people respect that they deserve and at times you don't get it back with some people but you have to deal with that too, and realize they may be going through things or whatever. You have to be non-judgmental...and you just need to relate to individuals in an manner that you'd like to be, you know, receive yourself...I would like to be the kind of nurse who can walk in, sit down in the chair, and talk to the patient for 25 minutes.

Patient advocacy, one of the roles of a nurse, was seen as a means of providing caring. This provided a reciprocal commitment in the caring relationship. Carl discussed this:

> Patient advocacy. You've got to care enough, each one of these patients are individual people. You can't clunk them all together as "patients." And you've got to play different patient advocate or a different patient role for each individual. And what I learned from that is, if you're playing patient advocate, they're in turn gonna play an advocate for you.

Many of the participants also mentioned that relationships with families were necessary parts of caring. As Phil asserts:

> It's not just with the patient, it's with the whole family. You try to make the family more comfortable, like teaching them what's wrong with the patient and helping the patient through their illness...Like making contacts with them, with other health care facilities, and making sure they get their medicines and prescriptions filled.

Origins of Caring

This essence was composed of three parts. Role models in their families were seen as the greatest influence in the participants' development of caring. Caring was also seen as an innate characteristic. The effects of caring as taught in the curriculum were viewed more as supplemental to their basic caring, rather than being the origin of their caring.

Role models and caring. Most of the respondents cited that they learned about caring in their family. Parents, especially mothers, were given credit as role models for caring. The following examples were given to cite the family as one of the most important origins of caring. Phil's perception of his origin of caring was:

> Probably my mother. She's the one who took care of me growing up. And my dad would work most of the time, but he was always there, too. I'm the youngest, me and my brother (Participant 1) are the youngest in the family so, we have older brothers and sisters who always looked after us, too.

Jake's family, especially his mother, was seen as the origin of Jake's caring. As he stated:

> I would have to say it started when I was a child. You know, through my parents and through my family, and our interactions together, and being very close to one another, and grandma, grandpa, just togetherness....I think it was probably more so from my mother....I had three brothers and a sister, so it was like she was doing that with all of us, and she never made any of us feel like

> we were any more special than the other ones....she's unique in that way. But, I think that's probably where it came from. The caring came from her.

This statement came from Paul concerning his origin of caring. He also credited his family as his origin of caring.

> When I grew up, everybody got along well. I had a mom and a dad, and they were always there, no divorces or anything. And I just, I guess my parents taught me how to care, care about people, and care about other people, and treat other people.

Caring as an Innate Characteristic. One third of the participants also believed that caring was innate or inborn. Caring was seen as a characteristic that was needed to be a good nurse. An individual could develop this inborn trait, but caring was not seen as something that could just be taught. Kris described his perception about caring as, "I don't think caring is something that you can really learn. I think it's just there, you just have to develop it. And that's what I've seen out of me through the program anyway."

Besides believing that his family was his origin of learning about caring, Paul also believed caring was innate. He stated:

> I think it's something that's innate. It's something that you already have, that you care about. If you are a caring person, you're going to be a caring nurse...they taught us all about this stuff, but in my opinion, it didn't do anything to change the way I feel or change me.

Interestingly, only one participant mentioned religion as an origin of caring. Carl's response was:

> How did I learn about caring? I've always been the type of person, that I'm just a very feely, touchy person, and I've always been that way, you know, as long as I can remember, putting my arms around someone, or have someone put their arms around me, or just to touch somebody's hand. I mean, I think the way I look at them, the hands were created to heal...And before modern science, I mean, ever since we were created, people were healing each other with spiritualism and people believed in healing powers...I think my religious upbringing has a lot to do with healing.

Caring in the curriculum. All the nursing programs in this study included caring theory in the curriculum. Most of the participants believed they did not learn basic caring in their curriculum, but that the theory supplemented or "added to" the caring learned in their families. Frank talked about curriculum theory reinforcing basic caring.

> In nursing school, it reinforced just to take the fine details of caring and how important it is other than all the others, taking care of the disease, people, you know, making sure that you care for them as a person.

In his view, Glen also acknowledged that caring theory and nurse theorists were included in the curriculum. He reiterated: "...It was covered theory wise. Yeah. That's like the first thing....We kind of touch on everybody and what their concepts are caring and nursing, and then we were asked to develop our own concept of nursing."

Caring is the conceptual basis for one nursing program. Jake was originally skeptical, but became aware that this caring theory remained consistent throughout the curriculum. His view of caring theory was:

> Well right off the bat, our nursing program hit us with their conceptual basis, which is caring...That is the conceptual, philosophical basis of ... (school of nursing) program is caring. So we went through a lot of learning about the basis of the interrelationship between the patient, the nurse, the family system, the environment; more taken in a holistic viewpoint of nursing in relationship with the caring process....At first, I thought, it's just a bunch of malarkey but I found it's like that throughout. They still have incorporated guidelines for us....So, it's been an ongoing process. So they've been really consistent and sticking to that.

Another participant from the same nursing program concurred that caring was an integral aspect of their curriculum. Ray stated:

> How did I learn about caring? Besides just from parents and the type of people that they were, but also through the curriculum here through Swanson's Five Caring steps, that the knowing, being with, and doing for, maintaining belief and going the distance, things like that...And it's been really a strong part of the curriculum here.

When asked about where he had learned about caring, Michael reiterated that if an individual had a basic caring personality, these caring behaviors can be further developed with theoretical knowledge. He explained:

> How did I learn about caring?...In the classroom they do a lot of theoretical concepts of what constitutes a therapeutic relationship and what the nurse's, her responsibility as far as caring for the patient is supposed to be....I think it's just something that somebody has to have to some degree and nursing like promoted me. The techniques that you learn might help you, but if you're not a caring person to begin with I don't think you're gonna have a whole lot of success, you're not going to enjoy nursing.

In the perception of Lance, caring was based more on the experiential learning in the clinical setting, rather than on the theoretical classroom knowledge. His comments included:

> Not through books...basically getting in the clinical setting, dealing with the families, dealing with the other nurses and how they got around problems, helping the client feel less anxious and stuff...just little techniques from each of the nurses I worked with and the professors taught me....it was mostly in the clinical setting, not really out of any text or anything like that. I mean you can only read so much and take from the book, but once you get out there, you really learn the little tricks of the trade and really actually caring about the patient.

Lived Experiences of Caring as Student Nurses

Experiences of caring were exemplified by the participants. The examples were experiences that facilitated a sense of satisfaction and accomplishment for the caring they provided. Caring was exhibited in the nurse-patient relationship and through the use of therapeutic communication. The participants provided "being with", presence, support, and comfort through their interactions, advocacy, problem solving, and incorporating spirituality. Not all participants were able to think of specific examples where they had provided caring. Adam described his most memorable experience:

> A little boy who was about 13, and he tried to kill himself. He shot himself with a 30/30 deer rifle. He stuck it up under his chin, and he took the entire front part of his face off....He wouldn't say anything to anyone, and the parents and everyone thought the reason he tried to kill himself was he got into a fight with his girlfriend. And so did she, because right after the fight is when he went and did it...I had him for three days, and I just kind of sat in there and talked with him and I noticed he always had Sportscenter on...so I'd sit there and just always kind of bring up things here and

there. That's kind of how I got to him. I started off with that. And then he's come out and he told me the reason that he did what he did was because his parents were in a custody battle. In this state, at age 13 or something like that, you have the right to choose which parent you want to stay with. So they were gonna make him choose and he didn't want to make that choice. And the fight with his girlfriend was just the thing that set him off...But I was the first one he told that. After that I went and I talked to his parents and they came to a decision that they would have joint custody if that's what he wanted. So, that's something that really sticks in my mind.

The most memorable caring experience for Carl involved interactions with a child that was not his assigned patient. He recognized the importance of being a role model and father-like figure for an ill child.

> He was 2 1/2 years old and wasn't my patient but I just went into the room, I had some free time...I came to find out a little about this boy. He had a tumor, had just developed on the back part of his head, and they couldn't cut it out. The parents, the mother, visited every two weeks. The father was in denial that his son was dying. So, his father never came. So the child had no male interaction. And I really hadn't thought to this point about a two-year old with another guy...And literally, the kid's eyes just like lit up. The kid, at one point, he could walk, he could talk. He could no longer do any of this. He was totally bedridden. The other nursing student in the room goes, "I don't believe this." Cause the kid just like popped up. Cause he, there had been no other guys in the room. I took a ball and just rolled it to him and he actually went and pushed the ball back to me...I would go in and spend an hour with him.

One of the most rewarding caring experiences provided by Frank was based on presence and support provided to an obstetric patient. Her gratitude and appreciation also enhanced his satisfaction. He reiterated:

> When I had my maternity experience, my assignment was this one girl...she was in for preeclampsia and she was really having a hard time that morning. The doctors were trying to sedate her. They

were trying to put in a spinal on her and she was just having a real hard time. And it seemed like he was so concerned about getting that in, he wasn't considering the patient at all. So I was in there and I was holding her hand and just telling her that "everything will be all right"...I came back the next week and she was out on the floor because she had delivered her baby. And she actually called for me over the intercom to come and see her. Now, I don't know how she knew I was on the floor...So, I heard my name and we went back there and we talked for a while. And she just wanted to tell me how she really appreciated all the work I did for her and that I made it alot easier for her to deal with the pain she was having that day. So that was probably one of my most rewarding instances as a student because of the caring that I showed for her.

The experience which had an impact on Ray was when he provided comfort and presence to a grieving family. He discussed this situation:

> In the emergency room when I was on my clinical rotation, a family member was brought in and basically he passed away even though we tried to resuscitate him. But I observed and also was there for the family, let them ventilate, and just talk, and just being with and comforting to the family.

Jake described an experience related to caring and communication with a patient who kept saying that everything was fine, but who was eventually diagnosed with cancer. He felt he had provided caring for this man.

> So just letting him talk, and implementing some of that therapeutic communication...after a time he told me that his wife had died about a year ago of breast cancer and that he had lost two brothers from cancer....I finally felt good about myself because it was like I actually did something Here he was able to talk about, where as before it was like, he was just always, "No, I don't have a problem." So to me, just being able to spend time with him, being able to sit down with him for a half hour and talk to him and listen to him, and to not be judgmental and not offer him any false hope or anything like that, just really listen and be with him was valuable

The ability to apply theoretical knowledge in a clinical situation was one of the ways Kris provided caring for this patient. Problem solving was used to determine an appropriate method of communication. He described his memorable caring experience in the following statement.

> In the emergency room we had a lady who had a seizure...she bit her tongue severely, lacerated it very bad. She could hardly talk. And I, being a student, had the opportunity and time to sit in that room with her and try to figure out a means of communicating. So we did the blink your eyes once for this and two for no and raise your hand, thing like that, if you wanted this or that. She was very shaky, had IV's, wasn't able to write for me and it really hurt her to talk, so I found a way for us to communicate.

Being with and comforting a grieving husband was a memorable caring experience for Lance. He also incorporated prayer and the spirituality needs into his caring. He described this situation:

> She had a reaction to the chemo and she went down hill real fast. Later she was a hundred times worse, and I basically stayed with the family to the end. It was a learning experience to see that somebody could come in with a pretty good diagnosis and fall so fast...I think the husband would have had a lot harder time if I wasn't there, because I sat and talked to him a lot and I taught him a lot of what she was going through and keep the hope, and praying, and stuff like that. We did a lot of that together. Great guy, and I think it really helped him through alot with her and himself and to accept it in the end. And I think he went home feeling a little better about it than he would've if someone wouldn't have taken time to do that.

Nick had the opportunity to follow the course of the illness and death of a particular patient over a three year time period. As his most memorable caring

experience, he thought that he had been able to make a difference to this patient through the caring he had provided over time. His description was:

> I think the best example of all the patients that I had, he was one of my first patients my sophomore year. Then I had him in my junior year. Then I had him again at the beginning of my senior year and then he passed away. He was really, in his last few weeks, he was really in a lot of pain and stuff. And so I stayed in his room just about the whole time during clinicals and pretty much just catered to him. He was constantly eating ice chips and stuff. And I think that he really appreciated it a lot. And I know it made me feel better when he passed away to know that I helped him.

Caring and Technology

Caring and technology were both necessary components of nursing, according to all the participants. In the care versus cure dichotomy, technology is seen as more relevant to cure. The care/technology dichotomy was explored through examining the differences which occurred in individual perceptions of whether caring and technology were equal and intertwined or if they were separate entities, as well as in each individual's preference for caring versus technology.

Caring focused. Those who believed that they were more focused on caring valued caring in their own practice, but often saw caring as less valued than technology. They expressed their dissatisfaction concerning the discrepancies of caring as it should be and as it really was exhibited and practiced.

In the following comment, Adam gave his opinion of caring as the basis of nursing. He ascertained:

> Caring, I kind of see as a fundamental thing in nursing, and I really think you can know all the technical stuff in the world, but if you don't care about what you're doing and the people you're doing it for, you're in the wrong place.

Ray expressed his perceptions about caring. His experiences as a patient who had heart surgery, having helped take care of his chronically ill grandmother until her death, dealing with the death of his sister when she was in nursing school, and concerning his mother's recovery from a serious car accident had an impact on his meaning of caring.

> I couldn't feel comfortable with myself if I wasn't providing the best care that I know that I could be giving...but that's just what I feel...I couldn't just go to my job, put in my eight hours without feeling something or if I lost the caring and that...I don't think you could go on...you don't enjoy what you're doing, it shows, and it's very obvious.

According to Kris, caring and technology were both relevant to nursing, but he was more of a caregiver than technological focused nurse. He stated:

> They're still two entirely different things. I hope that technology and caring don't ever become synonymous. Caring is completely different...taking care of a person's emotional needs, all the technology in the world isn't gonna help that. If I need to put a 16 gauge catheter in someones's arm so they can receive blood, that's different than what I need to tell them and their family about why they're receiving this blood, and what's going on with them. And a machine can't hold someone's hand...A machine can't say "OK, I'm gonna listen to you." It can beep and cause them to worry about what's going on. It can make family members go berserk when the machine's bonging and the heart rate thing's going clean off the screen because the patient's moving or whatever. Those things need to be explained. I guess technology's more of a barrier to actual caring than it is an aid, in my view....Well, there's a definite need for both. I definitely feel from the program I've went through, and from my personal experiences and what I know about myself and how I was raised, and what I know about other people and what they may or may not, may not like, or just from my own personal experience, I guess I would definitely be someone who is a caregiver more than a technological person. I mean there are definite skills that you

> must have and be able to do, but there's also a way to go about doing that by explaining things to the patient and making them comfortable.

