The Art of Caring: Male Nurses Providing Personal and Intimate Care With Female Patients

By

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A Thesis
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The Art of Caring: Male Nurses Providing Personal and Intimate Care With Female Patients

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A Thesis/Practicum submitted to the Faculty of Graduate Studies of The University of Manitoba in partial fulfillment of the requirements of the degree of

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ABSTRACT

An exploratory study of male nurses working in an acute care setting was undertaken using a person-centered interview approach with an ethnographic orientation. The study involved semi-structured interviewing of 15 participants who provided personal and intimate care with female patients. The aim of the study was to identify behaviours, strategies and interventions used by the participants to ensure that female patients under their care did not experience physical, emotional or psychological discomfort during the provision of personal and intimate care. King's conceptual framework, which addresses personal, interpersonal and social systems, was used to guide this study.

Data analysis revealed four main strategies used by the participants when providing personal and intimate care with female patients. The strategies were 1) Communication Strategies and Interventions; 2) Cognitive Strategies; 3) Emotive Strategies and Interventions; and, 4) Behavioral Strategies and Interventions. Workplace Settings or Situational Factors were also found to influence the provision of personal and intimate care.

The provision of personal and intimate care is a highly complex interaction requiring well-developed assessment skills and the ability to choose and adjust the appropriate strategy anytime during the provision of the particular nursing intervention. Implications for nursing practice, administration and education are identified. Recommendations for future research are discussed.

LIST OF APPENDICES

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CHAPTER I

STATEMENT OF THE RESEARCH AIMS AND OBJECTIVES

Introduction

In the last generation there has been a shift away from sex-role stereotyped professions. With increasing numbers, women are entering what in the past has traditionally been considered male dominated professions (Cummings, 1995; Villeneuve, 1994). Although females are being encouraged to enter professions such as medicine, law, engineering, accounting, science and other traditionally male oriented professions, there are still people within these professions and society that maintain sex-role stereotypical expectations. Until these expectations change, females may not always be completely accepted in some of the professions, but, with changing societal beliefs and values the impetus has begun to ensure that females are provided the same opportunities as males as far as career choice is concerned.

In general, one would be hard pressed to find disagreement with the premise that gender has nothing to do with the ability of persons to perform the required functions of their job. Unfortunately, although ability has nothing to do with gender, perceptions, cultural beliefs and values often influence the perceived ability or appropriateness of a particular gender (Arnold, Martin & Parker, 1988; Domar, 1986; Harr, Halitsky & Stricker, 1975; Kelly, 1980). There are people within society who still believe that male physicians are somehow more intelligent and knowledgeable than female physicians (Arnold, Martin & Parker, 1988; Harr, Halitsky & Stricker, 1975; Kelly, 1980). People should not be prevented from working in any area or in any occupation based on gender. Although "old boy" networks, role stress, harassment, tradition, and unwritten or unseen systemic forces or

pressures, as well as personal preference and choice are reasons that may prevent women from working as miners, fire fighters, correctional officers in male facilities, or urologists and orthopedic surgeons; there are no legal barriers that prevent women from entering these fields.

Unfortunately, the same career opportunities do not always hold true for males. Men also are redefining traditional sex-role occupations and have been entering what has traditionally been viewed as female dominated professions. Men are becoming telephone operators, dieticians, dental hygienists, and with increasing frequency, nurses. Although women are not prevented from working in particular areas of their chosen profession because of their gender, men do not always have the same rights and privileges, strictly because they are male.

In some jurisdictions in the United States male nurses have been legally prevented from working in obstetrics simply because they are male, and the type of care required in these areas includes personal and intimate care of a female patient (Brown, 1986; Greenlaw, 1982; Hall, 1993; Ketter, 1994; Trandel-Korenchuk & Trandel-Korenchuk, 1981; Villeneuve, 1994). Much discussion has occurred regarding the appropriateness of having opposite sex care givers in areas where personal and intimate care is required. Why is being cared for by a male nurse any different than being cared for by a male physician? Why should a person's gender affect their professional role and their ability to provide morally and ethically sound care? What is it specifically about nursing that permits a blatant form of sexual discrimination to be acceptable by a number of courts in the United States (Brown, 1986; Greenlaw, 1982; Ketter, 1994)?

Perhaps the answer lies in the arguments put forth by those who are against male

nurses working in areas requiring personal and intimate care with female patients. Their response to the above questions is that physicians are viewed as performing medically required procedures and tasks that may necessitate brief observation, manipulation and temporary intrusion into the personal space or privacy of the patient. Nurses, on the other hand, are viewed as providing not only those necessary procedures and tasks that have a nursing or medical basis, but also performing many of the most intimate and personal tasks normally carried out by the person their self, such as assisting with hygiene and elimination. This perspective may arise from the fact that women have traditionally been the caregivers of the family and society from birth to death. The hygiene and elimination needs required by children until they were able to perform these functions themselves were, and to a large extent still are, expected to be carried out by women. It was a natural extension for women to perform the same type of care for those adults who required assistance with bodily functions. This practice however was not expected of men, and this may be one reason that some people argue against males providing nursing care.

There are very few professions in the world necessitating the performance of procedures and duties that would normally be considered an invasion of the personal privacy, boundary or space by the majority of people. Because personal privacy can have psychological, emotional, spiritual, cultural or intimately physical components (Barron, 1990; Carlson, 1991; Estabrooks & Morse, 1992; Glen & Jownally, 1995; King, 1981; Scott, 1993; Seed, 1995), it is important that the person performing these functions do so with the utmost attention to the effect these duties have on the recipient.

Those professions that, at times, not only require the sharing of deeply personal and intimate information about the patient, but also the consenting acceptance of having the

body exposed, poked, prodded, invaded or in some way manipulated (oftentimes with a whole entourage of other people of varying levels of educational attainment present) are commonly referred to as the helping professions. These helping professions are generally the professions that deal with health care.

The two professions most commonly associated with the physical exposure and manipulation of the body, are medicine and nursing. It is acknowledged that many health care professions (eg. radiology and physiotherapy) require the exposure and manipulation of the body. However, it is in medicine and nursing that the majority of people accept, sometimes grudgingly, but more commonly willingly, the concept that they may be required to disrobe, expose and allow to be manipulated, poked or prodded any area of their anatomy that the doctor or nurse deems necessary. They do this with the understanding that any or all of these procedures, manipulations or invasions are necessary to achieve a desired goal. That goal, is the complete, thorough and appropriate provision of health care. This ensures that the recipient of the health care has the opportunity to attain his/her highest potential level of health and wellness.

Many people acknowledge the need for certain procedures to be performed on a routine basis that will promote good health by early recognition of potentially serious diseases, conditions or threats to the body's integrity. Many women perform monthly breast self-examinations and there are men who perform regular testicular self-examinations. Few would argue the appropriateness or need for these procedures to be performed and even fewer people would have concerns or reason to not perform these basic health-promoting behaviours. However, there are many people who do not perform these preventative behaviours, and there are myriad reasons for their decisions. Time constraints, lack of

knowledge, being unconcerned or unmotivated, and fear, are just some of the possible reasons that people will not have the procedures done or will not perform them themselves.

Other reasons that some of these behaviours may not be performed are modesty as well as personal, familial, societal and cultural expectations, inhibitions and restrictions. To touch oneself, or to be touched, in areas of the body that through the ages have been given the connotation of being "dirty", "unclean", "unwholesome", "ungodly", "not nice" and "untouchable" can create a psychological deterrent for some people. The above-mentioned behaviours have been for the most part deeply ingrained in many societies (including to some extent our North American, Western society). If indeed, a person will not perform certain health promoting behaviours on themselves due to modesty or the perception that it is unacceptable according to society's standards; it is not surprising that this person would feel embarrassed or emotionally or psychologically distressed if certain procedures had to be performed on them by someone else. It can be assumed that this discomfort would only be intensified if the person performing the necessary procedure were a member of the opposite sex.

Background Information

A male nurse had the opportunity to care for a female patient in an outpatient dialysis area. Through time the patient and nurse got to know each other and were comfortable in sharing information. The patient told the nurse that although she thought he was a good nurse, if she ever had to enter hospital as an inpatient, she would not want him to care for her because he was a male. The patient had unstable diabetes and inevitably had to be hospitalized. As fate would have it, the male nurse was assigned to care for the patient. The patient was very ill and for a period of time had to have assistance with all aspects of

her care. During this time the patient had no concerns whatsoever as to the gender of the nurse caring for her. The nurse provided the required care and nothing negative ever resulted from the situation. This situation identifies two variables that may have to be considered when opposite-sex caregivers provide personal and intimate care. The first variable is: How well does the nurse and patient "know" each other? And the second variable is: Does level of health influence gender acceptance?

Another male nurse described a situation that he encountered as a general duty staff nurse. He was working nights with another registered nurse in a coronary care unit. A call light went on and the nurse went to see what the patient wanted. The female patient wished to use the bedpan but asked the nurse if she could have the "other" nurse come and help her. The nurse acknowledged the patient's request and asked his partner to go assist the patient onto the bedpan. When the second nurse went into the patient's room the patient again asked for the "other" nurse. The second nurse left and sent back in the first nurse. It was at this point that the nurse realized that the patient wanted a female nurse to help her onto the bedpan, however, there were only two nurses on that evening and both of them were male.

A male nursing student had the opportunity to care for a young female patient during the maternity rotation of his program. The patient was approximately the same age as the student. The instructor informed the student that he had to apply a breast binder to this patient as she had decided to not breast feed her baby. The student was aware that to prevent engorgement of the breasts a binder had to be applied and although he had practised this in the learning lab, he had never done this with a real patient. He went into the patient's room and informed the patient what was about to occur. Even though the student was anxious and concerned about doing the procedure correctly, he was empathetic enough to notice that the

patient appeared very uncomfortable with the idea of this young man performing the procedure. The patient's discomfort increased the student's anxiety as the student felt embarrassed for the patient. Even though his instructor was present, his fingers turned into ten thumbs and the student proceeded to "manhandle" the patient's breasts until the binder was finally in place. That evening the student reflected back on the experience and decided that if he was going to remain in nursing, he had better find a way to "handle" situations that required personal and or intimate care to be performed on a patient, especially a patient of the opposite gender.

Significance of the Problem

> "Nursing involves not only doing things which are traditionally assigned to females, and learning to do them by experience and practice, but also crossing social boundaries, breaking taboos and doing things for people which they would normally do for themselves if they were able" (Lawler, 1993, p. 30).

The above vignettes provide three examples of situations where male nurses have needed to provide personal and intimate care with female patients. In these situations a common concern expressed by the patients was that a male, rather than a nurse, was about to do something with, to, or for them and the women consequently felt anxious or uncomfortable.

There may be a double standard in today's society regarding the acceptance of male nurses providing personal and intimate care with female patients. Personal perspectives, cultural beliefs and values, and societal expectations influence a person's acceptance or rejection of an opposite-sex caregiver. Neither gender should be forced to accept a caregiver of the opposite sex if the idea of being cared for by this person creates emotional or

psychological discomfort. It is important for the overall health of the patient to accommodate the patient's wishes as much as possible. Society accepts and expects their caregivers to be female. With this expectation is the implied acceptance that although they may not appreciate the need for personal and intimate care to be provided by the nurse, it is alright for the nurse to provide this care as long as the nurse is female. If the nurse happens to be male, however, then the implied acceptance for the provision of personal and intimate care is not as evident. Being cared for by a male nurse is fine as long as personal and intimate care is not required. Interestingly, due to society's acceptance and expectation that females will be the caregivers, it is infrequent that one hears a concern from a male patient about the personal and intimate care that was provided by a female nurse.

Perhaps one of the most disconcerting aspects of the concern expressed by female patients having personal and intimate care provided by male nurses, is the implied connotation that male nurses for some reason cannot be considered professional enough to perform these duties solely because of their gender. Cole (1993) writes that male nurses are the perpetrators of much of the physical, mental and sexual abuse inflicted upon patients. One cannot however generalize the inappropriate behaviors of some male nurses to all males in nursing. The implication that male nurses, because of their gender, cannot be trusted to provide morally and ethically sound personal and intimate care, is tantamount to agreeing with Savage (1989) and Watson (1991) who comment that some people believe that female nurses are sex objects. The potential for the patient (male or female), or the nurse (male or female), to sexualize the intimate and personal care provided cannot be taken lightly and needs to be addressed by the nursing profession (Lawler, 1993; Savage, 1989; Watson, 1991). This brings us to another aspect, and that is, the concept of touch or

touching.

Touch

"Nurses touch strangers (patients) in ways totally unacceptable in any other context" (Carlson, 1991, p. 225). Touch is a multi-faceted concept that includes not only the actual skin to skin physical contact, but also a psychological and emotional component. "Touching can be associated with pleasure, satisfaction, and rewards or with anxiety and punishment" (Burd and Marshall, 1963, p. 297). Touch can be a positive or negative experience and it can mean different things in different situations. Touch is a form of communication and the message received frequently results from the context that the touching occurs. People learn "the socially acceptable norms of touch from outside the family" and "learn that touch rarely connotes simply comfort in our culture, but rather is laden with implicit sexual meaning" (Estabrooks and Morse, 1992, p. 451). Jourard and Rubin (1968) state that "touching is equated with sexual intent, either consciously, or at a less-conscious level" (p. 47).

Therefore is it the actual touching of the patient that causes concern, or is it the type of care being performed? Could it be the sexualizing of the touching that is at the root of the concern? Maybe it's a combination of all of the above? If one considers touch by itself there is only the physical aspect whereas, if one tries to empathize by considering the feeling evoked from the touch then there is an undeniable connection between the two (Hollinger & Buschmann, 1993).

If female patients feel uncomfortable, either psychologically or emotionally, when they have personal and intimate care performed on them by male nurses, what then is the actual cause of this discomfort? Touch is a form of communication, so it is imperative that the nurse doing the touching communicate what this touch means, and what task needs to be

accomplished.

This interaction will ultimately result in the attainment of a goal mutually agreed upon by the nurse and patient. A conceptual framework that lends itself to the interaction necessary to accomplish the above goal is the framework proposed by Imogene King (1981).

Conceptual Framework

Appendix A provides a visual representation of the conceptual framework posited by Imogene King (1981). This framework deals with the concept that nursing is a discipline focusing on the care of human beings. The premise of the framework is that "human beings are open systems interacting with environment (sic)" (King, 1981, p. 10). These interacting systems are dynamic and include a central personal system that incorporates the individuals included in the interaction. A middle interpersonal system encompasses the groups to which these individuals belong while the surrounding social systems represent society (King, 1981).

Each of the above systems are comprised of concepts that enable one to better understand the system as a whole and how all three systems are interrelated. Each concept in its respective system will be addressed with the ultimate goal being to identify how that particular concept relates to the previously mentioned concerns of male nurses providing personal and intimate care to female patients.

Personal System

The personal system is comprised of the concepts of perception, self, body image, growth and development, time and space.

Perception

King (1981) describes perception as being a representation of reality related to past experiences, the concept of self, biological inheritance, education and socioeconomics of the person. King further characterizes perception as being universal, subjective, personal, selective, action oriented in the present and includes transactions. The perceptions of the nurse and patient are important considerations when personal and intimate care has to be provided. If the perceptions of either participant in the interaction is negative then it will make the interaction that much more difficult or perhaps even impossible. "An important element in nurse-patient interactions is accurate perception of each by the other. This accurate perception is a first step toward mutual goal setting and toward exploring means to move toward those goals" (King, 1981, p. 24). Even with an accurate perception of the situation, a female patient may be embarrassed or uncomfortable with a male nurse providing personal and intimate care. However, without an accurate perception of the situation, there may be an increased likelihood that a female patient may become embarrassed or become uncomfortable in a situation requiring the performance of personal and intimate care by a male nurse. It is therefore important for the nurse to assess the perception of the patient and to strive to deal with any misperceptions the patient may have as to the purpose of the interaction. The perception held by the patient is influenced by the person's concept of self.

Concept of Self

"Self is what I think of me and what I am capable of being and doing. Self is subjective in that it is what I think I should be or would like to be (King, 1981, p. 26). The self is characterized as being dynamic, an open system and goal-oriented. Because the self is

dynamic it is open to change. Change may occur if the individual experiences inconsistencies in their beliefs or values. When discrepancies occur "the self tries to avoid them or clarify them" (King, 1981, p. 26). If a female patient is introduced into a situation different from her own beliefs and values, such as being cared for by a male nurse, she may try to avoid the situation or clarify her own concept of self. It is important for the male nurse to be aware of how the concept of self can be altered and how the situation may be inconsistent with the patient's own beliefs and values. These beliefs and values often are related to the person's developmental level.