Nick voiced concern that technology ofter overshadows caring. Nick's perception of the differences between caring and technology are that:

> It seems like the more technical, the less caring you see. I don't know if that's just my perception...it's like whenever you're with monitors, a lot of people just look at the monitor and don't pay any attention to the patient...And it seems like if you're concentrating on the technical part, it kind of pushes caring to the side.

One participant was especially adamant concerning his feelings about the primacy of caring in nursing, but that nursing unfortunately seemed more focused on technology. Jake elucidates his frustrations:

> Unfortunately from at least this point...I see nurses now as being more technical. Unfortunately, maybe that's only because it just recently happenened, as being overworked on the floors, and not having the time to take care of their patients, their assignments; not being able to take care of interventions, such as giving them a back rub, touching, more hands-on....I see them going on different avenues....You know, nursing's just getting too technical....It's like if you weren't so caring, and if you didn't let yourself, if you could like stop yourself from letting things bother you, then perhaps maybe you'd be better off...later on, I think I came to the realization that that's not necessarily so. It's like when I stop caring, then that's when I quit being a nurse. That's like when I need to find a new job....I always want to be like hands-on with the patients, and right there, and at the bedside taking care of them.

Technology focused. Even the participants who were more technologically focused in their own personal practice acknowledge that caring is a vital

component of nursing. Caring was seen as a necessary requisite of providing technological care. As Glen remarks:

> I'm very technology oriented. I like technical things...But I think it's the job of the nurse to make technology comfortable for the patient....I think technology is a good thing in most cases and I try to make it a positive thing for the patient. And I think that's where the caring comes in, why you're making it a positive, you're showing the patient that it's a positive thing for them.

Caring and technology were deemed as compatible to coexist by Michael. He believed that technology was a necessary requisite in today's world.

> I think they have to, they have to fit together. I think technology's great...There's medical advances available. I think that the patient deserves to have them and that without them medicine would be handicapped. I think sometimes it's intimidating for patients and I think they feel like cogs in a big machine sometimes...I think it leaves them a little overwhelmed...I think technology and caring can coexist.

Paul acknowledged his perceptions of the care versus technology aspects of nursing. His comments are that:

> It's probably the more technology, the less caring... It seems like the more computers we have to deal with...the less time you have to spend with the patients...I can do it all...I think I have good interpersonal skills, communication with the patients, but yet I'm computer literate, and I know how to work all the equipment and it's probably easier to work the equipment than to talk to a patient.

Perceived Gender Difference Relating to Caring

This second theme contained two essences. The first essence was the difference in the caring provided by male and female nursing students as perceived

by the participants. Some of the participants acknowledged that the caring they provided was the same as the caring provided by female students. Initially, others were ambivalent or noncomittal about the differences in caring provided based on gender; however, they then proceeded to give examples in which they perceived their caring was better than the caring that was provided by the female students. Only a few mentioned any positive perceptions of caring provided by the female students

Differences in caring received from the faculty based on gender was the second essence. All the participants identified that they had received equal or special treatment from their faculties based on their gender. The general perception was that there were more caring than noncaring faculty. Most noncaring behaviors and experiences were usually with only one member of the faculty. Both caring and noncaring behaviors by faculty members were experienced by the participants.

Differences in Caring Provided by Male and Females Students

Caring provided was the same. Over half the participants expressed that there were no differences in the caring they provided than the caring provided by female nursing students. Ray posited that:

> I don't feel that it's any different. I think that to say that would be totally unfair either way to having it said that males give better care or females....Overall, my own feelings, I don't feel that I give any different care than the females, cause it's totally on an individual basis, I feel.

Jake concurred that caring is individual based, and is not based on gender. He commented:

> I think it's really an individual thing. I don't think that a female nurse just because of her gender is able to give better care than I would be able to, and I don't think that because me being male, that I would be able to give better than she would. I really think it's totally individualistic. I think it depends entirely upon the person.

Further agreement was provided by Kris. He did not elaborate on his perception when he replied: "I really cannot, I couldn't say there is a difference between the care I give and the care that a female student might give. I just don't know how it would be different."

Perceived caring attributes of male students. Some of the participants were noncommittal and did not specifically verbalize whether they believed there were differences, similarities, or sameness in providing care. However, they proceeded to give examples of how the caring they provided was different, and often better, than the care provided by their female student peers. One area where differences in caring were perceived was in communication styles. Perceptions of the caring provided by Dennis were as follows:

> Actually, not to brag or anything, but I think my caring is better....I just think males, certain males can look at the whole picture... I think even though we're considered to not open up as much, I think there are some of us that are really compassionate. So, I think my caring is better than I would say the majority...of female nurses....I think I'm more empathetic than they were. I think I'm a little bit softer like giving bed baths and stuff, not nearly as rough...I'm always talking, where as a lot of them have, I think they feel like they have a communication problem..

In his comments, Glen described the differences he perceived in the caring provided by male and female students. When asked if there were differences, he stated:

> I think so. I really do...Girls are mushy when it comes to that stuff, and I don't think I am....Maybe not all female nurses....sometimes I see a lot of females "oh, honey," you know, "oh sweety," and I don't do those things. That's just not me. I talk to a patient like I'm talking to you....I had a couple of people comment to me, and say, "Glen, why don't you go to be a doctor?....Well, you're just so good with the patients...you're so professional and you come across as being professional but you can tell that you are there for them. And you really have a good bedside manner, and we think you'd make a great doctor." And I said, "Well, I guess then I'll make a great nurse, too. What do you think?"

Paul also alluded to communication differences between male and female students. He remarked:

> I don't know how to say this, but it seems like the females are more, it's like they don't, they're not themselves...they'll go in and they'll start talking real, like raising their voice a little bit, like "Hi, how are you doing?"...that's not how they are in real life...I just go in like I am and I treat, I talk to the patients like they're an equal or whatever...it seems like sometimes all the girls will go and they'll talk to them almost like they're a little kid or something, like older people....I don't really change the way I am, or try to act different because I'm with another patient. I just kind of be myself, and I'm not saying all women do that, but a lot of the girls in my class are like that. It seems they're always raising that voice up and acting a little bit differently.

Ambivalence about the differences in the caring provided by female students as opposed that provided by males students was exhibited in the comments made by Evan. He responded that:

> I've had several patients tell me that they'd rather have me as a nurse than a female nurse....For the most part I don't see any real difference. I have at times, and I've been told at times by not only the patients, but the patient's families, nursing staff...I believe there's some degree of differences at times. You know, I'm not saying that female students aren't any better than me, but I just feel at times I do stuff differently

Lance also showed ambivalence in his perception. First he stated the caring provided by male and female students is similar, then he gave an example of the differences that he perceived.

> I think it's pretty similar. As a male, I think I can connect with people in a different way, but I mean they perceive in a different way, but I think I come across the same. The male patients will treat me a little different...like guys joking around and stuff like that, and we get along really well.

Perceived caring attributes of female students. Only three participants mentioned any positive attributes about any female students. Emotional aspects of caring were seen as different. Phil said, "Females, I guess, show more compassion. I tend to sometimes hold my feelings in." Concerning the clinical area of OB/GYN Glen deemed that, "Sometimes, women are better equipped to handle certain situations...it was a very female thing and that's not something I can understand...I really feel uncomfortable. So maybe in that area, I think a woman is better equipped to handle that." Michael's perception about the differences were, "Personally, I think nurses, females, female nurses in, at least in my class seem to be a little better at being empathetic and getting across with a caring attitude than I

do, or maybe some of the other male students do...They try to be more professional."

Perception of Faculty Caring Related to Gender

Although all the participants perceived the caring they received from faculty members was equal to or superior to the treatment of the female students, many were also quick to give examples of uncaring behaviors by the faculty. However, all concurred that there were more caring than noncaring faculty.

Equal versus special treatment received. Faculty caring was described positively. All participants identified that they had received caring treatment from the faculty in a manner that was either equal to the treatment the female students received or that they received special treatment as male students. Bill thought that the caring he received from the faculty was the same as that received by the female students. His commented, "I'd say mostly the same. I never had an incident where I was favored, or looked down upon, or anything else." Nick also suggested he received the same or better treatment from the faculty due to his gender. He commented, "I think about the same....Sometimes you think maybe the teacher's being nicer to you because you're a male or I've never had any that I thought treated me bad because I was."

Receiving special treatment from the faculty was described by Glen. He suggested that this was due to being the only male student in his class, as well as that this was deserved special treatment due to his openness and willingness to help others. He states:

> I know that a lot of time I ended up being the center of attention of our class, both good and bad, just because I'm the only male student

> nurse...Yeah, sometimes I do think I get special treatment ....sometimes I think I deserve it too, because to be honest with you, I'm the person that a lot of people come to. "How do I do this? I don't know how to do this."....or "How do I answer this question?" or "Can you explain this to me?" Heck, I was explaining to instructors how to do math problems because I have an engineering degree, I had a lot of math. And, a lot of girls have come and cried on my shoulder.

When asked his perception of the caring he received from the faculty, Paul also acknowledged that he believed that he got special treatment which is based at least partly on his gender. His response was:

> Well, honestly, I think they might, they don't treat me badly at all...it might be the opposite. You know, they might give me a little bit more special attention because I am a man, because I'm a minority, I guess. I don't know, maybe it's just my personality. I get along with all the faculty pretty much, and I talk to them, and I don't know if it's that or that I'm a male, or if it's just the way I am....I think at least one of my teachers, she's always asking me to do stuff and calling on me first and I'm not sure that's because I'm, I think it's partly because I'm a male, but not totally....I've never had any unfair judgments against me because I was a male.

Experiences with caring behaviors from the faculty. While all the participants responded positively to the caring received from faculty, over half also listed negative aspects of faculty caring. Even those that made both positive and negative comments acknowledged that faculty interactions were more caring than noncaring. Some examples of caring received by the students are listed below. Caring behaviors were described by Bill. His example of caring from faculty was:

> I have a private tutor to pass the boards--and the professor that helps me out right now, she showed me pretty much she cared. She showed her willingness to help and she wants, she's trying to get me to do my best....I guess basically one on one teaching.

Another example of caring behaviors by faculty was given by Adam. The caring by this faculty increased his respect for the faculty member. As he replied:

> Yeah, I had one instructor who she really cared what was going to happen to me professionally because she was always on my case. But it wasn't in a bad way, you know. I mean she was always pushing me....I've talked with her since and she just said that she felt that I was gonna be a good nurse. And she was gonna do everything she could to help me get there...so I really have a lot of respect for that faculty member.

Problems in the personal lives of the students were identified as areas in which faculty demonstrated caring behaviors. Dennis discussed the caring he had received from the faculty in the following comments.

> I was going through a separation/divorce type thing and I went in and talked to some of my faculty, two of my faculty members. They offered me emotional support. They recommended me to counselors. They were very supportive, called me at home and let me, gave me extensions on some class projects and things like that.

Another participant also believed that he had received caring from faculty during times of problems. Nick explained what this caring entailed:

> When I went to Guard this semester, they were really, a couple of them in particular was really willing to help, and offered to let me do a home, a self study course on it....The same instructor, one other time, my kids were sick and she told me just not to worry about coming to class and she even called me that evening to ask how the kids were doing, if I needed anything.

Extra effort by a faculty member to provide a missed clinical experience was the example of caring mentioned by Frank. He discussed this incident.

> I totally lost out on that experience on my OB rotation. Well,during my med/surg experience she called me and I was able to go see a C-section. You know, she was able to arrange for that, but she had to schedule me in and find out beforehand if everything was OK.

Caring was provided for Ray through faculty availability and willingness to help. He described his happiness and pleasure concerning the caring he received.

> Well, I've had many, I mean from my own faculty, because there was a time when I didn't pass a class, so I had to go back and take it over, and even not just saying that I have problems with classes, but anytime you were there, you had a problem, the door was always open, so they welcomed you, and they were more than willing to go, if you went to them to help you....they really weren't giving the answers to any tests but they were clarifying things, always being a resource person there to help you out....they've always been there and they've been real comforting....I've been happy and pleased with the way I've been cared for.

One instructor's unexpected caring behavior was special to Jake. This caring remained memorable to him, as he reiterated in the following comments.

> She called me into her office, and I went in there, I didn't know what to expect....she said "you know, I've just like noticed things about you...you're kind of different from the rest of your classmates"....she just shared things that she went through...and things that happened to her when she was going through nursing school. And she just like kind of reassured me that it is OK to be different and that was a really good thing...she said "you care, you care about people." And she said "it was like something we aren't seeing a lot of, not that we don't see it, but we don't see much of it especially in our male students." You know, so it was like to me was like special. I felt kind of overwhelmed....And I always will remember it. She even gave me an article that she had written and told me I should read it.

Experiences with noncaring behavior of the faculty. Noncaring behaviors were usually limited to one or a few faculty members. Most of the examples of noncaring behaviors were given by the same participants who described the above caring experiences. Previously, Adam had described caring from faculty. In this comment he explained negative caring behaviors:

> I think from the faculty, it's a little different, because I think that, and not in a bad way, I think the faculty thinks because you're a male that they have to explain a little more about how to care for someone with the emotional part of it. And it's like in post conferences they would ask me more questions about "How did you feel about this situation? How did you feel about this situation?...I was never taken aback from it but I always noticed that they had a view that because I was a male I didn't or I couldn't care quite like they could.

Ambivalence about caring behavior and noncaring behaviors by faculty was verbalized by Dennis. On one hand, he thought he was more respected and considered more independent than the female students. On the other hand, he believed that the female students received more help from the faculty but that the male students had to seek the instructor for help.

> I think I'm more respected. I don't know if it's just the male/female thing, but I just feel like I'm more respected. You know, in clinical sometimes they view me as more independent and the fact that I don't get as much help from the faculty is what, like I said, some of the female nurses do. But, I guess they consider me more independent...they work with female students more than they work with, I feel than they work with male students....I feel it's a negative aspect....it seems like I have to go get them, where the faculty just go gets, where they just go right to the female student nurses, but they don't come to the male student nurses, we just sort of have to go get them.

Another participant thought faculty caring and noncaring behaviors extended from one end of the spectrum to the other, although Carl conceded that more caring than noncaring faculty existed. He described his perception as:

> It's gone from one end of the perspective to the other...I can recall one nursing instructor that did not like us. I mean she treated all guys like shit. But, I know there were nursing instructors that loved guys, and we got anything we wanted. And I probably say the other ones were just sort of in the middle. So, I mean, it's probably equivalent....more caring than noncaring. I mean other than that one instructor, all my instructors have been very willing to teach and very willing to accept.

In an initial interview prior to entering nursing school, Lance experienced a very noncaring comment. However, he decided that he was not going to be deterred from entering nursing by this faculty member. He believed his efforts to work in an appropriate style and his personality eventually improved their relationship and the treatment he received from this instructor

> I went in for the interview and I said "Are there instructors in this program who are biased against men in nursing? And she looked at me and said, "Yes, there are instructors in this program who are biased against men in nursing and I am one of them." I'm not the kind of person who's gonna sit there and argue...We didn't have no further discussion at that point in time. I did decide to go into the program, and my first class and my very first clinical was with that instructor...during her class I felt like I was on my tiptoes...I just made sure I conducted myself in a professional manner and showed her that I was there to give care, not goof around or whatever....I never did have a problem with her. Actually, we ended up getting along very well...I never felt treated unfairly at all. And with any of the other instructors I've never had a problem as far as, you know, because I'm a man.

Caring behaviors were previously identified by Nick, who described noncaring behaviors exhibited by faculty. His experiences included:

> There's only been like one incident where one didn't seem like she really cared a whole lot, kind of blew me off, she just acted like she didn't like me too well...But the others were really caring and helpful....One instructor whenever we were in clinicals with her, like you would never see her. And if you would go ask for help, sometimes she would tell you she'd be with you later and then you'd never see her...She wrote something like, "Didn't, doesn't assume responsibility for her own actions." I asked her to set up a meeting to talk about it to see what, why she had done that. She would never answer my calls or answer my letter or anything....And I just felt like she didn't, her attitude was that she just didn't care....In class there have been comments sometimes that kind of make you think, "That wasn't very nice or professional."....I can't remember which professor it was, but they made a comment about nursing being like seventy or eighty percent or whatever, ninety-seven percent female. Then she said something about, "We should try to keep it that way."

Jake had a lengthy comment about noncaring and discrimination by one specific nursing instructor. His comments included derogatory remarks made about males in general and males in nursing and a discrepancy in clinical grades in the obstetrical rotation between the male and female student.

> I was in clinical one day and it was my OB rotation...I was sitting there and she had always given me a hard time and she'd given the other male nurses a hard time...she was constantly giving me a hard time...just every thing I did, nothing was right....She put on the board one day, we were all sitting around in report and just after the other nurses and staff had left she wrote up on the board DAD and underlined it. And she says, "Do you know what that stands for?" And I said, "No." And she said, "That stands for Dead Animal Detail...that is the only thing men are good for is burying dead animals." And I was like, "Excuse me?" And she was like,

> "Don't think I'm joking with you. I'm serious." And I was like, "Right, ha, ha. That was funny." And she was like, "No, I'm serious. As far as I'm concerned that's all men are worth, it's all they're good for." And I was like, "OK, I'm like out of here." Well then, I had gotten my clinical packet back at the end of the day, and it was like all my grades on there were really bad and I mean I hadn't done bad work...I'm going to start comparing some of them to the other guys. And their grades were like really bad. And I went to the women--all their grades were like really high. And I was like, something's going on, this isn't right. So I went to the library and photocopied it, and I went to the Chairperson and talked with the chairperson about it. Well, I turned in my logs and everything the following week, I got my grades back. She had redid all my grades and put them all back in there, because I told her, "You know I didn't like your comment and went, because I'm following my chain of command because you've really been discriminating against me. I'm not going to put up with it. And don't think I'm not vocal enough to say something." And so I pursued it. ** (President of that college) became involved...I had the copy because since the report, she denied that she had changed the grades.

At a previous nursing program at another college, Michael had many noncaring experiences, one of which culminated in a very bitter grade appeal. He stated that he had transferred to another college nursing program because he feared he would receive further discrimination. In his present program, he reiterated that he had not received any noncaring behaviors from the faculty. .

Perceptions Concerning Nursing Education and Nursing

The third theme was the participants' perceptions concerning their nursing education and nursing. Since the process of nursing education had an impact on the participants perceptions concerning nurses and nursing, it seemed that these two groups of perceptions were appropriate to be the essences that comprised this theme.

Perceptions of Nursing Education was the first essence. Reasons for entering nursing, perceptions prior to entering nursing education, perceptions of clinical experiences, and perceptions of the educational process comprised the components of this essence. This encompassed their educational process prior to and continued through their evaluation of their entire nursing program.

Changes occurred in the perceptions of nurses and nursing as the participants advanced in their educational process. Some of the participants also recounted perceptions about experiences with nurses.

Perception of Nursing Education

Reasons for entering nursing. There were multiple reasons for choosing nursing as a profession. All the participants listed more than one reason for their choices. The chief reason was related to the opportunities available in nursing, which was seen as a good career, an open field, and contained multiple areas that were available for specialization. Paul verbalized his awareness of the opportunities and that being a male would have advantages in nursing:

> I wasn't sure what I wanted to do and I heard nursing was a good field to get into. They said "You being a male, it'll be pretty easy for you to get a job and you'll be able to go do so many different things and move up" and all that stuff...sounds like a good profession to me.

Beside the availability of opportunities in nursing, the results of placement tests had an impact on Paul's decision to enter nursing. In his account, he stated:

> My decision to become a nurse was based on I took a placement test. Originally, I came to college to wrestle. I didn't have any plans of being a nurse or didn't know what I wanted to do. So, I took a test, an inventory test on things I was interested in: medical field

> came up and teaching, coaching came up. Then I took another test on placement, and I had a poor chance of getting a job as a teacher, I had a very high chance of getting a job in the medical field. So I chose nursing based on that and the fact that I was enrolled in biology courses and my grades were excellent, and I was still able to do whatever I wanted. I was wrestling, going out every weekend, and I could still get good grades in that field.

According to Phil, opportunities were also a main reason for entering nursing. His explanation was: "I grew up in Pittsburgh, so there's a lot of hospitals, a lot of job opportunities." Bill also concurred with the opinion that nursing would be a good choice for a career. As he stated: "It'd be a good career, because there's, I thought there was a lot of opportunities."

Another major reason many chose nursing was wanting to help people by being in the health care profession. Jake exemplified the desire to help people in the following statement:

> When I was in the service, I loved taking care of the patients that I had. I loved working in the health care environment...I finally decided that I didn't care what it was gonna cost me, I was going back into it, cause that was what I loved.

Dennis had mentioned that his mother had influenced him to become a nurse In addition to this, he decided to pursue a nursing career because:

> When I was in the military in the Persian Gulf, I seen the nurses doing much of the work over there. And the physicians and the other health care workers weren't doing near as much. I thought that was something I wanted to do. I wanted to be involved, so that's when I decided to become a nurse.

Five of the participants mentioned personal experiences with illness and death as influences for becoming nurses. Their experiences had a powerful impact

on their decisions. Ray had several poignant experiences that had a great impact on his decision to become a nurse: (a) he had helped take care of an ill grandmother until her death, (b) his sister died one month before graduating from another nursing school, (c) his mother had been seriously wounded in a car wreck and (d) in his senior year in high school he was diagnosed with a heart condition that necessitated major heart surgery. He further states that his heart surgery had a definite impact because he received tremendous care at that time. Lance also was influenced to become a nurse by living through the experience of his grandfather and his mother having had cancer, while Phil was impressed with his father's successful heart surgery. Interestingly, his twin brother, Bill, did not mention this as an influence on his decision. With Glen, his indecision about a desired career change was resolved as he experienced his grandfather's death from cancer. The last personal experience was the reaction of Evan to the following tragic experience:.

> When I went to college my first year, I didn't know what I was going to do...I was undecided. I was up there to play football, and my roommate at that time was killed in a car wreck. And I believe that had a lot to do with why I decided to go down that path, because when he was lifeflighted to Charleston, I went down, and the nurses down there were superb. And the time that he spent on life support while down there, they were real supportive. It was just a role that I'd like to have. You know, something to give back.

Role models. Nine had relatives who were nurses or worked in healthcare. Four of their mothers were nurses, while four had one or more aunts who were registered nurses. Although Dennis's mother was not a nurse, she influenced him to become a nurse

Frank had the opportunity to have both his mother and several aunts to be his role models in nursing. He also alluded to nursing being a stable job as he described:

> I've grown up in a household full of nurses--my mom, my aunts, I have several aunts who are nurses. And all growing up, they always had a job...And my dad, he works construction. And when I was in high school he ended up losing his job because of the depression...And I just always saw that my mom was stable in her job. She liked what she was doing. My aunts enjoyed what they were doing. And I knew I wanted to do something in the health care field, so I kind of focused in on nursing after I was here for about a year.

Adam's mother was an intensive care ward secretary and monitor technician. He described the influence of going to work with his mother.

> My mom works in a critical care unit. She is a monitor and ward clerk. And I've always been interested in the sciences, and I knew that health care was something that I was kind of interested in...so I went to work with her for a few days and just went around with different people...I really liked how nurses were always with the patients. Everyone else kind of came in, did their thing, and left. But nurses were always there. We can get insight to what patients think when other people really can't. So, that really appealed to me.

Lance, who was having a difficult time deciding on a career, was influenced by his aunt who was a nurse educator to consider nursing. His search for a major was described as: "I went through multiple majors: accounting, business, things like that, and just didn't find those things interesting. And my aunt teaches nursing...she suggested it, and I tried it out and loved it, so I stuck with it. "

Prior to entering nursing education. All of the participants' perceptions about nursing education prior to entering nursing proved to be inaccurate. Nursing school was thought to be easy. The demands of the curriculum, the knowledge base required, the realities of actual patient care, the holistic caring focus, and the various roles of the nurse were some of the areas in which the participants either lacked or had inadequate information. As Evan stated, "Coming to nursing school, I thought, well, this won't be too hard. I can just glide through this. And I was wrong....it was far more difficult than I thought it would be." Another participant echoed the sentiments of the previous participant. According to Glen,

> It's much more work than I thought it would be. I thought, "Oh, I made it through engineering with a 3.66; I'm going to have no problem with nursing school." And it hit me like a 2x4 because it is much harder than engineering. Nursing is the hardest thing I've ever done....I have to study all the time.

Paul had no awareness of the depth and applicability of nursing knowledge, nor of the relevance of critical thinking. He was accustomed to just using rote memorization, but not applying theory to practice.

> Well, it's not the sciences, I never had any problems with. It's just the actual nursing classes...everything builds on everything else...you might take a test and a question on the test might be something you learned a year ago or something like that, and everything's just like interrelated from every class you take. You really, if you read all the material for that week or that test, you might read it and know it all, but still you might not know the questions on the test because they might be from something totally different. So, I mean, it's really hard to learn new stuff and then remember the old stuff and be able to apply everything...I've never done poorly in class, but it's just harder than I thought it would be.

> It's harder than microbiology or anatomy or something where you can go in and learn what they tell you and if you know it, you get an "A". But it's not like that in nursing...Memorization will not help.

Several thought nursing education would be more focused on technical skills than all the nursing theory and concepts, pathophysiology, science courses, and general studies. Evan related his perception of what nursing entailed, "Oh yeah, giving shots and wiping butts. That's about all. The management part wasn't in there. I never thought of the leadership part."

The expectations of Michael were also different from the reality of the nursing educational process. He commented, "I expected more practical, hands-on skills and less theory and less written busy work....I've been amazed at how much of the written work I think is unnecessary."

Nursing education and nursing were not like Kris expected. His expectations were mostly related to technical skills. There were much greater expectations than he thought, as he discussed in the following statement.

> I had an aunt that's a nurse, so I knew maybe a little bit about it....I knew that it involved...the stereotypical, doing the bedpans, that sort of thing. The medication part. The actual knowledge that you know as a nurse compared to what I thought prior to, I guess, I didn't think it was going to be nearly as hard or challenging as this was, what it has been, and is what it is. There's a lot more to it than I thought, prior to becoming a nurse. I thought it was a lot more skills oriented...I thought it was technical, not having to deal with people holistically, all the other things involved.

Surprisingly, a few had no idea about the actual interactions with patients and their emotional, psychosocial, and spiritual needs. As mentioned in the previous comment by Kris, dealing holistically with people was not thought to be

part of the role of the nurse. Lance further exemplified this misconception in the following statement.

> I didn't think it was going to be as hard as it was...you have to be more of a well rounded person and I didn't think I was going to be dealing with people's emotions as much as I was. I always put more pathophysiology and stuff like that, really basics with meds; and it's more with getting near the families. Teaching's a big thing I really didn't see in it....I thought it was really cut and dry, and it wasn't as in-depth with theory, where they're at and their emotions and stuff like that.

Perceptions of Clinical Experiences

Clinical experiences provided valuable learning opportunities and relevance in the curriculum. Although there were many different clincial rotations, the clinical rotation that was discussed in depth was the obstetric (OB) or maternity rotation, since it had implications related to caring and gender. The OB rotations encompassed both positive and negative experiences and perceptions. Gender issues were explored in relationship to patients that refuse to be taken care of by a male student.

Positive perceptions of OB experiences. Five of the patients felt positively about their experiences in this rotation. As Evan stated, "I loved OB. I think that's the best rotation I had...it was a lot of fun." According to Nick, " I like it a lot. I'd already been in with my wife when she had both her kids...I really enjoyed it, because it seemed like I was learning a lot that I had no idea about." Carl described his experience.

> My OB experience was awesome...I had the best experience because I actually got to help pull and deliver a baby...I saw five C-sections. I saw eight births. I saw tubals. You name it, I saw...I

> saw a lot...Everyone was really nice and they kind of did this, I'd come out of one room, they'd pull me into another room...I had a really good experience, but I think the thing that helped, my instructor was really nice.

Discomfort became enjoyment for Kris as he experienced the OB rotation. He explained:

> It went well. At first I was hesitant. I mean the first time I walked in the room and had to do a post-partum assessment and had to feel a woman's breast, it was uncomfortable, but you focus on what you have to do, what you're assessing...it wasn't incredibly hard or terrible for me, I mean, I don't believe, I really ended up enjoying the nursery part of the rotation...it went very well.