Growth and Development

King (1981) does not provide a great deal of information about how growth and development affects the personal aspect of the framework. She does, however, discuss how growth and development includes changes in cells, molecules and behaviours that are dependent on genetics, meaningful and satisfying experiences and environmental impact. This aspect of the personal system is important for male nurses to consider because at certain stages in an individual's growth and development the idea of privacy is of utmost importance. If a male nurse had to provide personal and intimate care to an adolescent or teenage female, the possibility of patient discomfort with the situation may be much greater than for a female patient in a different developmental stage. This possible concern deals with the next concept of the personal system, and that is, the concept of body image.

Body Image

Body image is personal and subjective. It is also a dynamic concept that changes throughout a person's lifetime. It is important for nurses to be aware of how a person's body image affects the patient's self-concept. If a male nurse needs to provide care to a female

patient who has had a mastectomy, the change in body image of the patient may affect her self-concept as well as her perception of the situation. This may result in a feeling of discomfort experienced by the patient because of the individual's beliefs and values surrounding sexuality and the meaning a woman's breasts have in society. The concepts of body image and self directly affect the person's perceived concept of space.

Concept of Space

King (1981) included space in the personal system of the framework because of how individuals use space, and how it is related to perception and body image. She characterized space as being universal; personal - that is, it is learned and communicated through the person's culture; situational - that is, the need for space can be expanded or contracted depending on the situation; dimensional and transactional - that is, the use of space is dependent on the perception of the situation. The need for nurses to be aware of the concept of personal space is important because of:

> "the close distance that is involved when giving personal care to patients. Many procedures are performed in the intimate zone described by Hall (1963). Some patients may view touching as a comfort and a sign of caring while others may view it as a discomfort and a frightening sign" (King, 1981, p. 38).

King goes on to say that:

> "Defense of personal space can be observed by people's gestures, postures, and the visible boundaries they erect to protect their space from trespassers. Use of space and defense of space is non-verbal communication. The change in distance between people as they interact tends to communicate different messages to different people" (1981, p. 38).

It is this personal space that is infringed upon when a male nurse needs to provide personal and intimate care with a female patient. The patient's perception, self-concept, growth and development, and body image all play a factor in the personal space the person identifies as theirs. Time is the final concept in the personal system that impacts on the interaction of the patient and the nurse.

Time

King (1981) characterizes time as being universal, relational, unidirectional, measurable and subjective. The two characteristics of time specifically relevant to the care of patients are that time is subjective and relational. It is the person's perception of time and the situation in which something occurs that affects the concept of time. If a patient perceives a situation as uncomfortable they will then also perceive the situation as taking longer than it actually did. Because time is subjective, the meaning of the situation and how the patient perceives it will define the length of time a procedure took to accomplish. This length of time may be shorter or longer than the real amount of time the procedure actually took.

Personal System Summary

The concepts of perception, self, body image, growth and development, time and space all affect how a person or patient will act or react in a given situation. People's perceptions, their past experiences and their beliefs and values all play a factor in how they communicate with other people. When a male nurse has to provide personal and intimate care with a female patient the personal systems of the patient and the nurse influence how the interaction will proceed. The means to attain an acceptable outcome regarding the goals of the patient and nurse are dependent on the concepts of the next system. King's second

system, the interpersonal system addresses how one's personal system affects interpersonal communication.

Interpersonal System

King's conceptual framework identifies the concepts of interaction, communication, transaction, role and stress as the components of the interpersonal system (1981).

Interaction

The process of human interaction, that is, nurse-patient interactions, incorporates the concepts of the interpersonal system (Appendix B). "The process of interactions between two or more individuals represents a sequence of verbal and non-verbal behaviors that are goal-directed" (King, 1981, p. 60). When a male nurse and female patient begin interacting with each other they bring the totality of themselves to the situation. Therefore, they each perceive the other person and the situation, make judgements, take mental action or make a decision to act and react to each other and the situation (King, 1981). This interaction is accomplished through communication.

Communication

Communication is used "to identify concerns and/or problems" or "to share information that assists individuals in making decisions that lead to goal attainment" (King, 1981, p. 146). The interaction and communication that occurs between a male nurse and female patient when personal and intimate care is required will ultimately decide just how the next concept in the framework will occur, and that is, transaction.

Transaction

Transaction includes the aspects of bargaining, negotiating and social exchange. It is during transaction that values and commonalities are shared between the nurse and patient

thus promoting the attainment of mutually agreed upon goals. However, these transactions are influenced by role expectations and role performance (King, 1981).

Role

Roles are learned while interacting within the social systems of a society. The "role of a nurse can be defined as an interaction between one or more individuals who come to a nursing situation in which nurses perform functions of professional nursing" (King, 1981, p. 92). In a situation where a male nurse provides personal and intimate care for a female patient there is a possibility of role conflict both from the patient's perspective or the nurse's perspective. This conflict may result in the development of stress, which is the final concept in the interpersonal system.

Stress

King (1981) describes stress as dynamic, individual, personal, subjective and having a temporal-spatial dimension. King also discusses the importance of being able to identify stressors within the patient's environment and to alleviate these stressors. If a female patient is stressed because of the gender of the person providing her care, then it is up to the nurse to be able to identify what is causing the stress or discomfort. The nurse must then do something to help alleviate or at least minimize the stress, and this may include the decision to not provide the care.

Interpersonal System Summary

The concepts of interaction, communication, transaction, role and stress comprise the interpersonal system. It is the interaction and communication between the nurse and patient that allows the transaction of goal attainment to occur. The role a person has in a particular situation, such as a male nurse providing personal and intimate care with a female

patient, can create some concern if the role is not congruent with the beliefs and values of the recipient of the care. This incongruence in role expectation, or the possibility of role strain can create stress. Some of the stress felt may result from the beliefs, expectations and values of the society from which the patient or nurse comes. These societal aspects are considered in the last system of the conceptual framework, the social systems.

Social Systems

"A social system is defined as an organized boundary system of social roles, behaviors, and practices developed to maintain values and the mechanisms to regulate the practices and rules" (King, 1981, p. 115). King goes on further to discuss how these systems:

> "provide the framework for social interaction, define social relationships, and establish rules of behavior and modes of action. Beliefs, attitudes, values, and customs are learned within social systems, such as family, school, and church" (p. 114).

The concepts of a social system that have relevance to nursing are: authority, power, status, organization and decision making (King, 1981).

Authority

"Authority is power to make decisions that guide the actions of self and others" (King, 1981, p. 122). Authority is situational. Society and organizations within society, such as hospitals, have provided nurses with the authority to practice nursing and all that it entails and to make nursing decisions based on the needs of the patients (King, 1981). This would include the provision of personal and intimate care to patients requiring assistance. To be able to accomplish these interventions the nurse must have the power to do so which

is the next concept of the social system.

Power

King (1981) describes power as "an ability to control events and behaviors in specific situations" (p. 127). Because power is situational a person may have legitimate power in one setting while in another situation the person would be powerless (King, 1981). This is readily evident in the authority a nurse has to cross personal space and boundaries, generally defined by society, to touch or observe areas of a person's body that, in another situation they could be charged with a crime. A related concept to power and authority is status.

Status

Status relates to a person's role. It is the prestige attached to a position and once again is situational. Status can be achieved, for example, becoming a registered nurse, or it can be ascribed through birth, such having a higher social class (King, 1981). The concept of status could have some influence on the patient's perception of the situation and thus affect the interaction between the nurse and patient.

Status, power and authority are interrelated concepts that affect the communication between the patient and nurse. The interaction between patient and nurse should be one of mutuality and agreement in goal setting. However, some societies (including to some extent our own North American society) bestow upon certain disciplines a degree of power, authority, and status that other members of society do not possess.

If a female patient perceives the male nurse as having power and or authority, then they may accept any care received from the nurse without question. If the patient believes or feels that the nurse's status as a nurse necessitates the acceptance of care provided then

again, there may be no noted voiced concern. However, if the patient or the nurse believe that there is a mutuality of respect in the interaction, and, that the nurse has no special power, authority or status over the patient, then the patient should feel confident enough to voice concern if the nurse providing their care makes them uncomfortable because of their gender. The next concept in the system is important because the organization in which the nurse works may regulate situations that could cause concern for patients or nurses.

Organization

This concept is important in that the previous three concepts require the organization to acknowledge the authority, power and status of the nurse. If the organization believes that any nurse has the professional right to provide personal and intimate care to patients of either gender, and the patient is uncomfortable in the situation, then the patient may be affected. If, however, the organization does not agree with nurses providing personal and intimate care to patients of the opposite sex, then it is the nurse and the nursing profession that will be affected. The discomfort a patient may experience from being subjected to personal and intimate care provided by an opposite-sex nurse must take precedence over the nurse's or the profession's concern about a nurse being refused the opportunity to provide nursing care solely because of the nurse's gender. That is, after all, what being a nurse is all about. However, the appropriateness of any member of a profession being prevented from performing some aspect of their job, solely because of their gender, has to raise concerns as to the power and authority the profession has regarding the actions of its members. The provision of personal and intimate care by a male nurse with a female patient requires the male nurse to make some critical decisions, which is the last concept of the social system.

Decision Making

Ultimately, the decision making ability of the nurse in a particular situation should provide the necessary ingredients to ensure that the patient does not feel uncomfortable. It is the ability of the nurse and patient to interact and communicate with each other that will decide the outcome of the situation, that is, if the patient is uncomfortable or comfortable with the care being provided by the male nurse. It is understood that the perceptions of each participant in the situation have been influenced by the social systems that each of the participants were exposed to throughout their life.

Summary of Social System

The social system is a mechanism to ensure the beliefs, values, attitudes and customs of a society are upheld. Within a social system there are people, such as nurses, who are provided certain rights and liberties because of the authority, power and status they hold within the society. Organizations within which nurses work determine if nurses are provided the authority, power and status to provide all aspects of professional nursing care. If the organization supports male nurses to provide personal and intimate care to female patients, it is important that the male nurse be able to identify a patient's discomfort in the situation and make the appropriate decisions that will help achieve the mutual goals of the patient, nurse and organization.

Summary of Conceptual Framework

King (1981) has identified the personal, interpersonal and social systems within a society as a conceptual framework for nursing. The perceptions of the individuals involved in a particular situation, such as a male nurse providing personal and intimate care with a female patient, are important influencing factors in how the interaction and transaction will

progress. The process of communication and the need for accurate perceptions of the situation will influence whether or not the goals of the patient and nurse are accomplished.

The social systems within which the participants belong provide certain rights, liberties and status not given to every member of society. The authority and power provided and accepted by society includes the provision of personal and intimate care by a nurse for a patient requiring assistance. Societal acceptance understands that to be able to perform such care, the standard space and boundary limits normally established by the person must be breached. It is this infringement into the patient's personal space and intimate areas of the body that may cause concern for a female patient if a male nurse is performing the required care. This brings us to the purpose of the study.

Purpose of the Study

The purpose of this study is to explore and better understand the strategies, behaviors and interventions used by male nurses when they provide personal and intimate care with female patients in order to minimize any psychological or emotional discomfort that the care might create. When a nurse has to provide personal and intimate care with a patient there is a risk that the touching and exposure required to accomplish the procedure will be perceived as an invasion into the patient's personal space and will create feelings of anxiety, stress or discomfort (Allekian, 1973; Brown & Yantis, 1996; Carlson, 1991; Estabrooks & Morse, 1992; Glen & Jownally, 1995; Scott, 1993; Stillman, 1978). It is an accepted societal norm that caregivers have traditionally been female and therefore the majority of nurses are female. However, the numbers of males entering the nursing profession is increasing and society is witnessing and coming to accept the caring capabilities of males.

However, it appears that even though males are becoming accepted as nurses, there are situations in which the gender of the nurse is cause for concern because of the nature of the nursing interventions required. It seems that the performance of personal and intimate care by a male nurse with a female patient can create psychological or emotional discomfort strictly because the person performing the procedure(s) is male (Lemin, 1982; Mathieson, 1991; McCann, 1991; Haywood, 1994; Saunders, 1981; Seed, 1995; Taylor, 1981; Woodhams, 1984).

It is important for nurses to try and alleviate any discomfort experienced by their patients. Therefore, it is of utmost importance to identify strategies, behaviors or interventions that could be utilized by a male nurse when the need for personal and intimate care is required by a female patient, if the care required causes psychological or emotional discomfort because of the nurse's gender.

Problem Statement

The problem statement can be expressed as follows:

What are the strategies, behaviors and interventions used by male nurses in the provision of personal and intimate care with a female patient that enables the patient to feel psychologically and emotionally comfortable?

Research Questions

The lack of research in this particular area of nursing provides opportunity for additional questions to arise from the problem statement. A secondary purpose of this study is to explore the following questions:

1. From the male nurse's perspective, is there an actual or perceived concern by patients or society with the concept of male nurses providing personal and

intimate care with female patients?

2. Are there circumstances or situations in which the performance of personal and intimate care by a male nurse with a female patient is acceptable, and, at other times not acceptable for the patient?

3. When a male nurse provides personal and intimate care with a female patient, what verbal and non-verbal behaviors indicate to the nurse that the patient is experiencing psychological or emotional discomfort with the situation?

Definitions

Personal space or boundaries are often used interchangeably and have had many variations in their definition. Scott (1993) describes Louis's (1981) definition of boundaries as "the outer limits of an invisible area that an individual designates as personal space" (p. 13). Carlson (1991) describes boundaries as "an individual's internally developed physical and psychological limits" that " provide a structure that separates one from the surroundings" (p. 226). Boundaries or physical space are dynamic in that they can expand or contract depending on the needs, wants and perception of the individual.

When performing personal and intimate care on female patients, male nurses are required to touch the patient. The concept of touch is multidimensional and will be defined as "a gestalt involving voice, posture, affect, intent and meaning within a context, as well as tactile contact" (Estabrooks & Morse, 1992, p. 450).

Personal and intimate care will be used throughout the study as a single interrelated concept. Webster's dictionary (1994) defines personal as "individual, private, of one's own"; and, intimate, as "familiar, closely acquainted or close". In this study, the definition of

personal and intimate care will be: the provision of a nursing intervention or procedure requiring the exposure and or touching of an area of the patient's body that would generally only be exposed or touched by the person themselves or possibly, by a significant, intimate other.

The final term that will be used throughout this study is the concept of comfort. Comfort is a term that defies easy definition. It has been described as being free from discomfort or dis-ease (Cameron, 1993; Kolcaba & Kolcaba, 1991), as well as having the components of touch, empathy and talking (Morse, 1983). For the purpose of this study, comfort will be defined as contentment and calmness resulting in a physical and mental feeling of wellbeing.

CHAPTER II

REVIEW OF THE LITERATURE

Introduction

This literature review will focus on studies and declarative articles which will enable the reader to become more fully aware of how significant the provision of personal and intimate care is for the emotional or psychological comfort of female patients when being cared for by a male nurse. Societal expectations and norms surrounding sexuality, modesty, taboos and sex-roles will be analyzed and discussed as will the types of care provided to patients. Also, the same societal expectations and norms will be considered from the male nurse's perspective.

In any basic fundamentals of nursing textbook, comfort and the provision of privacy are two aspects of nursing that are considered important when providing care to patients (Potter & Perry, 1997; Taylor, Lillis, & LeMone, 1993). Comfort is experienced when the physical, emotional and psychological needs of the individual patient are met (Cameron, 1993; Hamilton, 1986; Kolcaba and Kolcaba, 1991; Morse, 1983). If a patient experiences discomfort when being cared for by a nurse it is important for the nurse to be aware of the potential causes of that discomfort. One of the possible causes for emotional or psychological discomfort, is the perceived lack of privacy or embarrassment experienced by patients when nurses are required to provide the personal and intimate care necessary to render safe, competent and professional nursing interventions.

In developed countries, almost without exception, it is an accepted societal expectation that unless a person is in the appropriate situation with the appropriate person,

men and women do not normally touch, nor do they observe the naked bodies of others, especially if the other person is of the opposite sex. If that supposition regarding societal norms is correct, then it follows that if a person is required to be touched or to have their body exposed to someone of the opposite sex, the potential exists for that person to feel uncomfortable in that situation.

Comfort

Comfort is an ambiguous and personal concept. In one situation a person may feel physically, emotionally and psychologically comfortable, while in another similar yet different situation that same person may feel uncomfortable. For example, a female walking with another female down a deserted, dark alley at night may not feel physically safe and may be emotionally and psychologically uncomfortable. If that same female walks with a male down the same alley at night she may feel safer and more psychologically and emotionally comfortable. That same female as a patient requiring a personal and intimate nursing intervention, such as perineal care or a catheter insertion, may feel more psychologically or emotionally comfortable if a female nurse rather than a male nurse provides the necessary intervention.

Importance of Comfort to Nursing

Nursing textbooks; nursing standards and major theorists such as Orlando, Roy, Paterson, Watson and others; as well as society in general, all believe that the provision of comfort is such a basic tenet of nursing that it is embodied into the realm of nursing (Cameron, 1993; Hamilton, 1989; Kolcaba and Kolcaba, 1991; Morse, 1983; Potter and Perry, 1997). Therefore, providing comfort is synonymous with providing nursing care.

The literature suggests that comfort is inseparable from nursing. Nurses need to be

aware that the quest for comfort is genderless in that all patients want to be comfortable regardless of their sex. One possible cause for the patient to feel uncomfortable is if they are embarrassed by the personal and intimate nature of the nursing or medical intervention required for their care. Although embarrassment or discomfort may occur with male patients being cared for by a female nurse, or for that matter a male patient with a male nurse or a female patient with a female nurse (George and Quattrone, 1989), there is a lesser probability of an emotional or psychological discomfort being felt when a female nurse provides the necessary nursing care. The reason for this is that since most nurses are women, society has come to expect and accept that the care they receive from nurses will come from a female nurse (Dowler, Jordan-Simpson and Adams, 1992; Hesselbart, 1977; Struthers, 1995; Villeneuve, 1994).

Nurses have to be empathetic enough to know if their actions are providing not only physical comfort but also the psychological and emotional components of comfort that their patients desire. The type of care patients expect from nurses is described by Bottorff (1991) as a sense that "the nurse is close enough to feel with us, sharing the loss that accompanies the dis-ease we are experiencing in a sensitive, intimate way" (p. 244).

Strategies that nurses can utilize to promote comfort when caring for patients have been discussed by Morse (1983), Armitage (1983), Hamilton (1989) and Cameron (1993). These authors acknowledge the necessity to ensure that all aspects of comfort are addressed when caring for patients. If the actual nursing interventions result in discomfort for the patient, nurses must attempt to find ways to minimize that discomfort. However, if it is not the nursing intervention itself that causes the discomfort, but rather the gender of the nurse performing the intervention that is causing the discomfort what then can, should, or does the

nurse do to help alleviate that discomfort? There is little research on what male (and female) nurses do in these situations, however, this literature review will focus on the care received by female patients from male nurses.

Importance of Comfort to the Patient

The lower-level needs in Maslow's hierarchy of basic human needs include physiological, and safety and security needs (Potter and Perry, 1997; Taylor, Lillis and LeMone, 1993). If one accepts the premise that having one's lower-level needs met (which include physical and emotional or psychological components) causes one to feel comfortable, then being comfortable is a basic underlying expectation that all patients have or require when they are hospitalized. Various studies have investigated comfort from the patients' perspective and have found that in order for the patient to feel comfortable their physical, emotional and psychological needs must be met (Cameron, 1993; Hamilton, 1986; Kolcaba and Kolcaba, 1991; Morse, 1983).

Utilizing a qualitative research approach, Cameron (1993) investigated the nature of comfort employing in-depth interviews and participant observation methodologies to gather data from ten participants. Conclusions from the study indicated that during hospitalization, patients progress along a "comfort continuum" (p. 426) and through a process called "integrative balancing" (p. 434) actively work at seeking and attaining comfort through strategies delineated as monitoring, networking and enduring. Anything causing an uncomfortable feeling on the part of the patient started the process.

Monitoring involved seeking information regarding all aspects of their hospitalization. It included finding out about the doctors, nurses and "their socially correct or appropriate behaviour as a patient" (Cameron, 1993, p. 428). By observation, the

respondents were able to learn how to act as patients.

Networking provided information to the respondents by building a social network with other patients. A greater sense of comfort was expressed when the respondents knew that other patients were experiencing the same situations.

Enduring was a private self-comforting activity which ultimately involved "delving deeply within one's self, reviewing the past, grieving, revising, hoping and eventually integrating this experience into their lives" (Cameron, 1993, p. 430). During this stage the respondents believed that with time the situation would improve. Participants, researchers, former patients and nurses validated Cameron's results.

This study is important in that if a female patient is uncomfortable being cared for by a male nurse then the strategies of monitoring, networking and enduring may be initiated by the patient to try to actively attain an acceptable level of comfort. By observing how other female patients react and respond to the male nurse, by asking questions about the male nurse and by looking at their past experiences, beliefs and values, the patient may be able to confirm, or, she may need to re-evaluate previously conceived ideas about male nurses. This is similar to the concept of self as proposed in King's (1981) personal system. Alternately, the patient may decide to grieve the loss of her privacy, hope the embarrassment will pass and endure the situation, wanting it to end as soon as possible.

In a study analyzing comfort, Morse (1983) utilized what she called an ethnoscientific method of data collection. Utilizing a convenience sample of four Anglo-American females, Morse (1983) found that touching and talking were two main components of comforting. The amount of touching or talking required or appropriate when comforting someone depended on the situation and "the appropriate role-relations between

actors" (p. 12). Morse found that touching and hugging could only be used when there was an intimate relationship between the participants while talking-only was appropriate for strangers but inappropriate if a relationship had been established. Of significance to nursing were Morse's findings that touching with a little talking was appropriate for people who are sick, ill or in labour. This appears to provide one rationale as to why it is acceptable for nurses to intimately touch strangers. Another aspect is that although nurses are strangers when they first meet the patient, the context of the meeting and the usual scenario of the interactions creates the need for a relationship to develop and therefore talking alone is no longer appropriate for the situation.

The focus of the study was on comfort between the respondents and their husbands, children (their own and others), friends, self and strangers. No information was provided as to whether or not the respondents were questioned about male nurses providing care to female patients. Since in-depth interviewing provides more valid information and a more accurate understanding of the interviewees lived experiences (Simms, 1980; Williams & Heikes, 1993); the fact that it was white Anglo-American women who were interviewed is pertinent to this literature review, as the majority of the studies and articles reviewed, engage white Anglo-Saxon sample populations from North America or the British Commonwealth.

Hamilton (1989) interviewed 30 patients in a chronic care geriatric hospital. Her findings indicated five major themes that addressed comfort from the patients' perspective. Disease process, self-esteem, positioning, the approach and attitudes of staff, and hospital life were deemed important in the overall comfort experienced by the patients. Once again biological, emotional and psychological aspects are present in these themes and therefore

demonstrate some reliability as to the comfort needs that patients have when hospitalized. However, only 28% of the patient population met the criteria required to be included in the study. Therefore, the results may be questionable since 72% of the elderly population in that hospital were not questioned as to their comfort needs. Those patients unable to be interviewed because of a language barrier or physical incapacity may have had other comfort needs that were not elucidated during the research study.

Kolcaba and Kolcaba (1991) completed a literature review that analyzed the concept of comfort. The authors found six ordinary language meanings of the word comfort and discussed how those meanings are used in nursing. Comfort needs of patients were developed and divided into three classes of needs: "the need for being in a comfortable state", "the need for the relief from discomfort", and "the need for education, motivation and/or inspiration" (p. 1305). Their analysis provides further confirmation that as far as the patient is concerned, comfort means relief from physical, mental and emotional discomforts.

In summary, the literature on the patients' perspective related to the concept of comfort supports the fact that patients want to be comfortable. When hospitalized, patients will attempt to ensure their comfort by actively seeking ways to attain comfort, with the goal being to be comfortable not just physically, but also emotionally and psychologically. It is this emotional and psychological comfort that may be hindered if a male nurse provides personal and intimate care with a female patient.

Female Patient Perspective of Comfort

Societal Expectations and Norms Regarding Sexuality/ Modesty/ Taboos

One of societies' cultural norms or taboos is that people are not expected to view or touch the naked bodies of other people (especially strangers) unless they are in a situation or

relationship that permits this behaviour. This societal expectation refers not only to situations between genders, but also within the same gender. This societal taboo contributes to feelings of anxiety and embarrassment when exposure of oneself to observation or touch is required.

However, there are situations where it is expected that normal societal boundaries be crossed. The most common situation is in the realm of health care. Society is able to accept the role of health professionals to view someone's naked body, and to touch, poke, prod and introduce objects into this body in order to provide the best possible treatment for the person (Curtin, 1993; Domar, 1986; Hurst and Ward, 1991; Rowan, 1993; Seed, 1995; Vella, 1991; Vousden, 1980). This does not imply that the patient being subjected to the procedure will be physically, mentally or emotionally comfortable in the situation. Nurses, doctors or other health care providers need to be keenly aware of the breach in the societal norm that occurs when these tasks are performed, to ensure that their patients' emotional and psychological concerns are identified and addressed.

Patients are sexual beings, and as such, bring to their hospital experience their own sexuality and all the norms and expectations that society as a whole prescribes (Bernhard & Dan, 1986; Lawler, 1993; Savage, 1989; Seed, 1995; Watson, 1991). Some literature suggests that female sexuality differs from male sexuality in that female sexuality encompasses the entire woman and does not focus specifically on the genitals (Bernhard & Dan, 1986; Lawler, 1993; Sanford, Hawley & McGee, 1992). Instead, female sexuality includes the female's relationships and emotions, as well as her total body and life experiences. Male sexuality on the other hand is said to focus more on the genitals and not primarily on the male as a whole.

If there is a difference in sexuality between the genders, it is possible that a female patient may feel uncomfortable with a male nurse caring for her because of the need for him to intrude into her perceived sexual being which according to the supposition above, would be the patient's whole body. Accordingly, if a male's sexuality is only focused on the genitals, then a male nurse would not necessarily perceive any concern with caring for any part of a female patient other than her genitalia. These two differences in gender sexuality could therefore theoretically create emotional or psychological discomfort on the part of the female patient.

Backrubs and massages have a sexual connotation (Sanford, Hawley and McGee, 1992) and a male nurse providing these nursing interventions may be seen by the female patient not just as a nurse, but in particular as a male, and therefore create an uncomfortable situation for the patient. Nursing interventions of a more personal and intimate nature such as bathing, providing perineal care, catheter care or catheter insertion may create feelings of anxiety or discomfort for the patient if her life experiences, personal preferences or values are congruent with society's perceptions of what is acceptable and not acceptable in regards to males and females touching each other. Jourard and Rubin (1968) comment that "there are strong societal norms which regulate who will touch whom, and under what conditions" and "these norms have arisen because of the intimate connection between physical contact and sexuality" (p. 40). In their study of self-disclosure and touching, Jourard and Rubin (1968) provided a questionnaire (with a reliability between .80 and .98) to 54 male and 84 female university students. Results indicated that women and men are touched more frequently and in more areas of the body by their opposite-sex friends than by their mothers, fathers or same-sex friends. What is important about this review is that it was the

respondents opposite-sex "friends" doing the touching, not a stranger. Their discussion provided the view that consciously or unconsciously, touching is equated with a sexual intent and because of this, touching areas other than the hands, arms, face or shoulders is a societal taboo.

Perhaps one of the most common situations where anxiety, modesty, embarrassment or physical, emotional and psychological discomfort can arise is when a woman requires a pelvic examination (Bohlen Primrose, 1984; Durant, Seymore, Jay, Freeman, Sharp & Linder, 1987; McKie, 1992; McKie, 1993; Petravage, Freeman, Gomez, Sharp Linder, 1986; Weils, 1977; Willms & Newman, 1994). If one subscribes to the position that being exposed or touched by someone of the opposite sex is cause for modesty or embarrassment, then it would be expected that women experiencing this most personal and intimate examination would prefer a health care professional of the same sex. However, if there are instances where touch or exposure of the body to a stranger of the same or opposite sex are supposed to be acceptable, why then would some patients still feel uncomfortable in those situations? The answer may be elucidated in the next section which discusses the personal preferences of the patients.

Personal Preferences of Patients

The literature provides inconsistent and inconclusive findings, not only between research studies, but also within the studies reviewed, as to the preferences of patients with regards to the gender of their caregiver. Anapol and Wagner (1978) found that 56% of 100 women preferred to have a pelvic examine performed by a woman, while 30% preferred to be examined by a man. After completing a literature review on whether it matters to patients if a physician is a woman, Arnold, Martin and Parker (1988) found that female patients

were more satisfied with female physicians and that female patients "are more likely to see a female than a male physician" (p.730).

Similar findings were reported by Kelly (1980) in a survey of 50,018 patients, 56.7% of who were female. Kelly found that "female patients were 1.49 times as likely to select a female physician" (p. 430). A study of 409 female patients by Haar, Halitsky and Stricker (1975) revealed that 33.9% of the women preferred a female physician, 19.3% preferred a male, and 36.2% did not have a preference. All of the studies were performed in North America or the British Commonwealth. The size of the populations of these studies enable the reader to accept that the results may be valid, reliable and generalizable to the general populations within these areas of the world and within the cultures that they represent.

It is understood that religious and ethnic subcultures or past life experiences can have a major impact on the acceptance or rejection of societal expectations, norms or taboos (Galanti, 1991; Huerter, 1976; King, 1981; Lawler, 1993; Weyrauch, Boiko & Alvin, 1990). The ramifications of the effects of various subcultures and past life experiences on societal expectations, norms and taboos is beyond the scope of this study and will therefore not be considered. However, it is acknowledged that culture, religion and past life experiences of the patient do play a major role in the acceptance or rejection of societal norms and expectations.

While the above studies discuss female patients' preferences for male or female physicians, it can be seen from the results that not all women prefer to be examined by a physician of the same sex. The inconsistencies in the results may be a result of the changes in society's expectations or beliefs. When these studies were completed, it was not as

common to see female physicians, and therefore women may have preferred to have a male physician because of a societal acceptance or expectation. There may also have been a belief that the physician's gender somehow influenced the professionalism, understanding or respect that the physician had for the patient, or in some way indicated the intelligence of the physician (Haar, Halitsky & Stricker, 1975; Kelly, 1980; Weyrauch, Boiko & Alvin, 1990). Other possible reasons for women preferring to be examined by a physician of a particular gender may have resulted from the women's movement, or due to homophobia (Eliason and Randall, 1991; Eliason, 1993; Marland Hitchcock, 1992).

This section of the literature review has thus far focused on female patients and their preference for male or female physicians. However, in today's society nurses are required to provide nursing interventions to patients that in many ways are more personal, private and intimate than the procedures being performed by the physicians. Lawler (1993) discusses the role that nurses play in the care of the patient and how this care has been considered "dirty work" (p. 4), because of the need for nurses to do for the patients that which they are unable to do for themselves. In all areas of the hospital nurses perform very intimate procedures on patients, but perhaps the most obvious areas where intimate care is provided is in the obstetrical, gynaecological and maternity wards.

There is a paucity of research or literature on the preferences of patients regarding the gender of their nurse, and what exists focuses on female patients and male nurses. The majority of the literature on male nurses caring for female patients has focused on midwifery, maternity nursing or gynaecological nursing (Benda, 1981; Brown, 1986; Brown, 1987; Cooper, 1987; Lodge, Mallett, Blake, Fryatt, 1997; McKenna, 1991; Millin, 1981; Morrin, 1992; Mynaugh, 1984; Saunders, 1981; Sweet, 1974; Tagg, 1981; Watkin,

1975; Woodhams, 1984), with a smattering of literature on medical/surgical or psychiatric nursing (Bennett, 1984; George and Quattrone, 1989; Gilloran, 1995; Johnston, 1987; Lemin, 1982; Mathieson, 1991; Swaffield, 1988; Vestal, 1983).