Negative perceptions of OB experiences. Several of the participants had negative perceptions of their OB experiences due to negative experiences, as well as their own self-beliefs and personal discomfort. These participants acknowledged that any patient had the right to refuse to be taken care of by a student, but this related especially to women in OB who had the right to refuse male students. However, some of the participants still believed that this was unfair and that these patients should be informed that the male students were also there to do a job and to learn. It was thought that the patients had male physicians, so what was the difference with a male nurse? Frank belabored his negative experiences in the following comments:

> Some things I was a little uncomfortable with...but I was able to get through them. I tried to use the fact that I studied a lot for it and I kind of knew about that stuff, and I kind of knew what I was doing, and would try to give that impression that even though I'm a guy, I know just as much as women have because, although I'm not experiencing these and I can't say I have or will ever have these

> experiences, I can say I am knowledgeable about it, and I understand what you're going through. And that's one way I tried to make it easier for me and the patient...there's one time in OB where there was a lady delivering a baby who did not want me to come in and watch her because I was male...That affected me pretty bad... I know they have the right to do that, but it just really made me upset...Why wasn't the nurse able to explain to the patient that I'm just as much a part of her care as anybody else...They didn't understand that it was more for learning than, I mean, I wasn't getting anything else out of it. I was there to learn.

Although Glen said that one patient stated he was the best nurse she had, he still was uncomfortable in the OB area. He belabored his discomfort in the following:

> OB/GYN, I'm just not equipped to handle anything with that. I just don't like it. I don't want to be near it. And emotional care and that, that's just not for me. I just feel uncomfortable with it. I don't, I mean, unless it would be my wife. It's just not an area that I felt comfortable with because at that point and time, when a woman's having a baby, she doesn't want anybody around, that's how I felt...she didn't want a guy around...that happened to me alot..."No way do I want a male nurse." And it was, that was kind of weird because they have male doctors...I think a woman is better equipped to handle that...And then I finally did get one patient. And she had, in fact, she told me I was the best nurse that she had had. OB/GYN is not my area of choice. Like I said, I think women are better equipped to handle that.

Michael also was very uncomfortable in OB. He acknowledged that his discomfort probably had an self fulfilling impact on his relationship with these patients. He verbalized:

> I felt a little bit out of place in obstetrics, and I felt that the female nurses had a little bit of advantage over me, which I could very clearly understand, because if I was in the female patient's position, I would feel the same way...Part of it might be, my own, it's part of

> your mind, like you expect them to be a little uncomfortable with you, and maybe you're sending them a message that you're the one uncomfortable with it or something like that. And I know, a couple of things, like palpating the fullness of the breasts or something, for the milk gland, I just didn't do. And, I was afraid I was going to get into trouble if I tried to do some of these other things, you know, like when you have to inspect the lochia and things like that...I didn't feel comfortable doing that at all. And I think maybe that some of that contributed to the way I felt that they were uncomfortable with me, maybe it's a two way street.

Ray similarly described his own projections about the relationships in OB. In his own self examination he discovered:

> I was amazed because how I sort of set barriers for myself, like thinking, "Oh, this lady's not gonna want me in there in this situation." But overall, no, I didn't, I wasn't viewed that way. And I was the one who was shocked instead of the actually, the mother-to-be.

Gender issues in clinical. The issue of gender was identified as relevant in relationship to clinical experiences. Male students had patients refuse to allow the students to care for them because of their gender. These refusals occurred chiefly in the obstetrics units and by older female patients or ones with gynecological problems. Adam stated, "the only time my gender has ever came into play was at ... (the hospital) during the maternity rotation." Another example was given by Nick, "one woman asked not to have any male students in there (OB). I think it was more her husband, than her." Related to other types of patients, Lance stated, "I have been refused a couple of times for the older female patient. I think just because of embarrassment reasons for certain procedures like catheterizations and stuff like that."

Ray talked concerning the potential changes in the perceptions of patients as they become more familiar with male nurses. He explained:

> There have been patients in the hospital and they said "Oh, that male nurse, he was so good." When you're not there all the time and people really aren't used to you, then they're gonna look down upon you because just out of fear, not knowing, and then when they have this male, you know, female being the nurse role and not males. And then when they actually get caring from the male, then they might think "well, oh my!" So, like all the barriers and like the quotes that are put around the male as being "male nurse."

Two of the participants had near refusals from patients for providing care that were based on the student's gender and stereotypes. Both of these experiences were opportunities for the students to attempt to overcome the patients' stereotypical views about male nurses. One situation was discussed by Paul.

> I had one lady on a med/surg unit. She was really nervous about a guy being in there. And I said, "Well, your doctor's a man, isn't he?" And she was like, "Yeah." And I said, "What's the difference?" She said, "I'm not used to a guy seeing me in my underwear," or something. But she didn't, there wasn't anything that she didn't let me do, or tell me she'd rather have a female.

Another example was provided by Kris where he was able to satisfactorily provide care to a previously unwilling patient. His experience included:

> I have had patients ask not to have me as their student nurse because I was a male...I have also been in situations where I was there, the patient did not have a choice and at first did not want me to do whatever it was that I had to do, like a situation where I had to come and help a patient off the floor who had fallen. Well, she didn't want no man in there touching her or what have you. But I

helped her up and was able to then develop at least an interaction with her, establish some rapport.

Only one participant described an experience where a patient specifically asked for a male student nurse. Michael related this experience:

> I remember one male patient who had advanced bladder cancer, I remember he asked for a male nurse. And I felt real flattered because this was one of the few times that I felt appreciated, because it's usually get the male nurse out of here and get the female nurse in here.

Perceptions of the Educational Process

Near their graduation, many of the students expressed satisfaction with their education programs, as well as their knowledge bases and accomplishments. Personal growth and abilities were also matters of pride. Evan described his achievement as: "Going from not really, you know, not really giving a damn to what happens to actually caring about these patients...that would probably be the most memorable."

Frank reiterated his satisfaction with his educational program, as well as the accomplishment of completing a difficult undergraduate degree. He commented:

> I like this program and I think if you make the best out of something and if you work your hardest at something, then you're gonna get a lot out of it. That's what I've tried to do. So, I really enjoyed a lot of years here and I think I'm getting a good education and excellent learning opportunities. You just have to take advantage of the opportunities when they come...Nursing gives you a good background for everything. I think nursing is probably the hardest undergraduate degree to get because of all the bookwork

and the time that's put in that side of the classroom. So, it really sets you up to do anything.

In the following statement, Glen verbalized pride at all the knowledge and abilities he had accumulated during his nursing program. He explained:

> I, I actually feel like I have learned what a doctor learns in four years. I just feel like it's all been crammed into me. I'm sure that doctors go much more in depth in their specialties, those kinds of things, but I just feel like in four years I've learned so much, because I need to know a little bit about everything: physical therapy, medicine, nursing, pharmacy, I mean just everything. I feel I have to know a little bit about electronics.

Satisfaction with his nursing education was also voiced by Jake. He acknowledged: "I've realized that it's like I've like really got a good education out of the nursing department here...I really think I've really got a good grip on nursing." Kris credited self growth and development and his educational program for his changes and accomplishments. In his statement he elucidated:

> When I first came here I wanted to wrestle. I really had no ambition of really making anything out of myself. Through the nursing program and the psychology classes that I've taken self growth, self development has been unbelievable. The first year I was here, I probably would have been the kind of person that wouldn't have cared if you were walking down the street in front of me and fell down, I'd have probably walked right by you. Now, I help you get up and grab your books for you. That's one of the biggest things I've noticed about the whole program and myself. No, it's not just the program, it's about growing up. It's about maturing and I've noticed an incredible amount of that through my years. At first, it was party, party, party, have fun, don't care about anything. And then you get relating to people on a level that's very serious when you're dealing with patients or yourself. And then you start to take a little bit of that home with you, and when you're

> dealing with your family or other people. So, I've grown a lot as a person.

Only Michael voiced concerns about his clinical abilities. He was very satisfied with his theoretical knowledge base.

> I'm not the best clinical skills student. That's my weak point. I'm better in book learning and theory and classwork...I'm better at the analytical things than I am at the things like remembering when a drug has to be given, the exact times, and getting our bed baths done on time, and doing my charting. I'm better at assessing data, lab data, and drawing up pathologies, and things like that than I am at doing hands-on care...I learned more in the last four weeks that I spent with my preceptor than I have as far as practical skills in a whole year up here.

Perceptions of Nurses and Nursing

As the second essence of this theme, changes were identified in the participants perceptions concerning nurses and nursing. Clinical and theoretical experiences provided realistic exposure to the actualities of nursing. Experiences with nurses also had an impact on how nurses were perceived and the perception of treatment the students received.

Changes in perceptions of nurses and nursing

Nursing turned out not to be the easy profession that many of the participants believed it was before entering nursing education. During the educational process their perceptions of nurses changed. Respect for and appreciation of nurses and all their job entails were mentioned as one of the most noticeable changes. Perceptions of their experience with nurses had an impact on how nursing was viewed. According to Glen:

> I was always really proud, just really proud of people who were nurses. I was always very proud of my mom because I thought it was great that she was a nurse....It's made me much more appreciative of people who do the job.

Other positive changes in the perception of nurses occurred. Jake's new perception was: "I have a greater respect for the nurses on the floor and what they are able to accomplish in the time that they have to do it and the complexity of the patients that they're getting." Lance described his new perceptions as, "I think the world of nurses now...they're a special breed of people. I've really gotten to know a lot of nurses and I respect the career." Michael reiterated his beliefs about nurses.

> In a lot of ways, I still view it as they're doing most of the work and it's tough. I have a lot of respect for nurses and the work they do, cause I've seen how hard they do work, and how much pressure and responsibility they do shoulder and...compared to what the doctors are making.

Changes in their perceptions of the nursing profession have also occurred in the process of their nursing education. More realistic views about nursing were incorporated into their perception as they experienced the realities inherent in the profession throughout their educational process. Bill described how his perceptions changed.

> Before I thought it was just like curing people. So, now it's like taking their families into the picture, too, cause they're affected by their illness. Seeing what their total needs are, not just their illness....Nurses have a lot more independence than I thought before getting into nursing school.

To his surprise, Adam found that nursing exceeded his expectations, especially the amount of knowledge required. He discussed his new perspective. .

> I kind of looked at it more like the general public does. I kind of looked at it as something where you cared people, but there wasn't really a lot of knowledge-base behind it. It was more of just a caring thing. But now, I realize that nursing is much more than I ever dreamed it was. There's so much of a knowledge-base behind it.

Ray also admitted his awareness of nursing was expanded in the educational process. In the following statement, he delineated the changes he perceived .

> I view nursing now as we're really a strong backbone to medical care, and I view it really as being important. Because before, you always thought of nurses, not thought of them, but when you went to the hospital, you'd see them do hands-on care, then you'd see them sitting behind the desk, and you'd think that's all it was. Which now I know more, and to actually take the family into the, you're dealing with the patient, but also the loved ones.

Since Evan's mother was a nurse, he also had some preconceived ideas about the treatment nurses received. In this following statements, he reiterated that some things had never changed.

> My perception of nursing was, my mother was a nurse so I'm getting second hand information when she's coming from work. The doctors are all assholes, she's working long hours for no pay, she gets no respect, the list goes on. From what I've been told from her, there's no way that I would have considered being a nurse...it's just all sounded so bad....Some of the stuff mom was talking about I believe was right because, people ask me if I want to go back into being MD. That would never work. I don't, I can't work for somebody or do something I no longer respect, and at times I don't

> because of the way they still treat nurses, and I see it every day, and I've had it done to me.

In the next statement Frank voiced some disillusionment about nursing and his expectations. His disappointment was obvious.

> I guess it's not everything that I thought it was going to be at first...I don't see nurses getting all the respect they deserve. I think nurses are able to do much more than what they're allowed to do...their knowledge background permits them to do a lot of stuff that doesn't, they're not allowed to do on their own. I wish there was more autonomy for nurses and they were respected more, not only in health care, but in the public. I think there's not as much respect as they deserve.

According to Nick, he came to the realization that nursing was not the easy job he thought is would be. He admitted, "I now understand how complex it is and all the responsibility you have. I see that it's not as easy of a job that I thought it would be."

Perceptions about experiences with nurses

Many participants did not mention examples of their experiences with staff nurses. However, several participants verbalized relevent comments concerning their experiences and perception about nurses. Only Lance specifically stated that he had never had any problems with staff based on his gender. Carl described his frustration with some nurses:

> I get aggravated because I see...some nurses that just aren't happy being in nursing, and my view of it is, if you're not happy, leave...it's those few nurses that want to bring everyone down. And that's what, nursing doesn't have a bad name, but nursing doesn't have the title that it could have, and it's because of those few people...I wish more than anything, I think nurses need to realize at one point they

were students...I think if nurses could go back to the day they were students and see the anticipation on our faces and all the tiredness by our senior year, I think they would get a whole new outlook on life. Maybe they would decide a career change, or realize that they're losing that caring aspect.

Evan was disgruntled by the treatment he received by the hospital staff. He believed this treatment was related to the fact that he was a male nursing student. His description of his experiences was:

> When you get out in the hospital, I'm treated differently by the hospital staff. I don't know if they resent me being there or what it is, but I've got major attitudes from a lot of people around here...I felt the way they talk to you, the way they act, the way they look at you, just the way they conduct themselves around you, it is different. I don't know what it is. I've never done anything to any of these people. I do my job and I do it well...they questioned my quality of care. When I was on OB last year, labor and delivery, I was questioned all the time, not by my instructor, by people I was working with. "Did you do it this way? Did you do it that way? I don't think you did right." I would be like, "Yes." I did know how to defend myself.

It was perceived by Jake that there was a difference in treatment based on gender, but he did not elaborate. He asserted that,

> I think that a lot of the nurses here support me, but I don't think they deal with me in the same manner that they do with the female nursing students. Some nurses, I think, resent men coming into the nursing field...The other side of the coin, I've had nurses say, "Hey this is great. This is what we needed. We needed men in nursing"...they just think it's wonderful. They think it's outstanding and I think it is too...I realize that we are a minority, but I hope that people will stop having negative connotations about nurses, cause not all nurses are bad, and not all of them are in broom closets and stuff like that. So it's maybe people will start getting over that and

> start giving nurses due credit. And if by men going into the field that can be achieved, then so be it.

Both caring and noncaring nurses had been noticed by Paul. According to his following description, caring was seen as the characteristic that described a nurse.

> I see a lot of people that don't care. I've seen nurses that are hardened and it seems like, and they don't seem to really care about the patient, they're more concerned about themselves and what their jobs are. I don't know how many actually are like that. Then I see nurses that you can tell that they were born to be nurses, because they're so giving and they care a lot about the patients.

Treatment by the nurses varied at different sites for Adam. He perceived the differences were based on his gender. His recollection about his treatments was:

> At...(the hospital), very different. They made it a big deal every patient you had. You know, you need to go and see if this is OK with them, you know since you were a male...And personally, I thought that was kind of wrong. I'm a nurse just like anyone else. But, here at...(the other local hospital) there was no difference at all. They just saw me as a nurse. They didn't think it was anything out of the ordinary.

Stereotypes and Gender

The fourth theme was related to stereotypes and gender. There were 2 essences in this theme. The first essence concerned one of the most prevalent stereotypes about the sexuality of males in nursing. In the past, males in nursing were thought to be homosexuals. One of the biggest concerns was fear that others would stereotype them as homosexuals or at least question their sexuality. Acceptance of their career choices was very important to all of the participants.

Most were pleased with the positive response they received about becoming a nurse.

The second essence concerned gender role assumptions. Several mentioned that they had never known any male nurses prior to entering nursing. This lack of role models contributed to some of the participants believing some of the stereotypical ideas about nursing, including that nursing was a female occupation without many demands or prestige. Changes in their perception of the stereotypes occurred through their exposure to the reality of nursing in nursing education and to role models. Another aspect of the gender role assumptions was that people still believed that males must be physicians or respiratory therapists because of their gender.

Perceptions about sexuality

Most participants verbalized that they had no stereotypes about males in nursing concerning homosexuality, yet later in their interview made comments that negated their statement. Carl was one of the most verbal about this issue. He asserted, "Actually, I went in wanting to break the stereotypical ideas, because the stereotypical male is gay, you're a little, duh, duh, duh, and I wanted to break those."

Often the participants stated that others were the ones with the stereotypes. Evan expressed some of his stereotypical ideas and ambivalence about the stereotypes.

> All female...I never had any contact with a male nurse...so that's just all the stereotypical stuff you hear that I would know...You know, I didn't know any, and people that I, my peers, the perception was "they're either gay, or you know, there is something wrong with

> them"...And, I kind of shied away from that...I'm not gonna be stereotyped and have my sexuality questioned every time I walk into a patient's room.

Ambivalence about the stereotypes was also evident in the comments of Glen. Although he projects his ambivalent feelings on the comments of others, he did eventually acknowledge his own self doubt about how others would view his sexuality. He rationalized that other male nurses were married and had children, as a means to overcome the stereotypical thinking about male nurses being homosexuals. On the other hand, he felt he got support from his family and friends.

> I never really connected a man and nursing, you know, not that I had any stereotypes about it....did meet some guys who were going to be nurses and I thought they were great....Not in my family, not anybody that I knew, actually, most everybody that I know is interested in what I did...I mean I have had some negative reactions, but not from people I know. They kind of looked at me and you know, kind of raised an eyebrow, and one time somebody did say "Why do you want to be a nurse? What's wrong with you?" And I was just like, "Well, I'm going to get a job, and it's going to be a good job. But, I like it, so deal with it on your own time."...I guess I used to be supersensitive to it because I'd think, "Oh, God, what are people going to think of me because I'm going to be a nurse?". But now, I just, I don't even think about it anymore, because I know a lot of guys who are nurses, and most of them are married and have kids.

In his perceptions, Kris explained his lack of role models and his stereotypical views of nursing. He stated:

> I didn't know myself a male nurse. I didn't know anybody who did know a male nurse. So, it was difficult for me and it was hard for me because in high school I was the typical jock fellow...So I guess

> I don't fit the typical stereotype of a nurse, which would be woman probably with her cap on and her little suit.

In other comments, Michael denied he had any stereotypes about nursing and did not receive any from his family. However, he then made the following statements, which were indicative of the stereotype that nursing was not considered prestigious or an achievement. He further explained:

> I come from a family that is very professional...and in my family, they will look at nursing as not much of an achievement. I'll still be probably be considered the blacksheep in the family because I didn't become a doctor, and because so many of my uncles and cousins are doctors, but I'll still be considered inferior.

Other stereotypes about female nurses were mentioned by Jake. He described his perception of a nurse in two ways.

> that is what I always envisioned nurses to be. She is very pressed...she always presents herself very professional. She is very straight forward. She is very concerned. She is very therapeutic. She is like the ultimate nurse...bottle of shoe polish. They used to have that nurse on there that like came out of the fifties, and she was very, I don't mean to say the word rigid, but she was, her bearing was very astute and very professional...I can't say I didn't have like the negative connotations like you pick up in the media, such as the nurses are like looking for a doctor, or she's like always inside a closet somewhere with some doctor, intern.

Changes in stereotypes. The next two participants both mentioned changes in their stereotypical thinking. According to Dennis, he no longer considered nursing just a female occupation, "I thought nursing was mostly something females did...it was just that I didn't consider it much of a profession....It's changed it very much. I see nursing as a profession, as something that's needed." Evan

acknowledged that his stereotypical ideas were gone, "It's changed a lot. All the stereotypes aren't there anymore...The strenuous work and long hours and stuff, that's to be expected. But, in the end I think it's all worth it." He too had thought nursing was an all female job.

Ray also discussed his ambivalence and perceptions about the stereotype of male nurses. After much hesitation, he was able to accept nursing as his career choice.

> My biggest fear this summer was my 5 year reunion from high school...At first I was sort of hesitant to tell people. But then it was like, "Well I'm happy with my decision. I feel comfortable with what I'm going to do. And my main thing was job opportunities in, not so much just by being a male, not that way...I was sort of hesitant, because you just always thought of nurses as being female, or if it was a male, that the quote, you know, the stereotypes, and things like that.

Acceptance by families and friends was quite important to these participants. Adam, Frank, and Nick were surprised that they did not receive any stereotyping from others, while Lance was also pleased that he received positive feedback from family and friends. Also, Ray found, "I didn't have any difficulties with family members or friends or anything. I found them to be real receptive and real welcoming." Evan was also surprised with the responses he received. He explained:

> All my friends were real supportive. What I expected to happen didn't. I still at times when I meet new people, they'll ask me what I'm doing, and I'll be like, "Don't laugh." And that's just me. And they never do. It's like, "Well, that's great, that's super, sounds good." What I expected and what I've seen are not, are not the same.

Gender Role Stereotypes

Although only three participants addressed the second stereotype, this provided examples that many people still assumed that occupations were based on gender roles. Patients and families assumed because the students were male, they must be either physicians or respiratory therapists, according to Carl, Evan, and Glen. An example of this stereotype was provided by Glen, who stated, "Especially with older guys, like fifties, sixties...I try to make conversation with the things that they like and they're always surprised when I tell them I'm a nurse." Carl remarked, "Patients, I have to tell them I'm a nurse. They think I'm a doctor or a respiratory therapist."

Future Career Directions

The fifth theme was the future career directions of the participants. This encompassed the essences of future educational endeavors and career specializations. Also mentioned was whether or not the participants were likely to remain in nursing.

Future Educational Endeavors

Ten of the participants expressed that they plan to seek additional education at the Master's level or higher. However, even some of those who did not specifically state that they planned to seek additional education will need it in order to fulfill the requirements of the specializations they have chosen.

Career Specializations

All of the respondents listed several potential specialization preferences as future career plans. Since most of the students had not been hired at the time of

these interviews and with all the dramatic changes occurring in the healthcare field at the present, many were uncertain of the possibilities of being employed in their chosen areas.

The critical care areas were the most desired specialization, as evidenced by nine participants choosing this area. Nurse anesthetist and nurse practitioner were chosen by six different participants. Emergency Department was the choice of five participants. Both administration and the operating room specializations were each mentioned by three participants. Flight nursing and travel nursing were each mentioned twice. Each of the following were chosen by one participant: trauma, hospice/home health, physician's assistant, industry, exercise/orthopedics, and biomedical research.

Although most did not specifically say that they had no plans to remain a bedside or staff nurse, this is implicit in their choice of future careers and specialization plans. However, four did verbalize that they did not plan to be providing direct patient care or be a "floor" or "bedside" nurse. This was described by Evan, who stated, "I don't want to be a floor nurse, I've got no desire to do that. I'll do it while I have to, to get my foot in the door somewhere, and to get my time in." Lance also concurred with this idea when he reiterated, "Floor nursing is, floor nursing's good, but I don't know, it gets too repetitive for me, it gets too stagnant...I don't think I could do it for an extended period of time."

Although they had also listed areas of specializations they were considering, three of the participants were uncertain if they would remain in nursing. Nick planned to try out for Special Forces in the military, then go to dental school. As Frank stated, it depended on the course of his career whether

he remains in nursing. It was also very unlikely that Michael would still be in nursing, as he reiterated:

> Possibly in graduate school or in a health related field, not providing direct patient care...either in education, possibly counseling, or insurance company, something to that effect...I thought about it, but I've spent so much time looking that I'm pretty much burned out as far as education is concerned. And I don't think I would go on unless I identified, got into something and really knew this was it...if I went on in the health field, I'm not going on for a graduate degree in nursing. It would have to be, if I stayed in health, it would have to be medicine...I'm so burnt out on school at this point, if I ever went on, I'd go after the big, I want the main thing, go be a doctor.

Summary

Five themes have been identified in this study. The primacy of caring was the first theme. This theme included the characteristics of caring, the origins of caring, the lived experiences of caring as male student nurses, and the caring versus technology dichotomy. The second theme was the perceived gender differences relating to caring, with the differences in caring provided by male and female students and perceptions of faculty caring related to gender as the two essences. Perceptions concerning nursing education and nursing became the third theme, with the perceptions concerning the educational process as one essence and perceptions of nurses and nursing as the second essence.

Stereotypes and gender was the fourth theme. The two essences consisted of stereotypes about the sexuality of males in nursing. Gender role assumptions were the second essence. Future career directions were the fifth theme. Future

educational endeavors and career specializations were the two essences in this theme.

Correlation and differences in assumptions, biases, literature reviews, and the analysis of data are examined in Chapter Five. Implications of this study are also addressed.

CHAPTER FIVE

Reflections of the Findings

This chapter is based on the reflections of the findings of this phenomenological study about the lived experiences of male nursing students in regard to caring. The Swanson-Kaufmann and Schoenwald approach to phenomenology was used throughout this process. Five major themes evolved: (a) the primacy of caring, (b) perceived gender differences related to caring given and received, (c) perceptions of nursing education and nursing, (d) stereotypes and gender, and (e) future directions. Each theme was comprised of two or more essences.

Also in this chapter, the correlation between the original review of the literature and the findings of this study are reflected. Limitations of the study are identified, as are implications for nursing education, nursing practice, and nursing research.

Reflections Concerning the Phenomena of Interest

The first issue explored was why male students entered nursing. All the participants listed more than one reason for choosing nursing as a profession. The main reason was because nursing was seen as "a good career," "a lot of opportunities," and "an open field" which contained many specialization opportunities. One participant stated he was told by several people "You being a male, it'll be pretty easy to get a job and you'll be able to go do so many different things and move up." Other reasons were cited as: "I loved working in the health care environment," "I wanted to become involved," and "I really liked how nurses were always with the patients." These reasons were consistent with those given in

the literature. Cyr (1992) described the reasons that males entered nursing as: to help others, for a challenging career, job security, the actual work, advancement potential, and job flexibility. Fagin and Maraldo (1988) also suggested that some males entering nursing had an interest in biology and desired a humanistic work setting.

Others had personal experiences with illness, as well as the illnesses and deaths of family members, which influenced their decisions to become nurses. Also mothers and aunts that were nurses were mentioned as role models in their decisions. "I've grown up in a household full of nurses--my mom, I have several aunts who are nurses...they always had a job." One of the participants, who was having a difficult time deciding on a major in college, acknowledged he decides to enter nursing because, "My aunt teaches nursing...and she suggested it."

In Lemkau's study of males entering atypical careers, such as nursing, it was proposed that those males may have experienced a major family loss during their youth and may have been influenced by women in their career choices (Villeneuve, 1994). Both of these ideas were verified by the participants in their interviews.

Changes in Perceptions

There were changes in their perceptions concerning nurses and nursing relative to the nursing education process, as well as in their perceptions of experiences with nurses. Both positive and negative changes occurred; however, the changes tended to be more positive. Also, there was a more realistic view concerning nurses and nursing after their educational experiences.

Prior to entering nursing school, nursing was thought to be easy and not very demanding. There was either a lack of knowledge or misperceptions about the demands of the curriculum, the knowledge base required, actuality of patient care, and nursing roles. Examples given were: "this won't be too hard," "far more difficult," "nursing is the hardest thing I've ever done," and "I didn't think it was going to be as hard as it was." Most expected a greater focus on technical skills, but had no idea of the magnitude of holistic emotional, psychosocial, and spiritual needs of the patients and their families. Comments relevant to this included, "thought it was more technical, not having to deal with people holistically'" and "didn't think I was going to be dealing with people's emotions as much as I was." The participants were unaware of the degree of critical thinking and decision making required. This was exemplified by Paul's comment, "It's really hard to learn new stuff and then remember the old stuff and be able to apply everything...Memorization will not help."

Clinical experiences were seen as valuable learning opportunities and very relevant component of the curriculum. Both positive and negative perceptions of their obstetrical (OB) experiences were discussed, since this clinical rotation had implications related to caring and gender. The gender issues in clinical related to refusal to be cared for by a male student. Because of the intimate nature of caring provided, there was occasionally a sense of being uncomfortable by either the student or the patient/family. "I felt a little bit out of place in obstetrics," and "OB/GYN, I'm just not equipped to handle anything with it...I just feel uncomfortable with it" demonstrated that some students were not comfortable. Patients have the right to refuse to be cared for by students and nursing personnel,

which upset some of the participants. This mostly concerned intimate procedures on obstetrical, gynecological, and elderly female patients. Frank verbalized his frustration in the following comment, "That affected me pretty bad...I know they have the right to do that, but it just really made me upset...Why wasn't the nurse able to explain to the patient that I'm just as much a part of her care as anybody else?" Some of the participants felt that asking patients if they would allow male nursing student to care for them was unfair because they felt that they were there to learn and to do a job. The comment was made that many people have male physicians, so what's the difference with a male nurse?

Most of the participants expressed great satisfaction with the education they received, as well as with the knowledge they gained and accomplishments they attained. "I've realized that I really got a good education out of the nursing department here...I really think I've really got a good grip on nursing" was an accolade from Jake. "I think I'm getting a good education and excellent opportunities" was Frank's comment. Kris acknowledged his satisfaction in the following statement, "Through the nursing program and the psychology classes that I've taken, self growth, self development has been unbelievable...I've grown a lot as a person" Only one expressed concern about his clinical abilities.