Research or literature focusing on male nurses caring for female patients appears to be concerned with the same sociological phenomena that society is concerned with, that is, that nursing care requiring personal or intimate contact or examination of a patient is more appropriately performed by a nurse of the same gender. The findings of the following studies also indicate that in the majority of cases, the concern is not in being cared for by a male nurse, but rather, the concern is for what type of procedure or care the male nurse is required to perform. It should be noted that although some of the studies did not have very large sample sizes, the consistencies between the studies regarding the type of care provided by the male nurses which caused concern for the female patients, indicates that some agreement on the validity, reliability and perhaps generalizability of the results is warranted.

Results of these studies have also been inconclusive as to the preferences of female patients when it comes to male nurses. Sweet (1974) surveyed 1,000 patients at various stages of their pregnancies. Thirty-three percent of the women questioned would not want a male midwife to care for them at any point in their pregnancy, while 7% totally accepted the concept of a male midwife. However, 60% of the women provided mixed responses as to the acceptance of male midwives. The areas of least acceptance of male midwives had to do when more intimate personal bodily care was required. The procedures where concern was noted included: examining the breasts and providing advice about breast care, giving advice about vaginal discharge, performing internal examinations, delivering the baby, washing the patient after the delivery and examining pads, stitches and breasts or helping with

breastfeeding in the antenatal period. "Between 80% and 86% of all patients would dislike the attendance of male midwives for these procedures" (Sweet, 1974, p. 1620). A concern with this particular survey was that no mention was made of whether or not any of these women had ever been, or currently were being cared for by a male nurse. There is no way of knowing if the past experiences and perceptions of the patients affected the results, or if different situations or scenarios would have caused different findings. There was also no information as to the gender of their obstetricians. Also, the survey type of study that was performed was unable to elucidate the feelings that the women experienced regarding their beliefs about male nurses.

In a similar study, Cooper (1987) provided a questionnaire to 50 obstetrical patients ranging in ages from 17 to 42 with an average age of twenty-seven. Sixteen percent of the respondents had actually received care from a male nurse but it is not known if it was during the time the obstetric care was provided or during other situations. Cooper found that 88% of the women had some reservations as to the type of care they would feel comfortable allowing a male nurse to provide. Once again specific concerns of male nurses providing care focused on procedures of a personal or intimate nature such as inspecting sanitary pads, providing bedpans, breast examinations or teaching the proper use of the bidet.

In a different setting, Mathieson (1991) surveyed 25 female patients in a psychiatric hospital. Twenty-two of the respondents preferred female nurses while 17 of the patients "objected to male nurses carrying out bed-bathing, and 13 objected to being assisted to the toilet by a male nurse" (p. 32). Thirteen of the women would not discuss problems of a sexual nature with a male nurse. It should be noted that none of the patients had any psychiatric diagnosis that would influence or affect their ability to provide the necessary

information.

What is important to note is that the studies reviewed thus far indicate that the majority of women have some reservations about having a male nurse care for them in situations when personal or intimate care is required. In contrast, McKenna (1991) completed a review of the literature regarding the development and trends of male midwives. Her findings indicated that the concerns that were assumed to be of significant importance to the patients, that is, having intimate care provided by a male nurse, were unwarranted and unfounded. Of the studies she reviewed, the findings indicated that the majority of women do not object to being cared for by a male midwife and in a number of instances the women actually preferred a male midwife. It was felt that the gender of the midwife was not as important as the training and competency that the midwife possessed. The aspect of competency will be discussed later.

Studies by Tagg (1981), Lemin (1982), Woodhams (1984) and Mynaugh (1984) found that the majority of women did not object to being cared for by a male nurse regardless of the type of care required. The surveys and questionnaires were provided to large and small sample sizes and the results were consistent between the studies which leads one to accept the possibility that the findings are valid, reliable and somewhat generalizable.

Tagg (1981) obtained the results of a questionnaire from 34 women on an obstetric unit all of whom had been cared for by a male nurse during that particular hospitalization. Seventy-six percent of the women believed that they could confide in the male nurse, 65% were never embarrassed by the presence of a male nurse regardless of the type of care provided, and 100% of the women had no objections to being attended to by a male nurse.

Similar results were found by Mynaugh (1984) when she conducted a survey on 400

post-partum mothers. Her population ranged in age from 14 to 40 years old. Criteria for acceptance into the study included the vaginal delivery of a normal, healthy, full-term baby. This is important since the normalcy of the delivery and infant would help decrease any anxiety and discomfort that may otherwise have affected the results of the study. Only three activities: assisting with bathing, changing of a nightgown and assisting with breast-feeding provided results of less than 50% acceptance of the activity being performed by a male nurse. All other results were greater than 50% acceptance of the male nurse providing the care necessary regardless of the personal or intimate nature of care required. A letter to the editor (Hall 1993) and a declarative article (Clasper, 1993) both discuss how female maternity patients are not concerned as to the gender of their nurse.

The previous two studies took place on obstetrical units that obviously do not include long term or elderly patients. In the two studies that follow, it appears that the age and circumstances of the patients, as well as the setting where the nursing care takes place, plays a factor in the acceptance or rejection of male nurses providing nursing care to female patients.

Woodhams (1984) adapted Tagg's questionnaire to more adequately reflect the population he was interested in studying. He questioned 18 elderly patients on a geriatric unit and found that 100% of them had no embarrassment in any area of care provided by a male nurse, while 94% of those studied at no time strongly objected to a male nurse's presence when care was being provided. It seems unusual that 100% of the women were not embarrassed when being cared for by a male nurse, but 6% of the respondents would strongly object to the male nurse's presence when care was being provided. The differences in percentages could be that although the women were not embarrassed, they had other

unknown concerns causing them to object to the male nurse's presence. When asked if male nurses should work in all area of nursing such as maternity only 65% of the respondents agreed with the statement while 14% replied "no" and 21% did not answer. Woodhams provided possible reasons for the inconsistent results which included: "embarrassment or fear of hurting the male nurses' feelings", "any one of the male staff could have been seen as a favorite", "there could have been some conferring" between patients, and "the small sample size" (p. 21).

Other possible reasons for the inconsistencies could be that the respondents may have considered it acceptable to be nursed by a male because the elderly are often considered "asexual". Therefore the concern with intimate touching may not be considered as relevant as it would be with a younger woman on a maternity unit. Another reason could be that the respondents were in a long-term institution and they became "accustomed" to the presence of a male nurse. In addition, there was the opportunity to develop an appropriate nurse-patient relationship, whereas on a maternity unit the time and opportunity to develop the same type of nurse-patient relationship is not as readily available. It is worthy to note that some of the respondents in Tagg's study who would be embarrassed having a male nurse help with breastfeeding felt that if the "male nurse was suitably experienced to give help, and they were given time to establish a relationship, then they were sure that the embarrassment would pass" (Tagg, 1981, p. 1851). It therefore appears that it is important for the patient to develop a relationship with the nurse before embarrassment no longer is an issue.

Lemin (1984), using a convenience sample of all female patients visited in a one-week period, surveyed 493 female patients receiving nursing care in the home. Two

hundred and ninety of these patients had been in the hospital in the past and 167 of them had received nursing care from a male nurse or male nursing student while hospitalized. Seventy percent of these respondents said that having care provided by male nurses was fully acceptable and only 30% replied that it was moderately or completely unacceptable to have a male nurse care for them. The survey method utilized was unable to explain why these respondents found it moderately or completely unacceptable to have care provided by a male nurse, but again, the provision of personal and intimate care were the most frequently noted concerns.

The location where the care was to be provided also played a factor in the acceptance or rejection of male nurses caring for the patients. Fifty-two percent of all the respondents indicated that they would be unwilling to accept the same type of care they received in the hospital from a male nurse in the community. This number decreased to 37% if the respondents had no other alternative available. Unlike Woodhams' study, the more elderly respondents (87% were over 60 and 40% were over 80 years old) provided more negative results. Sixty-four percent of the respondents over 80 years of age would not accept care from a male nurse while an average of 44% of the respondents between the ages of 60 and 79 would not accept care from a male nurse. In the 20 to 59 age categories an average of 60% of the respondents would accept care from a male nurse.

The literature thus far has demonstrated that the preferences that female patients have in relation to the gender of their caregiver are inconsistent and inconclusive between and within the studies reviewed. Some of the studies support the contention that female patients would rather have a female nurse or female doctor provide the interventions necessary, while other studies support the contention that the gender of the nurse or doctor

is irrelevant. Another inconsistency is the fact that in many of the studies, it is unknown whether or not the respondents were currently, or had ever been cared for by a male nurse. It seems that findings regarding the acceptance or rejection of a nurse based on the nurse's gender would have more relevance if the study participants had personal experiences with both genders. That would enable the participants to make an informed comparison, and therefore decision, as to the reason for their preference. What does appear to be somewhat more consistent is the fact that societal norms and taboos regarding the touching and exposing of personal and intimate areas of the body by a stranger of the opposite sex is one aspect that can and does cause discomfort for female patients. As previously mentioned, patients have come to expect that the nurse caring for them will be female. Just as female doctors were not the norm 20 or 30 years ago, male nurses are not the norm now. A potential cause for emotional and psychological discomfort therefore is the idea that men are just not supposed to be nurses. This leads us into the next section of the literature review.

Sex-roles

Sex-roles are all of the behaviours, mannerisms and expectations that society expects to be exhibited by a particular gender. Society has come to expect that men and women will enter into particular occupations based solely on their gender, and those people who contradict the normal expectations and sex-roles of society create feelings of unease or discomfort in the rest of the population (Brown, Weir, Rideout & Ingram, 1995; Bush, 1976; Christman, 1988; Edgeland and Brown, 1989; Cummings, 1995; Greenberg and Burton, 1971; Hesselbart, 1977; Horman, Campbell and DeGregory, 1987; Laroche and Livneh, 1983; Segal, 1962; Tumminia, 1981; Turnipseed, 1986). Males entering the

profession of nursing go against the normal societal sex-role expectation and are therefore suspect. It is difficult for people to understand why a male would want to enter a profession that is not viewed of as a particularly high-status, prestigious or well-paying career (Bush, 1976; Hesselbart, 1977; Laroche and Livneh, 1983; Lawler, 1993; Segal, 1962). If a female patient values traditional sex-role expectations, then she may be unable to understand why a male would want to enter nursing which traditionally has been perceived as a woman's profession. The need for tender, caring and nurturing behaviours, which traditionally have been portrayed as female traits, do not fit the normal North American sex-role expectations of the male. If a female has this traditional view, it can be deduced that the patient may not feel as comfortable with a male caring for her needs as she would if a female nurse was providing the care.

No literature on the patient's perspective of male nurses (or female nurses) and the relationship to sex-roles was located. Studies have examined the patient's sex-role and how it relates to their preference for a male or female physician (Weyrauch, Boiko and Alvin, 1990). Other studies have looked at nurse practitioners and physicians based on sex-role stereotyping (Horman, Campbell and DeGregory, 1987). And studies have also looked at high school and university students occupational stereotyping based on sex-role (Hesselbart, 1977; Decker, 1986), but none have studied the concept from the patient's perspective. Literature has been found on sex-role stereotyping and how that stereotyping affects male nurses from their perspective and that will be discussed in the appropriate section of this review.

In summary, some of the studies demonstrated how societal norms and expectations regarding sexuality, modesty and taboos help promote emotional and psychological

discomfort in female patients when provided with personal and intimate care by male nurses. These norms and expectations help develop the personal preferences of the female patient and thus promote the acceptance or rejection of male nurses providing personal and intimate nursing care. What is considered to be an appropriate occupation for a woman based on "normal" sex-role expectations is seen to be incongruent with the expectations that society has of men and the careers that they choose. Because of this, male nurses may cause feelings of discomfort to female patients (and some male patients) when they have to provide some of the personal and intimate nursing interventions that nurses perform.

Type of Care Required

Personal and Intimate versus Non-Intimate Care

The literature has suggested that in many instances the gender of the nurse does not matter unless there is a need for intimate care. The terms intimate and non-intimate care have never been formally defined but, Lemin (1982), described intimate care as the exposing of breasts and genitalia, semi-intimate care involved some undressing and revealing of private articles of clothing, and non-intimate care was not defined. It appears to be an individual and personal, yet widely accepted opinion as to what is and is not intimate care. Intimate care inevitably surrounds the care required by a patient with areas of their body that have a sexual connotation or some physiological connection to the elimination of normal bodily functions or wastes. Other terms utilized in the literature that allude to the intimate nature of the care required are personal care, care requiring touching, or hands on nursing.

In one of the most thorough and complete research studies discussing personal and intimate care, Lawler (1993) interviewed 34 nurses (30 females and 4 males) with a wide

range of experiences covering all areas of specialization. Her research focused on the care of the body that nurses provide to patients and the difficulty that nurses have in providing that care. Lawler noted how nurses were "concerned with the object body (an objective and material thing) and the lived body (the body as it is experienced by living people)" (Lawler, 1993, p. 29). Much of her findings and discussion relate to the concerns that female nurses have when providing care to male patients. The concerns expressed by the respondents revolve around the need to provide personal and intimate care to a patient of the opposite sex. Lawler's findings indicate that the norms of society dictate how comfortable or uncomfortable a nurse feels when providing personal and intimate care to a patient (particularly of the opposite sex). She discusses how nurses are not taught how to handle the various situations and experiences that nurses run into when providing care to a patient, but rather, nurses learn to breach the normal boundaries of societal expectations through experience. Lawler discusses how nurses work behind screens (curtains) to ensure patient's privacy when the nursing intervention requires the nurse to do for the patient that which he or she is unable to do for them selves, the "dirty work" of nursing.

Because Lawler's sample population included 30 female nurses, the main thrust of her findings indicated the problems and concerns that female nurses had when caring for male patients. However, when Lawler discussed the perceptions and concerns of male nurses caring for female patients, the results were similar to the concerns expressed by the female nurses. Male nurses and how they care for female patients, or how they handle the provision of personal and intimate care with patients of the opposite sex has not been researched.

Some of the literature discusses the legal and professional obstacles that male nurses

face when they try to work in areas of the health care system that require personal and intimate care of female patients (Bennett, 1984; Boughn, 1994; Brown 1986; Brown, 1987; Burtt, 1998; George & Quattrone, 1989; Gill, 1995; Greenlaw, 1982; Hall, 1993; Hawke, 1998; Kaur, 1993; Poliafico, 1998; Squires, 1995; Trandel-Korenchuk & Trandel-Korenchuk, 1981; Welch, 1996). Trandel-Korenchuk and Trandel-Korenchuk (1981) discuss the landmark court decision of Backus v. Baptist Medical Center. The court agreed with the hospital that, "the majority of women patients will object to intimate contact with a member of the opposite sex" and "because of the intimate nature of the touching that occurred in labour and delivery all males were inappropriate" (p. 89). This decision not only supports the contention that intimate care is linked to the exposure or touching of a patient's genitalia or other sexually identified anatomical aspects such as a woman's breasts, it also demonstrates the supposition that male nurses should not provide intimate care to female patients.

The sexual aspect of the intimate care required during labour and delivery strictly because of their gender was discussed in two letters to the editor of a nursing magazine. Saunders (1981) comments that the woman in labour is "in an emotionally and sexually charged situation" and "the sex of the people around her is relevant; if this is denied then the emotions and reality of that woman are denied" (p. 9). Taylor (1981), in discussing her uneasiness with male midwives, comments that the "whole area of pregnancy and childbirth is sexually charged" and this "fact tends to be ignored by all professionals involved, which means an important dimension of women's experience is denigrated" (p. 9). The need for intimate care during this particular life experience of a woman demonstrates the societal expectations of gender roles and what is acceptable or not acceptable in these situations.

Male nurses need to be aware of the concerns female patients might have during these times, and do whatever is required, including removing themselves from the situation if needed, to ensure that the patient does not feel uncomfortable with the care being provided. Another aspect that will influence emotional or psychological comfort is the current level of health of the patient, which will be discussed in the following section.

Level of Health

Research was not located that directly addressed the patient's level of health and how it affects their comfort level in relation to the type of care required, or by the gender of nurse providing the care. It is assumed that the gender of the nurse will be less likely a concern the more acutely ill a person is, the more critical the situation, or the more immediate the need for treatment or intervention is required. Some insight into when the acuity level of the patient affects the acceptance or rejection of a male nurse providing care to a female patient has been documented (Lemin, 1982; Mynaugh, 1984; Johnston, 1987; Tagg, 1981).