Increased respect for and appreciation of nurses and their workloads were changes in perception. There was greater awareness of the complexity of the job, amount of responsibility, and the pressures of the job. Nursing was not the easy job that several participants had thought. A greater awareness of nursing roles, holism, and an increased knowledge base occurred. Conversely, one participant acknowledged disillusionment about nursing and the lack of respect for nurses.

Both caring and noncaring treatment from staff members were mentioned. Some of the participants felt disgruntled and that they were treated differently because of their gender. Comments were, "I'm treated differently," and "I don't feel they deal with me in the same manner that they do with the female nursing students." Some nurses were perceived as projecting negative attitudes toward nursing and students. It was thought that nurses needed to be more empathetic and remember their days as a students. Carl mentioned, "Some nurses aren't happy being in nursing...I think nurses need to realize at one point they were students."

Caring

Characteristics of caring. Chief characteristics of caring identified in this study were communication and relationships. Most participants viewed communication as a major component of caring. Talking to the patients was the seen as an important aspect of caring. In a study by Smit and Spoelstra (1991), nurses ranked "listens to patients" as the highest ranking caring behavior of 50 items described on the Caring Assessment Report Evaluation Q-sort (Care-Q) tool, while patients listed that statement as their second ranking behavior. In Mangold's (1991) comparative study consisting of senior nursing students and professional nurses concerning perceptions of effective caring behavior, both groups agreed that the most caring important behavior identified on the Care-Q was "listens to patients." In their study, Scharf and Caley (1993) compared studies by Larson (1984, 1986, 1987); Mayer (1987); and Komorita, Doehreng, and Hirchert (1991) that also used the Care-Q tool to determine perceptions of nurses' caring behaviors. In all the studies nurses chose "listens to patient" as the primary caring behavior. Relationships were identified as important in caring.

According to Watson (1994), by expanding the nurses' humanity to incorporate the humanity of others, the nurse focuses on the processes of trust and mutuality in the intersubjective human-to-human contact between the nurse and others. Components of this transpersonal relationship encompass the search for wholeness, healing, integrity, and harmony. Living, coping, growing, and dying are some of the health and quality of life issues comprising the human "being" in caring-healing relationships. Some of the participants alluded to relationships occurring in some of these areas, such as "being" with a dying patient, helping patients and families cope, and dealing with patients with chronic illnesses.

There is more to caring than communication and relationships. These components are a vital part of caring, but there is a much greater depth. Nursing theorists Jean Watson and Madeleine Leininger base their theories on the premises that caring is the essence of nursing. Other nursing authors who also supported the idea that caring is the essence of nursing included Bevis, Fry, Gardener, Gordon, Montgomery, Ira, Roach, and Boykin and Schoenhofer. Fry (1991) characterized other aspects of caring as a phenomenon, a life force, nursing science, a process, a behavior, an ideal, a value, a principle, a virtue, and the central unifying domain for nursing's body of knowledge and practices. Roach (1984) also identified compassion, competence, confidence, conscience, and commitment as characteristics of caring. These characteristics were not mentioned by the participants. This might be due to a lack of knowledge or superficial knowledge about caring by the participants, or the way they interpreted the questions asked in the interview. If caring is truly going to be the essence of

nursing, there needs to be more awareness and cognizance of what caring entails. As Gordon (1991) emphasized,

> Caring is also a fundamental human imperative that must be obeyed by all humanity, not just half of it. Thus, we hope to teach men to value caring, to share in women's caring work in home and workplace, to support truly care-centered programs in the political arena" (p. 45-46).

Origins of caring. Parents, especially mother, were cited as role models and the origin of caring for most of the participants. Others viewed caring as innate or inborn. Only one participant cited religion as an origin of caring. Caring was taught in the curriculum of all four schools. It was felt that basic caring was not learned in the curriculum, but that theory supplemented or "added to" the caring learned in the family or their innate caring abilities.

Caring and technology. All the participants acknowledged that caring and technology were both necessary components of nursing. Even those who believed their personal practice was based on caring often thought that caring was less valued than technology. The discrepancies between caring as it should be and how it is really practiced and exhibited were voiced. Caring was deemed a mandatory requisite of providing technological care even by those who acknowledged that their practice was more technologically focused. Coexistence of caring and technology was seen as possible.

The impact of caring has been minimized due to increased technology and biomedicalization in healthcare today which promotes a major focus on curing (Watson, 1994). As Segal (1987) contends, technology can either benefit or hinder human welfare and well-being, depending on who controls it and whose

interests it serves. Technology is a necessity and reality in today's healthcare, but caring is the essence of nursing. Clinical and technological knowledge, expertise, and power are vital to help heal, solve, or remove problems, but these curing functions should be used in a caring relationship to alleviate the vulnerabilities of patients and significant others, not just as a means to an end (Montgomery, 1994). There needs to be emotional, psychosocial, and spiritual healing, as well as physical. Caring and technology can coexist but caring must not be overshadowed or minimized.

Interestingly, Smit and Spoelstra (1991) found in their study of perceptions of caring that patient perceptions of caring behaviors focused high on proficiency in technical skill performance as a way to show caring. Also, patients and physicians in Scharf and Caley's (1993) study "did not value nontechnical activities as highly as they did technical activities" (p. 11). This is contrary to what nurses described in the previously mentioned studies about caring behaviors.

Lived experiences of caring as student nurses. Their lived experiences were exemplified by examples of caring as it was exhibited through the use of therapeutic communication and nurse-patient relationships. These were demonstrated in their interpersonal interactions through "being with," supporting, problem solving, comforting patients and their families, and incorporating spirituality into caring. A sense of accomplishment and satisfaction concerning the caring they provided was apparent.

It was the contention of Ericksson (1992) that caring begins with emotional abilities, ethical motives, and willingness to do something special. Providing warmth, presence, rest, respect, frankness, and tolerance are hallmarks

of this caring. In their accounts of their lived experiences of caring as male student nurses, the participants exhibited the qualities that Ericksson espoused.

Perceptions of caring provided. Several participants expressed that the caring they provided was no different than the caring provided by female students. These participants thought that caring was not based on gender, but was an individual attribute. However, others were noncommittal and did not state whether there were differences, similarities, or sameness in the caring they provided in comparison to the caring provided by female students. They, then, proceeded to describe examples of how the caring they provided was different, and often better, than caring provided by female nursing students. The main area they perceived differences and superior abilities was related to communication style.

Perceptions of faculty caring related to gender. Caring received from the faculty was deemed as equal or superior to the caring treatment received by the female students. However, many were also quick to cite noncaring behaviors by faculty. But even those who described positive and negative comments did acknowledge that faculty interactions were more caring than noncaring. Examples of caring behaviors were faculty availability and willingness to help with personal and academic problems. Noncaring behaviors were usually related to one or a few faculty members. Noncaring behaviors included having to seek out an instructor for help; discriminatory, sexist, or derogatory comments; and noncaring attitudes.

The need for a caring faculty has been demonstrated in the literature. As Hughes (1992) asserts, students are primarily socialized to the normative values and attitudes of their profession through their interactions with faculty. If students are to become caring nurses, there needs to be faculty role modeling. As

participants mentioned the noncaring behaviors exhibited by the faculty, it was evident that these did not instill a sense of caring for the students. A description of a climate of caring by the participants in Hughes' (1992) study was viewed as:

> one in which the faculty acknowledge and actively respond to the feelings of stress and anxiety that are experienced by students, provide opportunities for students to express their opinions and concerns without fear of reprisal, and place high priority on meeting the needs of students (p. 63).

If there are concerns about males and caring, it would seem logical for faculty members to be professional role models of caring. One way to demonstrate that caring and technology can coexist would be to incorporate caring behaviors during the process of performing technological skills.

Perceptual about sexuality. Groff (1984), Kelly (1991), and Cyr (1992) all mentioned the mistaken sexual stereotype that male nurses are homosexual, which had been a disincentive for males to become nurses. Most of the participants denied that they had any stereotypes concerning the sexuality of male nurses, yet later in the interview most made a comment or acknowledged ambivalence about this stereotype. Evan's sentiments echoed those of other participants, "I never had any contact with a male nurse...all that stereotypical stuff you hear...the perception was they're either gay or there is something wrong with them." There was much concern about how other would view their sexuality and much relief when family and friends approved of their decision to become a nurse. Many did not know any male nurses prior to entering school, but mentioned that once they were able to meet other male students and nurses, the fact that many were married and had children was a relief. This decreased their concern about sexuality of male nurses.

As Glen reiterated, "I used to be supersensitive...but now I don't think about it anymore, because I know a lot of guys who are nurses, and most of them are married and have kids."

Another sexual stereotype was that males become nurses because they are not smart enough to become physicians. None of the participants in this study voiced this as an issue. Cyr (1992) purported that some female nurses view male nurses as brawn, not brain. A few of the participants did mention that they are required to do more physical activities, such as lifting and moving patients, than female students or nurses due to their strength (or brawn).

Gender role stereotypes. Nursing has always been predominantly a female profession, since women have been delegated the role of caregiving and nurturing (Gardner, 1992). Since many of the participants did not know any male nurses, they assumed that nursing was a female job. The stereotypical dichotomy of a prim, proper nurse like the one on the white shoe polish bottle or the wanton nurse in the broom closet with the doctor or intern was voiced by one participant. As previously mentioned, most did not perceive nursing to be much more than taking care of physical needs. Nursing was not seen as requiring much knowledge or a sense of professionalism. These stereotypes deterred many males from entering nursing in the past.

The other aspect of this stereotype is that many people still assume that occupations are based on gender roles. In the results of Johnson's (1989) study, the respondents thought that the general public was likely to view male nurses as physicians, based on gender role assumptions. In this study, some patients and

families assumed that because the students in this study were male, they were either a physician or respiratory therapist.

Future educational endeavors. Most of the career specializations that have been chosen require additional education. A Master's degree is required to be a nurse anesthetist or a nurse practitioner. Nursing administration usually requires advance degrees Certifications, which recognize proficiency in specialty areas, are available through professional and specialty organizations

Many states, including West Virginia, are mandating continuing education for all nurses on a yearly basis. To be a competent, knowledgeable nurse, one must realize that learning is a lifelong process. Although the participants were not specifically asked and did not address the area of lifelong learning, many alluded to the fact that further education was an expectation. With constantly changing technology and information, the nurse must know the resources available to stay abreast in this informational society.

Career specializations. The main choices of these participants were highly technological specializations: critical care units, nurse anesthetist, nurse practitioner, Emergency Department, nursing administration, and operating room. Egeland and Brown (1989) contended that specialization preferences of male nurses were the areas of "administration, emergency, anesthesia, critical care, operating room, psychiatry, and occupational health." London (1990) stated that men tend to specialize as nurse anesthetists, psychiatric nurses, or administration, while Fagin and Maraldo (1988) maintained that males tended to specialize in psychiatric nursing, urology nursing, and emergency care. The participants' choices were closest to the preferences listed by Egeland and Brown. None of the

participants chose psychiatric nursing or urology nursing, and only one mentioned occupational health nursing. Few chose to remain as bedside nurses, since by the very nature of their choices the participants have chosen areas of high technology and career advancement. London (1990) and Villeneuve (1994) assert that males tend to be more career oriented and likely to make an active lifetime commitment to the profession.

Limitations of the Study

There were some limitations in this study, as in any study. The sample of participants was based on convenience and availability of subjects, not on a random selection. In any future study, the number of participants might be increased. Also, the participants in this study were from a limited geographical area in one state. Future studies could be conducted in other states or in other areas of the country to determine if there is any universality between their experiences.

Another limitation was that only male perceptions and experiences were examined. By also interviewing females, information would be provided concerning comparison and contrast of gender based issues and caring. Also, studies could be focused on the perceptions and experiences of the faculty concerning caring and gender related to their students.

The findings are also limited to the extent that the participants were able to recall caring experiences and their degree of willingness to share these thoughts, feelings, perceptions, and actions. In addition, the participants may have based some of their responses on what they thought I, as a nursing instructor, expected them to say.

Implications for Nursing Education

One of the first implications is that there needs to be continued focus on caring theory in the curriculum. As Leininger (1991) suggests, caring concepts need to be incorporated into the curriculum from the beginning and maintained throughout. There is a need to broaden the theoretical component of caring to include in-depth concepts, philosophy, characteristics, and evolution of caring.

Caring needs to come from the realm of hidden or illegitimate curriculum into the mainstream of legitimate curriculum, where it is no longer assumed that caring is being taught. Bevis (1991) suggests that the lived experiences of nurses, students, and patients/clients be incorporated in a curriculum development model as a method of promoting insight and skills related to caring.

Another ramification involves greater application of caring principles in the clinical component. Although participants in one school alluded to caring behavior being an integral part of meeting their clinical objectives, participants from the other three schools did not mention caring as being included in their clinical objectives. However, since this information was not specifically asked, this could be an erroneous assumption. Since caring behaviors are difficult to measure using behavioral objectives, there needs to be alternate methods developed to measure caring. Otherwise, there will be no consistency if the teaching about caring is based on the priorities, abilities, and knowledge of each individual instructor.

Strategies for incorporating more meaningful ways to assess and evaluate caring in clinical experiences are increased usage of dialogue, self reflection, and journaling. All three of these strategies are more relevant ways to measure caring behaviors than are the routine clinical behavioral objectives. Watson (1995)

promotes the use of dialogue between student and instructor. Through the use of dialogue, the student has the potential to understand and interpret contextual meanings and experiences. In the dialogue between the instructor and student there is an interchange of ideas, thoughts, and energy using reciprocal and open communication (Noddings, 1984). Students should develop regular practices of self reflection concerning their own practice. One form of self reflection of practice is done after situations have occurred. An example of this would be that students document their perceptions, feelings, and actions related to caring behaviors in their clinical experiences on a weekly basis and submit them to the instructor. This may include areas of problems or concerns, situational occurrences, and reactions to the caring provided, and would be separate from the actual nursing interventions and procedures performed. To further increase the students' self reflections of practice, the instructor might encourage journaling, which could be done on a weekly basis and collected by the instructor. This encourages the students to reflect on their own clinical practice, while providing the instructor with additional information to validate with the student (McKay-Greer & Holmes, 1995). Promoting the self-reflection of the students also helps to improve their abilities to develop greater clinical judgment and skills, as well as provide opportunities to critically think about actual individual cases. Students and instructor can also share these to enhance personal knowledge, increase individual sensitivities, and elucidate meanings about patients' patterns of responses and their ways of being in the world. Gender differences in caring could be explored in clinical conferences.