Tagg (1981) concluded that concern would be expressed by women being cared for by a male midwife in the home or hospital during the post-natal period, while none of the respondents would object to a male midwife caring for them while they were in labour. The idea of being in greater need of medical or nursing intervention as a hospital patient as opposed to the more non-medical, more natural, less "sickness" oriented home birth experience, may possibly explain why there was more acceptance by the respondents for male nurses caring for the patients in the hospital than there was for assisting in the home. It may also be argued that women in labour tend to be somewhat more focused on the task of delivering their baby than they are on the sex of their caregiver. However, once the birth is

complete and the woman no longer requires as much intervention from the nurse, it is at this time that the female may have more reservations about being attended to by a male nurse. Prior to the birth, the patient may have had the perception of being cared for by a nurse who happens to be male, however, afterwards there may be a change in perception to one of being cared for by a male who happens to be a nurse.

Similar conclusions were found by Mynaugh (1984). In her discussion, Mynaugh comments that the findings may result from the fact that the mothers "generally are healthier, more independent, and more capable of attending to their own needs after delivery" (p. 374). This indicates that a woman has a higher acuity level up to and including the time of delivery of her baby, thus necessitating an increased level of nursing intervention. In her study (N=400), 69% of the women would accept a male nurse assisting with a vaginal examination during labour and delivery. Acceptance of a male nurse checking for vaginal discharge or bleeding decreased to 55% in the postpartum period. Assisting with changing a nightgown was acceptable by 61% of the women during labour and delivery while only 47% of the women would allow this in the postpartum period. Assisting on and off a bedpan (which could conceivably have included cleansing of the perineum, although this information was not provided), was accepted by 55% of the respondents during the labour and delivery period. Allowing a male nurse to assist with bathing decreased to 39% in the postpartum period.

Observing the delivery was acceptable by 81% of the respondents but examining the breasts in the postpartum period would only be allowed by 60% of the women. The results decreased to 47% acceptance if the male nurse had to assist with breastfeeding. Mynaugh contends that the high acceptance rate of observing the delivery was because it was

educational and did not require touching, and, although the percentage results decreased, examining of the breasts was considered more of a medical necessity. Assisting with breastfeeding had the least acceptance. The respondents may have felt that a male was trying to help a female breast-feed.

Lemin's (1982) study (N=493 female patients) indicated that 71% of the patients would fully accept care from a male nurse while hospitalized. Twenty-four percent of the respondents considered being cared for by a male nurse in the hospital moderately acceptable while 5% considered the concept to be unacceptable. Lemin (1984) commented that "patients who require intimate care are usually quite ill" (p. 33) and therefore, concluded that it would not matter who cared for the patient in this situation.

Johnston (1987) discussed that in emergency nursing "less objection to intimate contact is generated" (p. 89). He believed that this was because of the high patient acuity, the unplanned nature of the care required and the short-lived nurse-patient relationship.

One of the limitations of most of these studies is the idea that most of the encounters discussed deal with hypothetical situations. However, if one accepts the premise that female patients admitted to the hospital are generally sicker or have a higher level of acuity, and if the acutely ill patients require assistance beyond their ability to perform normal daily functions, then it can be presumed that the patients may not object to the care provided regardless of the gender of the nurse. However, once the female patients are feeling better or are more able to care for themselves, then they may more readily object to the care they receive coming from a male nurse.

Male Nurse's Perspective of Nursing Female Patients

Male nurses may have essentially the same concerns when providing personal and

intimate care with female patients, that Lawler (1993) suggests female nurses have when providing intimate care with male patients. The reasons male nurses have concerns result from the same factors causing female nurses to have concerns, and that is, the psychosocial, cultural, spiritual and societal expectations that they are exposed to throughout their lives.

Societal Expectations and Norms Regarding Sexuality/ Modesty/ Taboos

Lawler (1993), utilizing a phenomenological approach, has provided in depth nursing research on sexuality of the body, care of the body and its by-products and nursings' problems in providing nursing care to patients. However, Lawler's population of 34 interviewees only included 4 male nurses and as discussed previously, the majority of her examples, discussion and conclusions focused on female nurses and the difficulties they encountered when caring for male patients. There is little research related to male nurse's sexuality and how it inter-relates with the care provided to female (or male) patients. The literature on male nurses, their sexuality, modesty, taboos and difficulties in caring for female patients, has been written as declarative articles stating opinions and beliefs with little or no research to back up the assertions.

Following societal norms and expectations, some articles appear to agree with the argument that men should not provide intimate care with women just because it is inappropriate (Burtt, 1998; Coombes, 1998; Cooper, 1987; Hawke, 1998; Lawler, 1993; McCann, 1991; McKenna, 1991; Millin, 1981; Rowan, 1993; Saunders, 1981; Swaffield, 1988; Tagg, 1981; Taylor, 1981; Vousden, 1980; Watkin, 1975; Woodhams, 1984). None of the articles discuss male sexuality, societal expectations or mores and how these factors inter-relate with the male nurses' ability to care for female patients. Two articles were found that suggested the male nurse's preference for caring for female patients. Again no

information was provided as to how or why societal norms regarding modesty or taboos did not play a factor in the care these nurses provided to the patients (Brown, 1986; Health Sciences Centre, 1988).

McKenna (1991) completed a literature review of the development and trends of male midwives. She found that in the 1970's, all male midwives required the presence of a chaperone when providing intimate care to a patient. The reasoning behind this was "to protect the patient from improper advances by an unscrupulous practitioner, and to protect the male from imaginary allegations of assault" (p. 483). Various court decisions and insinuations in some of the literature have also alluded to the idea that a male nurse should not care for female patients because of the potential for acts of sexual impropriety by the male nurse (Bennett, 1984; George and Quattrone, 1989; Hawke, 1998; Nursing, April/1995; Nursing, July/1995; Segal, 1962; Trandel-Korenchuk and Trandel-Korenchuk, 1981). In an article on the law and emergency room nurses, George and Quattrone (1989) discuss a court case in New York State where a male nurse lost his license to practice due to allegations of sexual misconduct with an emergency department patient as well as with some of his co-workers. The concerns of sexual impropriety by male nurses can cause feelings of discomfort not only for female patients, but also on the part of the male nurse when the morals and ethics of his sexuality and professionalism are suspect.

Modesty is not a unique feature of women. Males have the same societal mores, feelings of embarrassment, shyness and psychological restrictions in relation to sexuality, the exposure of the body to observation, touching and examination that women experience. These feelings occur regardless of whether or not the person is a nurse, doctor or member of another health care discipline (George and Quattrone, 1989; Lawler, 1993; Merrill, Laux

and Thornby, 1990). In 1989, Merrill, Laux and Thornby surveyed 350 senior medical students and found that 25% of the respondents felt embarrassed to ask the necessary questions to attain an accurate sex history of the patient. The numbers of male and female respondents was not reported, however, the researchers found that there were no differences between the sexes on the level of embarrassment felt in taking a sexual history or on a shyness-social anxiety scale. Fifty percent of the respondents felt that they had not been given adequate training in how to properly conduct a sex history. The authors did not address what could be done to alleviate the discomfort the medical students felt when asking the necessary questions or how they could decrease the discomfort the patients may have felt being asked these questions. The sample size encourages one to consider the findings to be valid, and may even be generalizable to other health care disciplines that need to take sex histories.

Lawler (1993) reported similar findings in that she discussed how nurses are formally educated in theoretical information but not in the practicalities of how to break the social norms of male-female relationships. Her results also indicate that the embarrassment male nurses feel when they encounter a female patient for the first time is not as acute as it is for female nurses encountering their first male patient. Lawler suggests this data may reflect what male nurses are willing to tell a female researcher or what female nurses are willing to share with another female. This is important since the gender of the person conducting the research does play a factor in the results obtained from the participants in a study (Williams and Heikes, 1993). It has been my experience, as a nursing instructor, that male students are just as concerned with their first encounter with a female patient as female nursing students are with their first encounter with a male patient.

Lawler (1993) discusses the fact that nurses emphasize the procedure being performed, that they learn to control their emotions and embarrassment, and, that they learn how to communicate effectively during these invasions of the patient's privacy to ensure that the patient experiences the least psychological discomfort possible. Lawler did not differentiate between male and female nurses in her analysis, and therefore, there is no way to know how, or if, male nurses actually accomplish this goal when providing personal and intimate care with female patients.

Much that has been written or researched on males in nursing has not focused on the male nurse's sexuality or societal expectations regarding modesty or taboos, but rather the focus has been on sex-role stereotyping. This aspect will be discussed in the next section.

Sex-Roles

Much of the research and literature on male nurses has focused on sex-role stereotyping and how this stereotyping affects males in nursing (Segal, 1962; Greenberg and Levine, 1971; Bush, 1976; Vestal, 1983; Johnston, 1987; Christman, 1988; Egeland and Brown, 1989; Heikes, 1991; Brown, Weir, Rideout & Ingram, 1995; Cummings, 1995).

Although dated, Segal (1962) interviewed 101 nurses (22 were male) in a psychiatric hospital to find out if males in nursing suffer from damage to their prestige and self-esteem because they chose nursing as a career. Segal concluded that male nurses suffer from a status contradiction. As males they were expected to exhibit the characteristics expected of males such as aggressiveness and competitiveness, while as nurses they were expected to exhibit "kindness, gentleness, sympathy and patience" (Segal, 1962, p. 32). Although no statistics were provided, Segal also found that the majority of the males in the study worked in areas of the hospital housing male or senile patients. Segal (1962) contends

that this was due to the fact that there was less likelihood for the need for intimate and sustained contact with the patients. By working in areas where there was less contact with female patients, there was a decreased likelihood that the male could be accused of sexual impropriety. There was also a decreased probability of the female patient feeling uncomfortable having a male nurse provide personal or intimate care. Working in areas that limited the amount of actual patient contact may have also been one of the ways that the male nurses decreased the perceived role conflict they experienced because they were not then doing "actual" nursing care.

Studies have indicated that men enter various fields of nursing with the goal being to minimize the strain that they feel from having an occupation that is incongruent with societal expectations of sex-roles. Areas that have been identified that decrease the role strain men experience are those specialties that minimize contact with patients in general or female patients in particular. Those areas are: urology, psychiatry, anaesthesiology, surgery (operating room), administration and public health, (Greenberg and Levine, 1971; Bush, 1976; Vestal, 1983; Johnston, 1987; Egeland and Brown, 1989; Heikes, 1991; Boughn, 1994; Villeneuve, 1994; Buchan, 1995). However, with the increasing number of men entering nursing, there is increasing numbers of men working in all areas of the hospital such as in medicine, surgery or pediatrics.

Greenberg and Levine (1971) researched role strain in male nurses by hypothesizing that male nurses would choose certain areas of specialization to minimize perceived role strain. The researchers interviewed 15 male nurses working in various areas of specialization and at various levels of the nursing hierarchy. All 15 respondents identified areas of specialization where role strain is decreased. Urology, dealing almost exclusively

with male patients, was the only hands on specialty where the requirement for intimate touching was deemed appropriate for a male nurse. The actual decrease in intimate patient contact or direct patient care resulted in the male nurse being able to avoid "many potential problems of contact with patients, and thus minimize conflicts" (Greenberg and Levine, 1971, p. 421). What was not provided was the identification of what potential problems or conflicts were perceived to be of a concern for male nurses in caring for patients. It is my contention that the societal norm of males not touching or observing females except in the appropriate situations, is not very different today than it was in the 1970's, and it is those "potential problems and conflicts" that were alluded to by Greenberg and Levine.

In another study, Bush (1976) randomly chose six male student nurses and four male graduate nurses to study how male nurses challenge traditional role identities. Utilizing focused interviews, Bush too, found that males entering nursing encounter role strain. Her findings indicated that if a male nurse is not technically competent, he is blamed by the patients as an individual, however, if the male nurse fails affectively as a nurse, he is blamed because his gender is male. Respondents also indicated that choosing specialties more appropriate for a male nurse assisted in minimizing the amount of perceived role strain. Areas most likely to decrease role strain were those specialties that minimized the provision of personal care. Once again, except for urology, the amount of care required of a personal and intimate nature is decreased in all of the specialties supposedly deemed most appropriate for male nurses.

Egeland and Brown (1989) sent questionnaires to 500 male nurses and received a 78% (N=367) response of usable results. One goal of the study was to determine which areas of nursing were more congruent with role stereotyping as perceived by the male

nurses. The areas identified as most congruent with the stereotypical male role were those same specialties previously listed, but also included emergency room, intensive care, coronary care, operating room and industrial nursing. The researchers also included the least congruent areas for male nurses to work, which included such specialties as home health, pediatrics, geriatrics and obstetrics. It is worthy to note that public health was considered an appropriate specialty in some studies but Egeland and Brown's study found that home health was not congruent with male sex-role stereotyping. It appears that in this particular study, the majority of specialties considered acceptable for male nurses have a technological component (which may be more congruent with the perceptions of male sex-roles), and that technological component may not be as readily apparent in the specialties deemed less appropriate for male nurses.

The authors concluded that most respondents preferred working in fields of nursing congruent with the male role stereotype. Of the results 46.2% of the males worked in such areas in their first job, 66.7% were currently employed in those areas and 72.3% expected to be employed in one of the areas deemed congruent with the male role in the future. It was suggested that males enter areas of specialization to minimize the amount of perceived role strain. However, Egeland and Brown reported that it was only when male nurses were actually working with patients in less congruent fields that the perception of role strain was increased. These findings could indicate that male nurses have greater role strain when working in areas traditionally looked on by society as areas more appropriate for females caregivers in general. That is, caring for children, the elderly, the "ill" family member in the home and assisting with childbirth.

Heikes (1991) utilizing a non-probability sample of 15 male nurses conducted in-

depth interviews to investigate tokenism. The author discussed the assertion that male nurses often gravitate towards higher paying specialties and, therefore, benefit from their token status. However, Heikes concluded that it was more likely that male nurses entered these specialties because of their identification with the more masculine role rather than the increased financial benefits.

Vestal (1983) and Johnston (1987) also discussed the role strain encountered by male nurses. Both authors indicated that it is the decreased need to touch or the minimizing of hands on nursing (especially with female patients) that encourages male nurses to enter those areas of specialization deemed more appropriate for male nurses. By doing so, the amount of role strain that male nurses would experience would be lessened.

In summary, of the studies reviewed, sex-role stereotyping and role strain appear to be a significant concern in the preferred areas of employment of male nurses. An underlying causative factor encouraging men to enter these fields of nursing is a concern with the need to provide hands on and intimate care to patients, particularly female patients. Societal norms and expectations continue to propagate the belief that male nurses cannot provide the intimate type of care required in nursing because of the males' inability to separate nursing care from the sexual aspect of personal and intimate care. It is my contention that anyone, male or female, entering the profession of nursing does so out of a desire to help people. Through the educational experience, the person acquires the professionalism, competence and ability to develop the interpersonal relationships necessary to care for the patients in whatever way is required, including the provision of personal and intimate care for a patient of the opposite sex.

Professionalism/Competence/Interpersonal Relationships

A professional possesses certain characteristics or abilities not found in people who are not a member of that particular profession. Characteristics commonly ascribed to professions, and therefore professionals, include the concepts of: knowledge, skills and attitude (Chapman, 1977; Curran, 1985; Gilchrist, 1987; Kerr and MacPhail, 1991). Professionals possess a unique body of knowledge particular to their chosen field, and nurses are no exception. Nurses, whether male or female, require the necessary knowledge, skill and attitude that will enable them to cross the normal societal boundaries with regards to caring for a patient's body and thus ensure that safe, competent and professional care is provided to the patient. Hughes (1980) and Cummings (1995) comment that the image the public has about nursing fails to recognize the knowledge and intellectual abilities required to provide competent nursing care. Lawler (1993) discusses how the public is unaware of what nurses do, the knowledge that they have and the professionalism that they possess, because most of the nurse's work is carried on behind the privacy of the curtains surrounding the patient's bed.