Mentoring is another strategy to encourage caring behaviors. Nurses that exhibit caring behaviors are positive role models for students. Nurses could be rewarded and given special merit for their proficient caring practices. Students would have the opportunity to watch and learn the role of an expert caring nurse in action. As one of the participants mentioned, he learned "tricks of the trade" from working with nurses. The experienced nurse would be a role model concerning ways to provide caring interactions, not just technological skills and procedures. The expert nurse could also demonstrate the coexistence of caring and technology.

Another implication for nursing is recognizing the relevance of "inclusive language" or gender free language. This is appropriate for all domains of education, not just nursing. However, if nursing is to be considered a genderless profession, it is imperative that nursing education incorporate a gender free language into its professional terminology. The term "male nurse" or "male student" should be eliminated from the vocabulary, as should "female doctor." Several participants had mentioned with displeasure that some of the instructors and the textbooks referred to a nurse as "she." Also, some of the participants had stereotypical ideas of nurses and nursing based on language and gender. One example of this was that a nurse would wear a white cap and uniform. Also, it was acknowledged by some of the participants that before entering nursing, their perceptions were that nursing was a female job. Interestingly, a few of the participants also used the feminine adjective "her" and feminine pronoun "she" when talking about nurses during the interviews. If the general public is supposed to see nursing as a profession that is not based on gender, then nursing education and the nursing profession must lead the way as role models of inclusive language.

No longer can the female/male dichotomy exist if nursing is to unify and survive in the hostile healthcare world of managed care.

The practice of asking patients if they will allow a male student to care for them also needs to be examined. It is not likely that patients are asked if they will accept a male doctor, since male have traditionally been physicians. As a few of the participants mentioned, many of the physicians are male, so what is the difference between having a male doctor and a male nurse? One argument is that patients choose and hire their physicians, but don't choose their own nurses. Since many nursing schools, like medical schools, are affiliated with teaching hospitals, patients are supposed to be informed that students may be taking care of them. Patients do have the right to refuse to be cared for by a student. However, as some of the participants discovered, once some of the reluctant patients received caring from that male student, the patient's reluctance became acceptance. Another realm that needs further research relates to the experiences of male nursing students in obstetric clinical rotations.

With the focus of healthcare moving from the acute hospital settings to outpatient treatment, home health and community care, and long term skilled care facilities, there is a need to change the focus of nursing education. As the findings of this study show, few of the participants even mentioned any of the above areas as potential career directions.

Implications for the Nursing Profession

The greatest implication for the nursing profession concerns making nursing a holistic, genderfree profession. Males are in nursing to stay and their numbers are increasing all the time. At the present time, the healthcare professions

are in turmoil and conflict due to the massive changes in healthcare. With all the turf wars being waged and the threats to the very existence of the nursing profession, nursing does not need a another battle to fight. As the greatest number of healthcare providers in the United States, nursing has a vast potential to have an impact on healthcare changes--if nurses would unite and work together. However, there are so many factions that this unity is unlikely to happen.

Another implication of this study for nursing is to reiterate a problem concerning many seasoned nurses. Instead of being nurturing and supportive to students and new graduates, many would rather "eat their young." As a few of the participants mentioned, nurses should try to remember that they were once students and that students are there to learn, not to do the staff's work as proficiently as the staff does.

Implications for Nursing Research

Several implications for nursing research were previously identified in the Limitations of the Study section. The number of participants could be increased in future studies. Studies could be conducted in other states and geographical areas to determine if male nursing students in these areas had similar or different lived experiences with caring in their educational process. Male nursing students in Associate Degree Nursing (ADN) programs and diploma programs could also be studied in relation to caring. A comparison of the lived experiences of male and female nursing students could also be undertaken. Caring concepts could also be examined in the context of curriculum development, viewpoints of students in different parts of their educational process, faculty perceptions and experiences with caring, and in the practices of experienced nurses at various stages of their

practice. Further studies could be done to determine if there is a difference in perceptions of caring related to various age groups of students

Communication was a major component of caring. Communication techniques could be studied to differentiate the effects of therapeutic versus social communication. Another option is to examine the communication techniques of male and female students in interactions with members of both genders.

Ramifications for research are several. The participants in this study were all Caucasian males. With all the culturally diverse populations in the United States, there is a need to explore the lived experiences of culturally diverse male and female nursing students relating to caring in their nursing education process. Stereotypes of student nurses and nurses, especially males, could be examined in the context of other cultural groups in America. Characteristics and concepts of caring could be studied from the perspectives of culturally diverse groups.

The use of phenomenology in nursing to uncover subjective meanings, relationship, essences, and themes is a method that attempts "to describe and understand human experiences as they appear in awareness," according to Watson (1988, p. 80). Human experiences are acknowledged through expression of feelings, moods, and emotions of experiences. One cannot study human experiences as if they were inanimate objects, neutral items, or objects (Boyd, 1993). This is relevant in studying the lived experiences of male students in nursing related to caring, as the researcher is able to understand the experiences from their perspective. In order to look at other variables, such as observation of caring behaviors or descriptive activities, this study could also be done from other research perspectives, using either qualitative and quantitative methodologies.

References

Allen, D.G., Allman, K.K. K., & Powers, P. (1991). Feminist nursing without gender. Advances in Nursing Science, 13(3), 49-58.

Allen, D.G. (1992). Feminism, relativism, and the philosophy of science: An overview. In J.L. Thompson, D.G. Allen, & L. Rodriques-Fisher (Eds.), Critique, resistance, and action: Working papers in the politics of nursing (pp. 1-19). New York: National League for Nursing.

Anderson, J.M. (1989). The phenomenological perspectives. In J. M Morse (Ed.), Qualitative nursing research: A contemporary dialogue (pp. 15-26). Rockville, MD: Aspen.

Baym, N. (1990). The feminist teacher of literature. In S.L. Gabriel & I. Smithton (Eds.), Gender in the classroom: Power and pedagogy (pp. 60-77). Urbana, IL: The University of Illinois Press.

Beck, C.T. (1991). How students perceive faculty caring: A phenomenological study. Nursing Forum, 27(2), 9-14.

Belknap, R.A. (1991). Care: A significant paradigm shift and focus in nursing for the future. In D.A. Gaut & M.M. Leininger (Eds.), Caring: The compassionatae healer (pp. 173-180). New York: National League for Nursing.

Bem, S.L. (1983). Traditional sex roles are too restrictive. In B. Leone & M.T. O'Neill (Eds.), Male/female roles: Opposing viewpoints (p. 31-35). St. Paul, MN: Greenhaven Press.

Benner, P. (1985). Quality of life: a phenomenological perspective on explanation, prediction, and understanding in nursing science. Advances in Nursing Science,8(1), 1-14.

Benoliel, J. (1984). Advancing nursing science: Qualitative approaches. Western Journal of Nursing Research in Nursing and Health, 7(1), 1-8.

Berger, P.L., & Luckmann, T. (1966). The social construction of reality. New York: Anchor Books/Doubleday.

Bergum, V. (1989). Being a phenomenological researcher. In J.M. Morse (Ed.), Qualitative nursing research: A contemporary dialogue (pp. 43-57). Rockville, MD: Aspen.

Berman, L. (1988). Dilemmas in teaching caring: An outsider's perspective. Nursing Connections, 1(3), 5-15.

Bevis, E.O. (1989). Making a difference. In E.O. Bevis & J. Watson (Eds.), Toward a caring curriculum: A new pedagogy for nursing (pp.345-367). New York: National League for Nursing.

Bevis, E.O. (1993). All in all, it was a pretty good funeral. Journal of Nursing Education, 32 (3), 101-105.

Bishop, A.H., & Scudder, J.R. (1991). Nursing: The practice of caring. New York: National League for Nursing.

Bland, S. (1985). Nursing: a women's field...bring men back into this picture. Imprint, 32(1), 37.

Blau, F.D., & Ferber, M.A. (1989). Economics determines gender roles. In N. Bernardo & T. O'Neill (Eds.), Male/female roles: Opposing viewpoints. San Diego, CA: Greenhaven Press.

Bowers, C.A. (1987). The promise of theory: Education and the politics of cultural change. New York: Teachers College Press.

Boyd, C.O. (1993). Phenomenology: the method. In P. Munhall & C.O. Boyd (Eds.), Nursing research: A qualitative perspective (pp. 99-132). New York: National League for Nursing.

Boyd, C.O., & Munhall, P.L. (1993). Qualitative research proposals and reports. In P.L. Munhall & C.O. Boyd (Eds.), Nursing research : A qualitative perspective (pp. 424-453). New York: National League for Nursing.

Boykin, A., & Schoenhofer, S. (1993). Nursing as caring: A model for transforming practice. New York: National League for Nursing.

Bullough, V.L., & Bullough, B. (1984). History, trends, and politics of nursing. Norwalk, CT: Appleton-Century-Crofts.

Bunting, S.M. (1992). Eve's legacy: An analysis of family caregiving from a feminist perspective. In J.L. Thompson, D.G. Allen, & L. Rodrigues-Fisher (Eds.), Critique, resistance, and action: Working papers in the politics of nursing. (pp. 53-68). New York: National League for Nursing.

Burge, P.L., & Culver, S.M. (1990). Sexism, legislative power, and vocational education. In S.L. Gabriel & I. Smithton (Eds.), Gender in the classroom: Power and pedagogy (pp. 160-175). Urbana, IL: The University of Illinois Press.

Burns, N., & Grove, S.K. (1993). The practice of nursing research: Conduct, critique, & utilization. Philadelphia: W.B. Saunders.

Butler, J. (1990). Gender trouble: Feminism and the subversion of identity. New York: Routledge.

Caplan, P. (1987). The cultural construction of sexuality. London: Tavistock Publications.

Chafetz, J.S. (1983).. Society determines sex roles. In B. Leone & M.T. O'Neill (Eds.), Male/female roles: Opposing viewpoints (pp. 21-26). St. Paul, MN: Greenhaven Press.

Christman, L. (1988). Men in nursing. Imprint, 35(30), 75.

Chodorow, N. (1978). The reproduction of mothering: Psychoanalysis and the sociology of gender. Los Angeles, CA: University of California Press.

Cyr, J. (!992). Males in nursing. Nursing Management, 23(7), 54-55.

Dietrich, L. (1992). The caring nursing environment. In D.A. Gaut (Ed.), The presence of caring in nursing (pp. 69-87). New York: National League for Nursing.

Dobson, J. (1989). Biology determines gender roles. In N. Bernardo & T. O'Neill (Eds.), Male/female roles: Opposing viewpoints. San Diego, CA: Greenhaven Press.

Doyle, J.A. (1989). Cultural influences on gender roles. In N. Bernardo & T. O'Neill (Eds.), Male/female roles: Opposing viewpoints (pp.). San Diego, CA: Greenhaven Press.

Duran, J. (1982). Nurture theories: A critique. In M. Vetterling-Braggin (Ed.), Femininity, masculinity, and androgyny-a modern philosophical discussion (pp. 49-59). Totowa, NJ: Littlefield, Adams, & Co.

Egeland, J., & Brown, J. (1989). Men in nursing: Their fields of employement, preferred fields of practice, and role strain. Health Services Research, 24(5), 693-707.

Ericksson, K. (1992). Nursing: The caring practice "being there." In D.A. Gaut (Ed.), The presence of caring in nursing (pp. 201-210). New York: National League for Nursing.

Fagin, C.M., & Marlado, P.J. (1988). Feminism & the nursing shortage: Do women have a choice? Nursing & Health Care, 9(7), 364-367.

Fields, R.M. (1985). The future of women. Bayside, NY: General Hall.

Flynn, E.A. (1990). Composing as a woman. In S.L. Gabriel & I. Smithton (Eds.), Gender in the classrooms: Power and pedagogy (pp. 112-126). Urbana, IL: The University of Illinois Press.

Fry, S.T. (1991). A theory of caring: Pitfalls and promises. In D.A. Gaut & M.M. Leininger (Eds.), Caring: The compassionate healer (pp. 161-172). New York: National League for Nursing.

Gabriel, S.L. (1990). Gender, reading, and writing: Assignments, expectations, and responses. In S.L. Gabriel & I. Smithton (Eds.), Gender in the clasroom: Power and pedagogy (pp. 127-139). Urbana, IL: The University of Illinois Press.

Gardner, K. (1992). The historial conflict between caring and professionalization: A dilemmn for nursing. In D.A. Gaut (Ed.), The presence of caring in nursing (pp. 241-255). New York: National League for Nursing.

Gilligan, C. (1982). In a different voice: Psychological theory and women's development. Cambridge, MA: Harvard University Press.

Goldberg, S. (1983). The dominant male needs no liberating. In B. Leone & M.T. O'Neill (Eds.), Male/female roles: Opposing viewpoints (pp. 103-107). St. Paul, MN: Greenhaven Press.

Gordon, S. (1991). Fear of caring: The feminine paradox. American Journal of Nursing (2), 45-48.

Grim, P. (1982). Sex and social roles: How to deal with the data. In M. Vetterling-Braggin (Ed.), Femininity, masculinity, and androgyny-a modern philosophical discussion (pp. 128-147). Totowa, NJ: Littlefield, Adams, and Co.

Groff, B. (1984). The trouble with male nursing. American Journal of Nursing, 84(1), 62-63.

Halloran, E.J., & Welton, J.M. (1994). Why aren't there more men in nursing? In J.C. McCloskey & H.K. Grace (Eds.), Current issues in nursing (pp. 683-691). St. Louis, MO: Mosby.

Held, V. (1982). The obligations of mothers and fathers. In M. Vetterling-Braggin (Ed.), Femininity, masculinity, and androgyny-a modern philosophical discussion (pp. 242-258). Totowa, NJ: Littlefield, Adams, & Co.

Hughes, L. (1992). Faculty-student interactions and the student-perceived climate for caring. Advances in Nursing Sciences, 14(3), 60-71.

Ira, P.C. (1992). The magic of caring. In D.A. Gaut (Ed.), The presence of caring in nursing (pp. 257-267). New York: National League for Nursing.

Jackson, M. (1987). 'Fact of life' or the eroticization of women's oppression? Sexology and the social construction of heterosexuality. In P. Caplan (Ed.), The cultural construction of sexuality (pp. 52-79). London: Tavistock Publications.

Johnson, L. (1989). Male nurses: victims of discrimination or "the privileged few"? Imprint, 36 (4), 23-24, 27.

Kalisch, P.A., & Kalisch, B.J. (1978). The advancement of American nursing (2nd ed.). Boston: Little, Brown, & Co.

Kaschak, E. (1992). Engendered lives: A new psychology of women's experience. New York: BasicBooks.

Kelly, L.Y. (1991). Dimensions of professional nursing (6th ed.). New York: Pergamon.

Kessler, S.J., & McKenna, W. (1978). Gender: A ethomethodological approach. Chicago: The University of Chicago Press.

Kramarae, C., & Treichler, P.A. (1990). Power relationships in the classroom. In S.L. Gabriel & I. Smithton (Eds.), Gender in the classroom: Power and pedagogy (pp. 41-59). Urbana, IL: The University of Illinois Press.

Leininger, M.M. (1984). Care: The essence of nursing and health. Thorofare, NJ: Slack.

Leininger, M.M. (1985). Nature, rationale, and importance of qualitative research methods in nursing. In M.M. Leininger (Ed.), Qualitative research methods in nursing (pp. 1-26). Orlando, FL: Grune & Stratton.

Leininger, M.M. (1988). Leininger's theory of nursing: Cultural care diversity and universality. Nursing Science Quarterly,2(4), 11-20.

Leininger, M.M. (1991). Culture care diversity and universality. New York: National League for Nursing.

Leininger, M.M. (1993). Culture care theory: The comparative global theory to advance human care nursing knowledge and practice. In D.A. Gaut (Ed.), A global agenda for caring (pp. 3-18). New York: National League for Nursing.

Lerner, G. (1989). Biology does not determine gender roles. In N. Bernardo & T. O'Neill (Eds.), Male/female roles: Opposing viewpoints. San Diego, CA: Greenhaven Press.

London, F. (1990). Should men be actively recruited into nursing? In R.L. Ismeurt, E.N. Arnold, & V.B. Carson (Eds.), Concepts fundamental to nursing (pp. 363-369). Springhouse, PA: Springhouse.

McPhee, A.T. (1984). Being male in a female profession, RN, 47(10), 71-72.

Mangold, A.M. (1991). Senior nursing students' and professional nurses' perceptions of effective caring behaviors: A comparative study. Journal of Nursing Education, 30 (3), 134-139.

Martin, J. (1982). Sex equality and education in Plato's just state. In M. Vetterling-Braggin (Ed.), Femininity, masculinity, and androgyny-a modern philosophical discussion (pp. 279-300). Totowa, NJ: Littlefield, Adams, & Co.

Montgomery, C. (1994). The caring/healing relationship of "maintaining authentic caring". In J. Watson (Ed.), Applying the art and science of human caring (pp. 39-45). New York: National League for Nursing.

Morse, J.M. (1989). Qualitative nursing research: A free-for-all? In J.M. Morse (Ed.), Qualitative nursing research: A contemporary dialogue (pp. 3-10). Rockville, MD: Aspen.

Morse, J.M., Solberg, S.M., Neander, W.L., Botoroff, J.L., & Johnston, J.L. (1990). Concepts of caring and caring as a concept. Advances in Nursing Science, 13(1), 1-14.

Moulton, J., & Rainone, R. (1982). Sex roles and the sexual division of labor. In M. Vetterling-Braggin (Ed.), Femininity, masculinity, and androgyny-a modern philosophical discussion (pp. 222-241). Totowa, NJ: Littlefield, Adams, & Co.

Noddings, N. (1984). Caring: A feminine approach to ethics and moral education. Berkeley, CA: University of California Press.

Parse, R.P., Coyne, A.B., & Smith, M.J. (1985). Nursing research: Qualitative methods. Bowie, MD: Brady Communications.

Piekle, R.J. (1982). Are androgyny and sexuality compatible? In M. Vetterling- Braggin (Ed.), Femininity, masculinity, and androgyny-a modern philosophical discussion (pp. 187-196). Totowa, NJ: Littlefield, Adams, & Co.

Polit, D.F., & Hungler, B.P. (1989). Essentials of nursing research (2nd ed.). Philadelphia: J.B. Lippincott.

Polit, D.F., & Hungler, B.P. (1995). Nursing research: Principles and methods (5th ed.). Philadelphia: J.B. Lippincott.

Reverby, S. (1987). A caring dilemma: Womanhood and nurisng in historical perspective. Nursing Research, 36(1), 5-11.

Roach, S. (1984). Caring: The human mode of being, implications for nursing (monograph). Toronto: The University of Toronto.

Ryan, S., & Porter, S. (1993). Men in nursing: a cautionary comparative critique. Nursing Outlook, 41(6), 262-267.

Sadker, M., & Sadker, D. (1990). Confronting sexism in tbe college classroom. In S.L. Gabriel & I. Smithton (Eds.), Gender in the classroom: Power and pedagogy (pp. 176-187). Urbana, IL: The University of Illinois Press.

Scharf, L, & Caley, L. (1993). Patients', nurses', and physicians' perceptions of nurses' caring behaviors, Nursing Connections, 6(1), 3-12.

Schweickart, P.P. (1990). Reading, teaching, and the ethic of care. In S.L. Gabriel & I. Smithton (Ed.), Gender in the classroom: Power and pedagogy (pp. 78-95). Urbana, IL: The University of Illinois Press.

Segal, L. (1987). Is the future female? Troubled thoughts on contemporary feminism. New York: Peter Bedrick Books.

Seidler, V.J. (1987). Reason, desire, and male sexuality. In P. Caplan (Ed.), The cultural construction of sexuality (pp. 82-112). London, Tavistock Publications.

Smit, J., & Spoelstra, S. (1991). Perceptions of caring: Do patients and nurses agree? Caring, 10 (10), 34-36.

Smithton, I. (1990). Introduction: Investigating gender, power, and pedagogy. In S.L. Gabriel & I. Smithton (Eds.), Gender in the classroom: Power and pedagogy (pp. 1-27). Urbana, IL: The University of Illinois Press.

Soble, A. (1982). The political epistemology of masculine and feminine. In M. Vetterling-Braggin (Ed.), Femininity, masculinity, and androgyny-a modern philosophical discussion (pp. 99-127). Totowa, NJ: Littlefield, Adams, & Co.

Squires, T.E. (1995). Men in nursing. RN, 58 (7), 26-28.

Swanson-Kauffman, K., & Schonwald, E. (1989). Phenomenology. In B. Sarter (Ed.), Paths to knowledge: Innovative research methods for nursing (pp. 97-105). New York: National League for Nursing.

Taylor, B.J. (1992). Caring: Being manifested as ordinariness in nursing. In D.A. Gaut (Ed.), The presence of caring in nursing (pp. 181-200). New York: National League for Nursing.

Tomis, J. (1986). Nursing: On becoming a genderless profession. Imprint, 33(1), 17-18.

Trebilcot, J. (1982). Sex roles: The argument against nature. In M. Vetterling-Braggin (Ed.), Femininity, masculinity, and androgyny-a modern philosophical discussion (pp. 40-48). Totowa, NJ: Littlefield, Adams, & Co.

Trebilcot, J. (1982). Two forms of androgynism. In M. Vetterling-Braggin (Ed.), Femininity, masculinity, and androgyny-a modern philosophical discussion (pp. 161-169). Totowa, NJ: Littlefield, Adams, & Co.

van Manen, M. (1990). Researching lived experience: Human science for an action sensitive pedagogy. Albany, NY: The State University of New York Press.

van Manen, M., Bergum, V,.Smith, S., Ford, J., & Maeda, C. (1987, May) Research for action-sensitive-understanding. Symposium presented at the 6th Annual Human Science Research Conference, University of Ottawa.

Vestal, C. (1983). Men nurses-who needs them? Attitudes toward men in nursing. Imprint, 30(2), 55-59.

Vetterling-Braggin, M. (1982). Femininity, masculinity, and androgyny-a modern philosophical discussion. Totowa, NJ: Littlefield, Adams, & Co.

Villeneuve, M.J. (1994). Recruiting and retraining men in nursing: A review of literature. Journal of Professional Nursing, 10(40), 217-228.

Warren, M.A. (1982). Is androgyny the answer to sexual stereotyping? In M. Vetterling-Braggin (Ed.), Femininity, masculinity, and androgyny-a modern philosophical discussion (pp. 170-186). Totowa, NJ: Littlefield, Adams, & Co.

Watson, J. (1985). Reflections on different methodologies for the future of nursing. In M.M. Leininger (Ed.), Qualitative reserach methods in nursing (pp. 343-350). Orlando, FL: Grune & Stratton.

Watson, J. (1988). Nursing: Human science and human care, a theory of nursing. New York: National League for Nursing.

Watson, J. (1990). The moral failure of the patriarchy. Nursing Outlook, 38(2), 62-66.

Watson, J. (1994). Applying the arts and science of human caring. New York: National League for Nursing.

Weeks, J. (1987). Questions of identity. In P. Caplan (Ed.), The cultural construction of sexuality (pp. 31-51). London: Tavistock Publications.

Weiler, K. (1988). Women teaching for change: Gender, class, and power. Boston: Bergin & Garvey Publications.

Wood, J.T. (1994). Gendered lives: Communication, gender, and culture. Belmont, CA: Wadsworth Publishing.

College of Human Resources and Education
West Virginia University
Office of the Dean

February 12, 1996

MEMORANDUM

TO: Patricia Jean Hedrick Young

FROM: Ernest R. Goeres
Associate Dean

RE: Human Resources & Education H.S.#96-013

Title: "The Lived Experiences of Male Nursing Students With Caring"

Your Application for Exemption for your above-captioned research project has been reviewed under the Human Subjects Policies and has been approved.

This exemption will remain in effect on the condition that the research is carried out exactly as described in the application.

Best wishes for the success of your research.

cc: HRE Dean's Office File
Student Advising and Records
Patricia Obenauf, Advisor

304 293-5703 ⊐ 802 Allen Hall ⊐ P O Box 6122 ⊐ Morgantown, WV 26506-6122
Equal Opportunity / Affirmative Action Institution

Curriculum and Instruction
West Virginia University
College of Human Resources and Education
PO BOX 6122
MORGANTOWN WV 26506-6122

Cover Letter

My name is Patricia Jean Hedrick Young, RN, C, MSN. I am a nursing instructor who is working on Doctorate in Education (EdD.) in Curriculum and Instruction at West Virginia University. I am sending you this letter to ask you to participate in a nursing study, which will help me to fulfill the requirements for my degree. Your participation in this study will help to increase the body of knowledge about male nursing students and the theoretical framework of caring through your lived experiences as a student nurse.

If you decide to participate in this study, you will be interviewed for approximately one half hour to an hour. The interview will be audiotaped. You will be asked questions concerning your personal background, including your age, previous educational experiences, previous work/military experiences, as well as your lived experiences as a male student nurse concerning care and caring. You do not need to answer any of the questions that you do not want to answer; however, it would be greatly appreciated if you answer all of the questions.

Your participation in this study is voluntary. You are not required to participate if you do not want to participate. All the information you provide will remain confidential. There are no risks or harm associated with this study. Also, you may withdraw from this study at any time.

If you have any questions or concerns, please feel free to contact me any time at the following numbers: 304-336-7253 (home) or 1-412-223-3592 (work). Please leave a message if my answering machine answers your call. Your willingness to participate is greatly appreciated.

Semistructured Interview

Demographic Information

Age

Marital status

Number of children

Residence location (rural vs. urban)

Previous educational experiences

Previous work/military experience

Previous experiences as caretaker (child, parent, etc).

Interview Questions

(1) Tell me about your decision to become a nurse.

(2) Describe your perceptions of nursing prior to entering nursing school.

(3) How did you learn about caring?

(4) How has being in nursing changed how you view nursing?

(5) How do you see caring in nursing? Give examples of experiences where you provided caring.

(6) Is the caring you give different than caring given by female students? Is the caring you receive different than the caring received by female students? If so, what are the differences?

(7) Tell me about a situation in which you experienced caring from a faculty member.

(8) What do you see yourself doing in the next 20 years?

ABSTRACT

Fifteen male nursing students from four baccalaureate nursing schools in West Virginia participated in this phenomenological study. The phenomena of interest was the lived experiences of male student nurses related to caring. Demographic data was obtained in the interview process. Semistructured interview questions were used in the individual interviews, which were all audiotaped. The methodology used was based on the Swanson-Kauffman and Schonwald method, which entailed the four step process of bracketing, analyzing, intuiting, and describing.

Five themes were identified. The Primacy of Caring was the first theme. Characteristics of caring, the origins of caring, the lived experiences of caring as male student nurses, and the caring versus technology dichotomy were the essences of the first theme. The second theme was perceived gender differences relating to caring, which encompassed the essences of differences in caring provided by male and female students and perceptions of faculty caring related to gender. Perceptions concerning nursing education and nursing comprised the third theme. The first essence related to the perceptions concerning nursing education, while the second one contained perceptions of nursing and nurses. Stereotypes and gender were the four theme. Stereotypes about the sexuality of males in nursing and gender role assumptions were the two essences of the fourth theme. The last theme involved their future career directions. including future educational endeavors and career specializations.

VITA

Patricia Jean Hedrick Young, RN,C, BA, BSN, MSN

Education

1973 West Liberty State College: Bachelor of Arts in Education in Social Sciences Comprehensive

1977 West Virginia Northern Community College: Associate Degree in Nursing

1980 West Liberty State College: Bachelor of Science in Nursing

1987 West Virginia University: Master of Science in Nursing

1997 West Virginia University: Candidate for Doctorate of Education

Experience

1989 to present: Nursing Instructor at The Washington Hospital School of Nursing. Teach psychiatric, maternal /child, community, medical/surgical, and management and leadership nursing courses. Have been Chairperson of Acute Health Care Nursing, Management and Leadership in Nursing, and at present Nursing II. For 2 years ran a family support group for Caregivers. Have been a member and chairperson of various major committees and

ad hoc committees. Have been co-advisor for the Student Nurses Organization

Member of Sigma Theta Tau, Alpha Rho Chapter; West Virginia Nurses' Association, District I, where I have served as co-editor of the newsletter; Tri-State Psychiatric Nursing Association, of which I am presently Co-President-Elect and recent past President; American Association of University Women; National Organization for Women; active member of West Liberty Federated Church, where I belong to several committees, work with SHARE FOOD program, am substitute Sunday School Teacher, and am in the choir.