For men to enter nursing, which goes against "normal" societal expectations, they must believe that nursing is a prestigious and appropriate profession to overcome the role strain that they will experience. Boughn (1994) discusses how men in nursing are practically motivated and to gain respect they choose areas of nursing that provide higher status and self worth. Men in nursing continue to have a propensity to follow the sex-role behaviours that society has deemed appropriate for them to exhibit, by striving to achieve a high level of professionalism in their nursing careers. Increased levels of education, subscription to professional journals, membership in professional organizations, beliefs that nursing is no

longer a "job", but rather, a career, and more lengthy employment in their chosen profession, all demonstrate the values that men in nursing believe important (Christman, 1988; Cyr, 1992; Hunt, 1991; Mannino, 1963). However, men entering the profession of nursing also have characteristics of the sex-role expectations deemed more appropriate for women, that being, caring and wanting to help others (Boughn, 1994; Cyr, 1992; Galbraith, 1991; Mannino, 1963; Perkins, Bennett and Dorman, 1993).

Mannino (1963) utilizing a normative-survey questioned why men chose nursing as a career. He provided a questionnaire to 516 males in nursing (480 graduates and 36 students) located in 33 states and other countries such as Japan, Germany, Iceland and the District of Columbia. Two of the top five choices indicated the wish to help people and to provide a contribution to humanity.

Cyr (1992) found comparable results when he conducted an informal survey of 25 male nurses. A questionnaire was provided and one of the questions the men were asked was why they chose nursing as a career. Helping others and a challenging career were the two most frequently listed responses, while the findings of Perkins, Bennett and Dorman (1993) were almost identical. These researchers questioned 146 male undergraduate nursing students as to why they chose nursing as a career. Helping and contributing was the second most frequent reason (N=22), after career attributes (N=62), given for choosing nursing as a career.

Similar findings were found by Galbraith (1991) when he questioned 57 men in nursing to find out what they felt was important in their career. Utilizing the Important Components of a Career Scales, Galbraith pilot-tested the tools and found the items ranging from .74 to .91 in reliability. Validity and reliability was rechecked during the study and the

range of coefficients ranged from .77 to .86 utilizing Cronbach's alpha. Results indicated that men in nursing valued the relationship with clientele (read patients) as most important in their careers. This is significant since the need to develop a trusting relationship with patients is of paramount importance when having to provide personal and intimate care. This is especially so when the care being provided is by a member of the opposite gender. Because of this, the comportment of a nurse is important for the psychological comfort of patients. The mannerisms necessary for a professional and competent nurse to portray, in some ways therefore, depend on the nurse's attitude.

Nursing is a helping and caring profession and having the right attitude is an important characteristic for a professional nurse. It appears that the literature provides confirmation that male nurses have the appropriate attitude to be nurses. A study by Weiss (1984) looked at verbal and non-verbal caring and non-caring behaviours. He also looked at technical competency and incompetency behaviours and whether or not they were perceived by male and female subjects as caring. Utilizing a 2 x 2 x 2 x 2 factorial design, 240 university students equally divided by sex were required to watch a video of various nurse-patient interactions. Utilizing three instruments including the Slater Nursing Competencies Rating Scale, Weiss pre-tested the questionnaires and found them to have internal validity. Although no information was provided as to the gender of the nurses portrayed in the videos, the findings indicated that both male and female subjects preferred nurses who demonstrated a combination of non-verbal caring behaviours and technical competencies. Interestingly, however, it should be noted that there were significant differences between the sexes as to which behaviours were deemed more important. The female respondents preferred nurses who demonstrated non-verbal caring behaviours over those nurses who

demonstrated technical competency. What this may indicate is that female patients being cared for by a male nurse may be more concerned about his expression of non-verbal caring behaviours than his level of competency. In contrast, the males in the study preferred nurses who demonstrated technically competent behaviours over those nurses demonstrating non-verbal caring behaviours. The male nurse, therefore, because he is a male, may be more concerned with his level of competency, than his ability to portray non-verbal caring behaviours. The effects of these gender differences may influence the patient's expectations. A 1993 article by Messner, indicated that "patients' unmet expectations rarely have to do with competence" (p. 38). This could mean that if a female patient does have unmet expectations about the care that they receive, it could be because their expectation was for the male nurse to demonstrate caring behaviors while the male nurse may have been more concerned with being competent. This is significant if the expectations that the female patient had in regards to the type of behaviours expected during the performance of personal and intimate care by the male nurse differed from what the male nurse perceived to be important in the performance of those same nursing actions.

Mackey and Lock (1989) interviewed 61 pregnant females to find out what expectations they had of the labour and delivery nurse. Findings indicated that three levels of involvement were expected from the nurses ranging from limited involvement (N=17), to moderate involvement (N=22), to extensive involvement (N=22). Although no specific statements related to the need for knowledge or nurse competency were provided, the importance of these factors can be deduced from the results. The results indicate that the provision of information (knowledge) and performance of a physical assessment (competency) was deemed to be important by all the patients. The need to be qualified to

perform the required tasks or duties of the "job" was also alluded to in surveys conducted by Sweet (1974) and Tagg (1981).

It appears then, that patients believe it to be important that their nurses demonstrate caring behaviors, but it is also important that the nurses be knowledgeable and competent when providing nursing care. Potential feelings of discomfort may arise when differences in the expectations of the care received or provided are due to differences in a particular gender's perception of what is important. If these differences in gender perception regarding competency and caring behaviours are significant, then it would be important for the male nurse to ensure that the feelings of the patient were taken into consideration when care was being provided. This would ensure that expectations regarding the care received would not be unmet and therefore feelings of discomfort would be prevented.

Summary and Discussion

The literature surrounding men in nursing and how they provide personal and intimate care to female patients without causing emotional and psychological discomfort is virtually non-existent. Qualitative and quantitative studies have demonstrated inconsistent findings as to the preferences female patients have regarding the gender of their nurse. The literature suggests that societal expectations and norms surrounding sexuality, modesty, societal taboos and sex-roles, causes female patients to either accept or reject the provision of personal and intimate care by a male nurse. That acceptance or rejection of the male nurse may be the result of how comfortable or uncomfortable the female patient feels when they require personal and intimate care. The literature further suggests that male nurses are also affected by these same societal expectations and norms.

This literature review has looked at the concept of comfort; the female patient's

perspective of comfort that included society's expectations and norms in relation to sexuality, modesty, taboos and sex-roles, as well as the type of care required (whether intimate or non-intimate), and level of health. Also reviewed and discussed was the male nurses' perspective when nursing female patients, including such aspects as sexuality, modesty, taboos, sex-roles and professionalism.

There is a paucity of research and literature about female patients and their comfort level when being cared for by male nurses. As nurses, one of the tenets of our profession is that we strive to ensure the comfort of the patients under our care. If our patients do not feel comfortable while care is being provided to them, we need to be cognizant of the fact that it may be due to the psychological discomfort that they feel being exposed to and touched by a male nurse.

Quantitative studies have provided some information regarding the types of nursing care women receive that cause the most concern when the female patient is nursed by a male. What has not been elucidated by research is an understanding of what strategies, behaviors or mannerisms the male nurse utilizes to minimize or prevent emotional or psychological discomfort when providing personal and intimate care with female patients.

Research needs to be carried out to explore and develop a better understanding of what male nurses do to ensure the emotional and psychological comfort of female patients when providing personal and intimate care. If female patients do feel comfortable being nursed by a male then it is important for nurses (especially male nurses), to know what it is that they can do to help minimize the amount of discomfort or maximize the amount of comfort felt by the female patients under their care. With this in mind I propose to conduct this research study utilizing the following methodology.

CHAPTER III

METHODOLOGY

This chapter will discuss the methodology used for this study. Topics that will be discussed include: design, sample, research setting, recruitment of participants, data collection, the criteria for rigor, data analysis, limitations of the study, ethical considerations, and a chapter summary.

Design

The type of research utilized in this study is qualitative. Qualitative research is preferred "when little is known about a group of people, an institution, or a social phenomenon of interest" (Polit & Hungler, 1991, p. 498). I have been unable to find any research regarding behaviors, interventions or strategies used by male nurses to minimize or prevent emotional or psychological discomfort when intimate and personal care is provided with female patients. Qualitative research is also utilized when the information to be gathered does not lend itself to numerical classification (Brink & Wood, 1989). The type of information that is required to answer this study's research question does not lend itself to numerical quantification. As opposed to quantitative research (including experimental and quasi-experimental designs), in qualitative research there is no randomization of the sample, control of the variables, preconceived hypotheses, or predetermined theory relating to the data (Polit & Hungler, 1995). This study is not conducive to sample randomization (see the section on sampling procedure), there are no variables that can or should be controlled, I have no preconceived hypotheses on the topic, and, as there is not enough information on the subject to propose a theory that "fits" the topic, and there is no particular theory that at

present could be related to the data. Benoliel (1984) suggests that qualitative research accomplishes the "systematic inquiry concerned with understanding (sic) human beings and the nature of their transactions with themselves and with their surroundings" (p. 3). This then is the type of inquiry that is required to answer the research question.

There are various types of qualitative research. Narrative research which focuses on story telling of the participants' lives and historical research which focuses on past historical occurrences were eliminated as possible choices for this research project because they would be inappropriate methods of inquiry for the kind of data that will be gathered. Grounded theory, phenomenology and ethnography were evaluated as possible qualitative methods to utilize for this research project. Grounded theory was ruled out as a possible choice because the emphasis of this mode of inquiry is the development of theory or the modification or elaboration of existing theory or "the generation of categories, properties, and hypotheses" (Polit & Hungler, 1991, p. 509; Simms, 1981). Utilizing the constant comparative method may have provided some insightful information however, the idea of sampling the concept or theory rather than the actors involved is not appropriate for the type of information that this study is trying to determine.

Phenomenology was also considered as a possible method of inquiry for this research but it too was ruled out. Knaack (1984) comments that: "the goal of phenomenological research is to understand human experience from the individual's perspective" (p. 108). Phenomenology describes the lived experiences of the subjects. Although this method would provide informative, interesting and insightful data, it would not be the type or kind of information that is required for the development of an understanding of what it is that male nurses do to decrease feelings of discomfort in female

patients when they provide personal or intimate care.

Another design considered was ethnography as the method of inquiry. More specifically, a descriptive mini or microethnographic basis for data collection while incorporating some exploratory aspects was considered. An ethnographic study provides "the emic perspective -- the insider's or native's perspective of reality" because "the insider's perception of reality is instrumental to understanding and accurately describing situations and behaviors" (Fetterman, 1989, p. 30). However, since I did not utilize observation of the participants, and the method of data collecting involved interviewing, I used the approach of person-centered interviewing as the method of data collection. By using this method of inquiry I was able to maintain the basic premise of ethnography by obtaining the participant's emic, that is, their perspective of reality, but I did this using person-centered interviewing.

Person-centered interviewing involves interviewing the participants and using them as both informants and respondents (Levy and Hollan, 1998). When being questioned the participants are used "as an informant, as an expert witness (albeit with a limited and special perspective) about some community procedure" (Levy and Hollan, 1998, p. 336). In this study the participants were expert witnesses because of their past experience with providing personal and intimate care with female patients. With person-centered interviewing the participant is also used "as a respondent, as an object of study in him- or herself; it explores what he or she makes of the procedure. The relation between the two sets of answers is directly informative" and, "person-centered interviewing moves back and forth between the informant and the respondent modes" (Levy and Hollan, 1998, p. 336). The interview questions and the ability to veer off of the structured aspect of the interview will enabled me

to utilize both informant and respondent information to better understand the perspective of the participants.

The advantage of person-centered interviewing is that "person-centered interviewing *generates* a field of often new phenomena, of reports and behaviors, that are then subject to interpretation" (Levy and Hollan, 1998, p. 336). Person-centered interviewing identifies the importance of addressing the needs and concerns of the participants. This method of inquiry also considers the interviewers' influence on the interview. The general stance of the interviewer, the need to self-monitor, guarding against wished-for responses, exaggerating the fragility of the interviewee, using open and closed probes, the aspect of sensitive topics (of which this study is based), and ending the interview are identified as important considerations (Levy and Hollan, 1998). The descriptive nature of this study allowed me to describe and classify the data while the exploratory aspect of the design provided possible factors that influence the behaviors or strategies used by the participants (Polit & Hungler, 1991).

The goal was to develop patterns and eventual themes extracted from the data that would provide information as to what behaviors, strategies or interventions male nurses utilize when providing personal and intimate care with female patients. These strategies and behaviors are incorporated into the care of female patients in an attempt to decrease the discomfort that may be experienced when being exposed and touched by a male nurse in personal and intimate areas of the body. Eventually this information could be used in nursing education to assist beginning students in how to deal with the issue of sexuality and the handling of the human body.

Sample Selection

This research study utilized a convenience non-probability sample consisting of 15 male registered nurses who work in tertiary and secondary care hospitals in the city of Winnipeg. The participants were registered with the Manitoba Association of Registered Nurses with the minimum educational attainment of a diploma or baccalaureate of nursing degree. These criteria were essential as registered nurses in Manitoba have the education and legal authority to perform all aspects of nursing care. The participants also had to have worked in an area of the hospital that required them to perform actual "hands on" nursing care that would include, but not be limited to, the provision of nursing interventions of a personal and intimate nature (for example: basic hygiene, assisting with elimination and catheterizations). The participants had to have worked with patients older than the age of sixteen (from the age of sixteen patients have the legal ability to make decisions as to the health care provided to them), with no upper limit of age restriction. The participants had to work with, or have worked with, female patients and had to provide, or have provided, personal and intimate care with these patients.

Sample Demographics

The level of education of the 15 participants was varied. Twelve of the 15 participants achieved their original nursing education from a nursing diploma program. Four of the participants had their Registered Nurse Diploma (RN). Three participants had their RN and had taken additional courses related to their field. Two participants had their RN and had additional university degrees. Two participants had their RN and were currently enrolled in a post RN degree program. Three participants had their Bachelor of Nursing (BN). And one participant had taken his RN, then his BN, and was currently a candidate in

a Master of Science in Administration program.

The participants ranged in age from 29 to 54. Twelve of the participants were married, one was engaged and the other two were single. The participants' years of nursing experience ranged from 2 to 23 years. All of the participants were Caucasian. All but two of the participants had worked in different occupations before entering nursing. Only four of the participants had any previous hospital or health care related experience prior to entering nursing. The reasons that the participants entered nursing ranged from having family members encouraging their entry, to having male and female friends who were nurses, to having an interest in health care, to accidentally "falling into it" and, to needing a more secure and permanent employment.

The participants worked in many varied areas of nursing - from surgery and medicine to the intensive care unit, to special procedure departments or specialty areas. All of the participants were currently working in an acute care setting although one participant was in administration.

Research Setting

Because some of the questions asked and some of the information gathered was of a sensitive nature, the research was conducted at a mutually agreed upon place of meeting that provided for privacy and participant convenience in a quiet setting. The preferred choice of setting was at the participant's home on a day and time of his choosing. Alternate settings were at the participant's workplace or the researcher's workplace. The preferred choice, or the alternate setting had: a room or area that provided privacy, an electrical outlet for the audiotape recorder, a room or area that could be utilized for the duration of the participant's input without interruption, and a room or area quiet enough to allow for ease of discussion

and ease of the audiotape recorder to pick up all of the conversation.

Recruitment of Participants

The chairperson of the Access Committee at the Health Sciences Centre (HSC) was approached to determine the feasibility of utilizing the HSC for the pool of possible male participants. A letter of explanation and invitation to participate was forwarded to the unit managers of potential participants through the chair of the Access Committee (Appendix C). The unit managers then gave the letters of explanation and invitation to the participants. I at no time knew who was being contacted and who was accepting or not accepting the opportunity to participate in the study. The participants were invited to participate in the research study and were asked to contact me via telephone within one week of receipt of the letter of invitation. When the necessary number of participants did not respond within two weeks, a second, reminder invitation to participate in the research study was sent to the nurses through the same channels as the first letter (Appendix D). The two letters sent did not provide me with an acceptable number of male participants. I therefore used a "snowball" sampling technique whereby the participants who agreed to the study were asked to approach their male colleagues in an attempt to recruit them into the study. The participants who agreed to contact their colleagues were requested to forward a letter of explanation and invitation to participate to male nurses that they contacted (Appendix E). The HSC and I did not know whom the participants contacted. A second reminder invitation was not sent, however, the process of participant recruitment by colleagues continued until the require sample size was obtained. The actual data collection began as soon as a participant agreed to participate in the study.

Data Collection

Data was collected utilizing a combined structured and semi-structured interview technique (Appendix F) that took approximately one hour to conduct. The participants understood and consented to the possibility of a second interview if additional information or clarification of information was required. A second set of interview questions was not developed, as the potential questions to be asked in a second interview were not elucidated before the initial interviews. A second interview did not occur with any of the participants.

The structured component of the initial interview provided the necessary demographic information about the participants which: "is useful in securing comparative baseline data" such as "qualifications and experience" (Fetterman, 1989, p. 48). Fetterman (1989) believes that structured or semi-structured interviews "are most valuable when the fieldworker comprehends the fundamentals of a community from the 'insider's' perspective. At this point, questions are more likely to conform to the native's perception of reality than to the researcher's" (p. 48). Although I did not work with the male participants; I am a male, and a nurse, and therefore, the questions and conversation that occurred during the interview could be perceived as coming from the perspective of an "insider" and thus be more in tune with the reality of the situations discussed. Using the semi-structured interview approach allowed me to keep the interview focused, while allowing for exploration of tangential information resulting from the interview.

Another consideration in the decision to utilize interviewing as the method of data collection is the fact that as a male interviewing another male, I may have been provided with information that would not be as accessible to a female interviewer. Alternately, there was also the possibility that the participants could have chosen to not reveal information to

me, again, because I am a male or also because I am a nurse. As Fontana and Frey (1994) comment "the sex of the interviewer and of the respondent does make a difference" (p. 369). Williams and Heikes (1993) also discuss the importance of the researcher's gender when utilizing in-depth interview techniques.

The interview guide was based on information extracted from the literature, my own experiences, discussions with my committee chair and male nurses not in the study, the research question itself and the other questions generated from the research question. Additional questions arose from the interviews and I had no sure way of knowing where or what bent the interviews were going to take thus confirming the need for a semi-structured interview process.

One of the concerns that researchers have with qualitative research is the need for a method to ensure rigor (Sandelowski, 1986). The next section will describe the established rigor of the research study.

Criteria for Rigor

Sandelowski (1986) comments that it is inappropriate to "evaluate qualitative research against conventional scientific criteria of rigor" (p. 27). The establishment of trustworthiness for qualitative research as discussed by Guba and Lincoln (1989) was utilized in this research study. The criteria for rigor: credibility, transferability and dependability as described by Guba and Lincoln (1989) will be separately addressed.

Credibility

Credibility is the qualitative equivalent to internal validity (Sandelowski, 1986; Guba & Lincoln, 1989). The term "truth value" has also been used when discussing the credibility of a research study (Sandelowski, 1986). "Credibility occurs when the people

(participants) involved in the research read descriptions and immediately recognize the lived experiences to be their own" however, "the description may be of another participant, but it is believed it could be that of the reader himself" (Yonge & Stewin, 1988, p. 64).

Because "a study is also credible when other people (other researchers or readers) can recognize the experience" (Sandelowski, 1986, p. 30), I planned to use objective third parties to establish credibility of my interpretations of the data. Although I did not actually canvas objective third parties I did receive feedback from my committee chair.

Transferability

"Transferability may be thought of as parallel to external validity or generalizability" (Guba & Lincoln, 1989, p. 241). This criteria has also been described or called "applicability" or "fittingness" (Guba & Lincoln, 1989; Sandelowski, 1986; Yonge & Stewin, 1988). Research on female patients acceptance of male nurses when providing personal care has focused mainly in the area of obstetrical nursing and midwifery (Mynaugh, 1984; Newbold, 1984; Sweet, 1974; Tagg, 1981). The majority of the concern expressed in the literature focuses on the aspects of the provision of personal and intimate care. No literature has demonstrated the male nurses' strategies in those or any other areas, but the potential for transferability cannot be negated. Thick description is necessary to ensure transferability (Guba & Lincoln, 1989). The interviewing procedure provided for the necessary thick description, which enabled me to extrapolate the findings to other situations. The findings were to be considered transferable by member checks and peer review which demonstrate applicability to the vastly different areas in which nurses work. This was accomplished by discussions with my committee chair.

Dependability

"Dependability is parallel to the conventional criterion of reliability, in that it is concerned with the stability of the data over time" (Guba & Lincoln, 1989, p. 242). This criteria is also called "consistency" or "auditability" (Sandelowski, 1986; Yonge & Stewin, 1988). Auditability is accomplished when "another researcher can clearly follow the 'decision trail' " and, "could arrive at the same or comparable but not contradictory conclusions" (Sandelowski, 1986, p. 33). To enable this criteria to be met I used field notes and memos to describe any observations of non-verbal behaviors that may have or may not have demonstrated congruence with the verbal answers provided by the participants. This method ensured adequate and appropriate documentation of the overall research process. This will allow "another researcher to follow the thinking, decisions and methods used" (Yonge & Stewin, 1988, p. 64) by myself to come to the conclusions put forth. Once the criteria for rigor was established, I began the process of data analysis.

Data Analysis

As Fetterman (1989) suggests, the data analysis section began with the first interview and continued throughout the research study. I transcribed verbatim the data from the audiotape recordings. This allowed me to become intimately knowledgeable about the responses provided by the participants. I looked for patterns of behaviors, strategies and interventions that the participants utilized when providing personal and intimate care with female patients. After a few interviews took place this information necessitated a slight revision of the interview guide in that I added questions as new and unexpected avenues of exploration opened.

I looked for key events that occurred with the participants that provided an avenue

of exploration to focus on during the analysis (Fetterman, 1989). An example of a key event that occurred with the participants was when a situation arose where the female patient did not want the subject to care for them because of their gender, but had no other alternative. The behaviors, strategies and interventions utilized by the participants during these key events stimulated further discussion, questions or understanding by myself.

The threat to the truth value of a study lies in the closeness of the researcher-subject relationship (Sandelowski, 1986). Because I am a male nurse who has provided personal and intimate care with female patients, it was a little difficult for me to separate my feelings and experiences from those of the participants. During the interview process I tried not to fall into a "conversation" and sharing of experiences with the participants. It was important to focus on the information provided by the participant and allow the interview to flow from the participant's experiences.

Burnard (1991) provides fourteen stages in the analysis of qualitative interview data, from the first initial steps to take after the interview, to the writing of the data and linking it to the literature. I used an altered version adopted from Burnard. I analyzed the data as follows: 1) I reread the interviews (after transcription) line by line and identified ideas, thoughts or concepts that I believed to be significant. 2) I then paraphrased identified segments of the interview that grasped the concept of the discussion. 3) Each paraphrased section was then identified by a few words. 4) Those few words were then categorized into single terms or words, which were then grouped into themes or concepts. 5) My committee chair was consulted and the findings confirmed. Writing the data analysis began at this point.

My own past experiences along with discussions with my committee chair and other

male nurses (not participants) allowed for the technique of triangulation to occur. Fetterman (1989) describes triangulation as "the heart of ethnographic validity, testing one source of information against another to strip away alternative explanations and prove a hypothesis" (p. 89). In addition to helping demonstrate the validity of the information, utilizing triangulation supports the aspect of internal consistency (Fetterman, 1989).

The next section discusses why the data analysis is not necessarily a true explanation of the strategies, behaviors and mannerisms used by male nurses when providing personal and intimate care with female patients.

Limitations of the Study

As with all research, there are limitations to this study that prevents the findings and conclusions drawn from being considered the definitive explanation or understanding of the research question. The limitations of this study are as follows:

1. A major limitation is that I analysed the data only as the participants described it. I could not verify the participant's information because there was no simultaneous observation of the described behaviors, mannerisms or strategies. Observation of the participants in the actual situations is essential to provide for documentation of congruence between the perceived reality of the participants and the actual reality of observed behaviors (Brink & Wood, 1991). Non-participant observation was ruled out as a possible method to utilize because of the sensitive nature of the research. It would be inappropriate for a researcher to observe the participants performing these personal and intimate nursing interventions because of the need and right for privacy of the female patients. In addition, the idea of having not one, but

two males (one being myself) present during these intimate procedures solely for the purpose of research would not have allowed the normal nurse-patient interaction to occur thus nullifying the results of the study.

2. Another major limitation was that even if the participant believed he had been successful in ensuring that his female patient was not emotionally or psychologically uncomfortable with the personal and intimate care being provided, there was no way of knowing if indeed the participant was successful without actually asking the patient. This would require further information and data gathering (possibly having a qualitative and quantitative component) that was beyond the scope of this research study.
3. Another limitation was the inability to assess whether or not the female patient would have been just as uncomfortable with the care if a female nurse had provided it.
4. A final group of limitations was the fact that the level of health, cultural and religious beliefs, personal preferences and perceptions of the patient may influence the emotional and psychological comfort level of the patient. Therefore, in one situation the patient may have felt uncomfortable with a male nurse providing personal and intimate care while at another time, or in another situation, this may not be a factor.

The limitations of this research have provided possible explanations as to why the findings of the study may not be transferable, however I believe that the findings are credible and dependable. The last and possibly most important aspect of this research methodology is the section on the ethical considerations utilized throughout the study. This

aspect will now be discussed.

Ethical Considerations

An application was submitted to the University of Manitoba Faculty of Nursing Ethics Review Committee for ethical approval. Approval was also sought through the Access Committee at the Health Sciences Centre (Appendix G). The reason for the study, as well as a complete description of the study and the expectations of the participants was thoroughly explained to the potential participants.

The participants were informed that they had the right to refuse to participate in the study for any reason, without cause or concern of repercussions from me or the institution to which they belonged. The potential participants were informed that they were able to withdraw from the study at any time without prejudice. Participation was entirely voluntary. Questions about the study were encouraged at any time throughout the course of the study. The participants were provided with a written consent form (Appendix H) that was read to them prior to the signing of the consent thus ensuring informed consent occurred.

Confidentiality was assured with myself being the only person aware of who participated in the study. Although the institution provided the names and forwarded the letters of invitation, they were unaware of the participant's participation or non-participation in the study. The "snowball" technique of participant recruitment was required. I however did not know whom the participants agreeing to forward letters of explanation and invitation to participate contacted. The HSC was unaware of these participants. The participants were informed that excerpts from the interviews may be utilized as examples within the context of my thesis or any possible future publication, with the knowledge that individual responses will be unidentifiable. Confidentiality of the participant and any patient

that he may have cared for was of utmost importance. Any identifiable characteristics were altered to ensure that neither patient nor participant could be identified.

The only identified ill effect resulting from participating in the study, was the possibility of a potential risk of psychological or emotional discomfort arising from the sharing of personal information. My experience as an educator, along with my ability to effectively communicate minimized the possibility of the participants experiencing any discomfort. I believe that participation in the study may have ultimately been beneficial to the participants and their future patients by making the participants more aware of this aspect of their nursing life. This awareness could cause him to alter or continue with the current behaviors he uses, in the situations discussed, that ultimately will affect the patient.

Methodological Summary

This chapter has discussed the methodology that I plan to utilize during the study that I have chosen to embark upon. A descriptive qualitative process using concepts associated with ethnography while using person-centered interviewing as the method of data collection was chosen for the design of the study. A convenience non-probability sample of male nurses will provide the data utilizing a semi-structured interview approach to data collection. Data collection will be analyzed using an adaptation of Burnard's (1991) fourteen step method of qualitative data analysis. Limitations of the study were recognized and provided potential future research questions. Finally, ethical considerations of the study were addressed ensuring the principles of ethical research were maintained.

CHAPTER IV

QUALITATIVE ANALYSIS

Introduction

This chapter will provide the results of the qualitative analysis of the fifteen interviews conducted. The analysis discusses the issue of male nurses providing personal and intimate care with female patients. The analysis includes: 1) Factors Influencing the Comfort of Female Patients When Receiving Personal and Intimate Care with Male Nurses; 2) Factors Influencing the Provision of Personal and Intimate Care with Male Nurses; 3) Factors Dealing with Societal Considerations and Expectations Relating to the Provision of Personal and Intimate Care; and 4) Factors Influencing Nursing Education as it Relates to the Provision of Personal and Intimate Care by Male Nurses.

It must be noted at the onset that this study was accomplished by interviewing male nurses regarding their provision of personal and intimate care with female patients. The data received was based on the male nurses' past experiences in caring for female patients therefore any information provided by the participants is based solely on the participant's beliefs, values, feelings, perceptions, understandings and recollections of the situations discussed. It is also based on the participant's own perception of the female patients.

Factors Influencing the Comfort of Female Patients When Receiving Personal and Intimate Care With Male Nurses

The concept of comfort is a priority for nurses in the provision of nursing care. Of all the questions presented to the participants, the responses relating to patient comfort were by far the most frequently expressed thought. Virtually every participant indicated that comfort of the patient was of paramount importance.

Factors influencing female patient comfort when receiving personal and intimate care with male nurses were: 1) the female patient's feelings and perceptions; 2) trust, confidentiality and privacy, 3) the age and body image of the female patient, 4) sexuality, 5) previous experiences of the patients, 6) the patient's condition or level of acuity, and, 7) the amount of control or choice held by the patient. Each of these factors will be addressed separately.

A major component of comfort that the participants expressed as being important when providing personal and intimate care with female patients was the patient's feelings and perceptions. This component of comfort is initially assessed cognitively, intuitively, or empathetically by male nurses prior to the commencement of providing personal and intimate care (sometimes within a matter of moments) and then continuously throughout the provision of all care provided.

The Female Patient's Feelings and Perceptions

Taking the female patient's feelings and perceptions into account is an important aspect of developing the nurse-patient relationship. The development of a positive nurse-patient relationship "allows" the nurse to do what needs to be done within the context of a therapeutic relationship. It is also important to take the patients' feelings and perceptions into account if the nurse wants the female patient to be emotionally, psychologically and physically comfortable. However, gender differences do come into play when providing personal and intimate care. As one of the participants stated:

> I mean you're a nurse, you're a nurse. You take care of patients. Again it's an issue of how does the patient feel with a male taking care of them? I think that's what's most important, is, how does the patient feel about it? ... The ultimate issue is how does the patient feel with a male taking care of them. (3, 282)

The male nurse tries to assess the patients' feelings and perceptions and takes this into account when providing personal and intimate care with a female patient. Very often the patients' feelings result from how or what the patient perceives to be occurring in a particular situation. Patient perceptions were frequently mentioned in regards to the comfort of the patient. As one participant expressed:

> What are their perceptions of a male doing a catheterization? Are they going to perceive this as me touching them? Can you make them comfortable enough to think this is just a procedure that is being done and that's all it is? You separate those two things. With experience you learn it is a procedure but you can do it in a caring way. Give the person comfort and help them through their perceptions of whatever you're doing. It's not just intimate care, but personal care, like being with a person, holding them through a very difficult time. (10, 577)

In another scenario it may be critically important that the male nurse be able to assess his patient's feelings and take them into account. For instance, the nurse may be the same gender as the perpetrator of an assault upon his patient and therefore could potentially create a negative influence on the comfort of the patient during a time when they are already emotionally and psychologically distressed. One participant described a situation where a young female had been assaulted:

> I felt sad for what happened to the girl. I didn't feel that myself being a stranger, a male and from a different race, that she needed me at that moment you know. She wasn't in a life-threatening situation, it was more of an emotional thing at that moment with her. I thought I might have just compounded things or the experience a bit longer in essence. You know, another part of the process for her. (6, 203)

At these times, and whenever the male nurse is providing personal and intimate care with his patients, he has to assess the level of comfort his patients are experiencing and react accordingly. As demonstrated above, patients' feelings and perceptions play a factor in how a male nurse provides personal and intimate care with his female patients. Another factor to

be considered is the importance of trust, confidentiality and privacy that a female patient has to have in the male nurse related to the provision of personal and intimate care.

Trust, Confidentiality and Privacy

The participants indicated that the patient's comfort often depended on the patient's ability to trust the male nurse. The participants also indicated that patient comfort would be enhanced if the male nurse preserved their female patient's confidentiality. During these discussions privacy was also identified as an important component in the provision of personal and intimate care. As one participant expressed, it is about:

> people feeling self conscious about exposing themselves. About providing those kinds of information to people that they don't know. Wondering whether or not you can trust this person not to tell somebody else who might in turn know you. I guess ultimately, the confidentiality issue is in there as well. (4, 665)

And another participant stated: "I suppose that the female patient might be concerned. Can she trust the caregiver? And I think it's an issue of trust. They're trusting you for more than just personal hygiene" (5, 635).

The participants believed that to help ensure the patient's comfort they would have to have a relationship based on trust. The patient had to trust the nurse not only with the physical hands on care that was being provided, but also had to believe that the male nurse would maintain her privacy and confidentiality. This privacy and confidentiality not only related to what the male nurse did with the patient, but also what they observed and what they knew about the patient. For example, knowing that a person has just been sexually assaulted; or that someone has just been physically abused by their spouse or guardian; or knowing how many abortions, miscarriages or sexually transmitted diseases one may have

had are very personal and private matters. This information is not normally disclosed to anyone other than ones' closest and most trusted friends, relatives or significant others, if to anyone at all. And yet nurses (male and female) are privy to this personal and intimate information and are therefore trusted to maintain confidentiality and privacy.

The perceptions of the nurse will be discussed more fully later in the analysis. However, it was in this section that the participants' own definition of what personal and intimate care entailed, that identified how complex and ambiguous the concept of personal and intimate care actually is. What was consistent throughout the interviews and was expressed by the majority of the participants was the idea that personal and intimate care was much more than just the provision of physical "hands on" care.

> I mean intimate care could be talking one on one. ... Being intimate with somebody you're being private with them. They will discuss things that they don't discuss normally with other people, strictly because of the context of the situation. ... They may discuss certain feelings they have. It could just be how they're doing at home. How they're coping at home. They will discuss certain issues with you that they would not necessarily discuss with other people. (5, 329)

While trust, confidentiality and privacy are important considerations in the comfort of the patient receiving personal and intimate care from a male nurse, another factor that can influence the patient's comfort is the age and body image of the patient.

Body Image and Age of the Female Patient

The participants believed that the comfort of the patient could be influenced by how modest the patient was, as well as how self-conscious or embarrassed the patient was in a particular situation. Modesty, self-consciousness and embarrassment often result from one's body image. As one participant stated:

> Women can be very uncomfortable if they're feeling that a man is there watching them be incontinent of stool or urine or that they have an infection going on. They

> don't feel good about themselves and they feel a man is seeing them weak and unclean. (8, 262)

Another participant spoke to the patient's self esteem.

> If someone was obese you may find that they're constantly explaining why they are and apologizing for it or may be even angry or defensive about their own body. A lot of their own concept of their body image or how they feel about themselves, self-esteem wise will make a difference. (11, 276)

In analyzing the data, numerous references were made relating to the age of the patient and how comfortable or uncomfortable the female patient felt when being provided with personal and intimate care by a male nurse. The following excerpts indicate that younger female patients experience greater discomfort when a male nurse provides personal and intimate care.

> It seems to be harder for younger patients. Younger female patients, and I'm not just too sure why actually. Simply put, a lot of men may not have seen them naked. For the most part older people are not as self-conscious. They've had a number of life experiences. (11, 210)

> Younger females tend to require the female nurse more than older people do. As you get older you have seen more of the world and see things from a bit of a different aspect. Younger people have more guidelines. They say well it should be female nurses for female patients and male nurses for male patients and many would prefer to have female doctors. (15, 137)

> It seems to be harder for younger female patients. For the most part older patients are not as self-conscious. Younger female patients probably are not even all that comfortable with their own body or their own sexuality. (11, 210)

A number of the participants identified that if a female patient was older, there was less of a tendency for the patient to feel uncomfortable with a male nurse providing personal and intimate care. As well, some of the participants commented that patient's feelings and self-consciousness relating to their bodies might be related to their age. For example:

> Age is one thing I've noticed as a big difference. Older women don't become as embarrassed as easy. Comments such as 'Oh, you've seen this already' and ' I'm

> this old, it doesn't matter any more'. While the younger ladies, well sometimes they're a little jittery and you can sense it. (9, 158)

> Older people can make you feel comfortable due to their easy acceptance of their body. They're used to their body. (14, 207)

Comments made by the participants also indicated that elderly female patients may or may not be entirely comfortable with having a male nurse provide them with personal and intimate care. For example some older women may have difficulty with male nurses providing personal and intimate care while others may not. This could be due to the patient's own perception of the situation or it could be due to their upbringing. As one participant expressed:

> Some people come in and they're in their eighties or nineties and they're from the old Ukraine and this was their religious and moral beliefs. The only one who sees me is my papa, my hubby and mommy and that's it. (12, 505)

While yet another participant expressed it this way:

> It depends on the patient's age and experience. Elderly women tend to be very shy and are not sure if it's correct for men to be involved with this type of care. But I've met older women who think it's wonderful. Younger women can be very uncomfortable. If anyone will refuse care it'll be a younger female in her twenties or thirties or a teenager. (8, 578)

It was while discussing the age of the patient that most concerns seemed to be expressed by the participants. It was in this area that most participants commented on the concept of sexuality and how sexuality can affect the patients' and the participant's perception of the situation. This brings us to the concept of sexuality and how the provision of personal and intimate care by a male nurse affects the comfort of the female patient.

Sexuality

As the term implies, the provision of personal and intimate care is just that – personal and intimate. The provision of personal and intimate care can be psychological,

emotional or physical of which any or all of these aspects can take on a sexual nature or connotation. To deny the fact that people in general and society as a whole tend to sexualize the male and female reproductive systems would be tantamount to denying a whole facet of being human. Because of this, there is an underlying sexual connotation to the provision of personal and intimate care. It is this sexualizing of care that has to be overcome when male (or female) nurses provide personal and intimate care with their patients. As one participant stated:

> Generally most women are quite open to having a male nurse care for them. But there are the sexuality issues that come into play depending on the age of the patient, especially if they are younger. (10, 58)

Another participant stated:

> I think it is a concern. It's something one has to be aware of. Sometimes it's not easy dealing with female patients in their personal care. It's something that has to be looked at. There is such a thing as sexuality. (14, 43)

And another participant stated:

> I think it's important because as nurses we're taught to take a holistic approach towards the patient. The one area that seems to be lacking is the sexual area. Nobody feels comfortable to bring up that type of topic or talk about it. If patients do talk about it, it sort of catches me a little bit off guard, but I am able to talk in a frank and informative manner. You know, when to resume sex after cardiac bypass surgery, that type of thing. (2, 115)

Participants were questioned if there was less of a concern when female nurses provide personal and intimate care with male patients. One of the participants responded as follows:

> I don't know if there's less of a concern. Again I think that it has to do with a lot of individual factors in how they feel about themselves. How they feel about the opposite sex. How they feel about sexuality. And how they kind of work that into their professional lives. So I think it's probably an issue also for them but I don't think it was something that was addressed in terms of like how do you undress. How do you touch another person. And how do you do things that are more than touching such as inserting tubes or manipulating people's genitals or things like that in a way that is professional. I don't think that's addressed. (8, 62)

It was previously mentioned that perception of a situation has a lot to do with the comfort experienced by the patient. The participants believed that patients might perceive personal and intimate care as having a sexual component or connotation. One of the participants expressed it this way:

> When I first thought about giving or doing a catheter or perineal care or whatever, you have it in the back of your mind that they will think of it as sexual. I don't think I actually thought of it as being sexual but you still think, like what is this person going to think that I'm doing this. You know what I mean? Like it becomes like what are their perceptions of a male going in and doing a catheterization. What are their perceptions? Are they going to perceive this as me touching them or whatever. Or can you make them comfortable enough to think no, that this is just procedure that is being done and that's all it is. (10, 585)

If indeed the perception of the patient is that this is a sexual experience then this could create extreme emotional or psychological discomfort for the patient. This discomfort may be a result of the patient's past experiences and history. As one participant stated:

> There will be some people that you will never alleviate that fear, for whatever reason. Often I think it's from their past. They've had traumatic experiences or something that's triggered this fear in them. Or it's just their upbringing of their own sexuality. And their comfort levels with let's say, let's say they've always gone to see a female doctor, you know, for whatever reason, that's probably because they do have a reason. That they don't feel comfortable with males looking after them. (10, 690)

Nurses have to deal with the whole patient. That includes sexuality and all issues pertaining to sexuality. Nurses also have to deal with the patient's perceptions regarding the personal and intimate care they receive from the nurse. If nurses do not identify or address the concerns expressed by their patients regarding the sexualizing of the personal and intimate care that they provide, they will have difficulties in ensuring that their patient's psychological, emotional and physical comfort levels are maintained. The concept of sexuality and the sexualizing of providing personal and intimate care with

female patients will be more fully explored later in the analysis.

One of the other factors that can affect the patient's comfort level when being provided personal and intimate care was described by the participants as the patient's previous experiences. This component will now be discussed.

Previous Hospitalization Experiences, Including Encounters with Male Nurses

How or why a patient accesses the health care system can play a major factor in how comfortable or uncomfortable a patient may feel when being provided with personal and intimate care. A young, healthy female who gets into an automobile accident that requires hospitalization versus an elderly woman living in a personal care home may have two totally different perspectives on the care that they receive. The unexpected need for hospitalization does not prepare one for the care that will be required, let alone the concept of that care being provided by a member of the opposite gender. As one of the participants commented:

> Younger females tend to be a little more self-conscious unless they've had a chronic illness. That requires them to get adjusted to that kind of thing. But the task you have to accomplish, such as inserting a catheter. Sometimes the age – the elderly may have had it done before. They're kind of used to it. Compared to a twenty-five year old female trauma victim. I mean she's uncomfortable and you know that she's embarrassed by you having access to that kind of situation. (4, 76)

Alternately, a female patient who has had personal and intimate care provided to them in the past by a male nurse will most likely be less concerned (provided the experience was a positive one) the next time they encounter a male nurse. As one of the participants commented:

> I think the number of hospital experiences prior to you encountering them makes a difference. They know that they need to check their dignity and self-consciousness at the door and pick it up when they leave. (11, 225)

The same participant also commented that: "It helps if they've been in the hospital system. They realize that people dealing with them will be professional and will be focussed on their area of expertise" (11, 266). Another participant stated:" If the patient has already had a male nurse they know what to expect. I think that they know that there is no difference" (13, 124).

While yet another participant stated that:

> I think some patients feel uncomfortable having male nurses because they're just not used to the idea of having a male in that role. I think that's changing. A lot of female patients after they've had a male nurse would rather have another male nurse look after them. The one's who have previously had male nurses don't have a problem with it. (13, 52)

It appears that if a patient has had care provided to them in the past by a male nurse, they are more accepting of the idea of having a male nurse provide personal and intimate care to them in different or future situations. Also, the more experience a person has in the health care system and the more exposure they have to personal and intimate procedures seems to increase the comfort level of the female patients when they have personal and intimate care provided to them by male nurses. As one participant commented: "If they've had it done before and they know that it was part of something, that was easier for them. They knew it had to be done, they had no real choice in the matter" (10, 436).

There is however another component of this section that can affect how comfortable or uncomfortable a female patient will be when provided with personal and intimate care by a male nurse. That component is the patient's condition or level of acuity.

The Patient's Condition or Level of Acuity

Providing nursing care, and therefore personal and intimate care, is carried out in

every imaginable setting and context. Anywhere where there is a patient requiring nursing care there is the potential that a male nurse may be the one providing that care. Although all of the participants currently work in urban hospitals I was amazed with the varied areas of nursing that these men had worked. Upon further reflection, I was struck by the similarities of their approach to patients regardless of the situation or context of their interactions with female patients.

When I analyzed responses related to the patient's condition or level of acuity, the setting or context of the situation appeared to influence the comfort of the patients experiencing personal and intimate care with male nurses.

Setting or Context

The setting or context of the situation plays a factor in the comfort level of the patient. In some situations the patient has more control over when or how their care will be provided as well as with who will be providing the care. In other situations the patient has little or no control or participation in the decision making process as to when, what or how the procedure will be done, let alone who will perform the actual nursing intervention. The reasons for this are varied, however, the most frequently expressed reason for the differences is the acuity level of the patient.

Some of the participants expressed that the more acutely ill the patient is, the less likely there will be concern expressed by the patient as to who provides personal and intimate care with them. As one participant stated:

> I guess that in a way the patients in ICU are probably the most vulnerable patients. They don't have too much say in their care. You're basically their care leader and you decide when it's time to be turned, if they need to be suctioned, if they have to go down for a special test, when it's time for personal hygiene. These and many other aspects of care are decided for them by the nursing staff. Whereas on the

> wards it's a collegial or you're negotiating with those patients on the ward about when it's time to do this or when you're going to do that procedure. Or 'You're having your lunch right now, I'll come back later'. Those type of things. (2, 384)

Another participant stated that:

> It depends a little bit on how sick this person is and they don't care anymore. When a person is really ill, critically ill, I think that becomes the last thing on their mind. But when a person is not seriously ill and has lots to time to think about these types of things that can make it as a factor too. (10, 698)

While yet another participant stated: "I've probably undressed hundreds of women in the last couple of months because they were too ill to help themselves" (15, 101).

At times it is not the acuity level of the patient, but rather the situation that the patient is in that can define whether or not a male nurse will provide personal and intimate care for a female patient. One of the participants had experience with women in labour and his comment was:

> When they come into the labour floor that's the last thing on their minds. Is that they have a male or female person looking after them. They just want care and somebody that's going to be compassionate. That's the key to providing good care where somebody will not worry about it. (10, 316)

Another nurse expressed the same thoughts but added in his personal feelings on the topic.

> I think its okay for men to be there. A female in that situation is in need and they don't care who it is. For me it's not the most appropriate place to be, but I don't have an interest in that area. (7, 394)

One of the participants gauged how ill his patients were based on his assessment of their comfort level with him taking care of them.

> I used to be concerned about how comfortable patients were with it. But their focus is usually on what they're going through, not your presence. If they were suddenly self- conscious by the fact that I'm there, that probably tells me that they're getting better. (11, 147)

As the comments above demonstrate, the comfort level relating to the provision of

personal and intimate care for the female patient often depends on how ill the patient is and whether or not they are in any condition to express their lack of comfort. If the patient is intubated, unconscious, sedated or for any reason not in complete control of their faculties, then it would be difficult if not impossible, for them to express their concern or lack of concern related to the gender of their care giver. Another aspect that was alluded to in this section, which plays a factor in the comfort level of a female patient receiving personal and intimate care from a male nurse, was that of control.

The Amount of Control or Choice Held by the Patient

Seven of the participants identified the importance of choice or control when caring for their patients. The need for the patient to have as much control as possible in the context of their health care experience was an important consideration and aided in the comfort experienced by the patient as well as the development of the nurse patient relationship. One participant stated that:

> I try to make a point of asking them 'If you feel uncomfortable with this you let me know.' And I try to let them know that I'm open to them telling me what they feel comfortable with and what they don't feel comfortable with. I try to make a point of letting them know that, yes, if you want to tell me that you are uncomfortable with me then by all means tell me. And I think just telling them that makes them comfortable. I mean, they have a certain aspect of control. Just by you allowing them to be able to tell you when they feel uncomfortable, I mean I think that puts them at ease. (3, 780)

Another participant stated: "I explain what's going to take place over the day. What's going to happen. I ask them right up front if that's okay. I know that I'm a male nurse. I give that opportunity to refuse" (9, 378). He then continued with: "Depending on the time situation, depending on the personality and what's going on in the unit and everything. It's not the ideal way to approach it but I do believe in giving them that chance right up front" (9, 389).

The control that was provided to the patient could be anything from when the actual care was going to be performed to whom would be performing the care. As one participant stated:

> I usually say 'Look, if you're really uncomfortable with this, for me doing this, I can have someone else come and do it – and then it's their choice. People should have a choice. I'd like to give them the option because that builds trust. Because you are putting it into their hands.' (10, 178)

Another participant explained that: "Everyone has a right to control some aspect of their care and if that's something that can be controlled by the patient and it's something that they feel is important, then you have to offer it to them" (8, 525). While yet another participant commented that: "The patient should have the right to pick if they don't feel comfortable with male care. They should have the right to have a female caregiver" (5, 206).

As described by the participants it appears that control or at least the perception of having control in one's care provides a measure of comfort for the patient. Having this control enables the patient to decide whether or not she will accept the provision of personal and intimate care by a male nurse. Even though the patient may feel uncomfortable with having a male nurse perform certain personal and intimate nursing interventions, the patient knows that if they so choose, they can have a female nurse provide the necessary care. That knowledge and control provides the patient with enough comfort and trust to allow the male nurse to provide the necessary care.

In this section I have identified seven factors that male nurses report influence the comfort of the female patient when provided with personal and intimate care by a male nurse. The areas discussed were: the female patient's feelings and perceptions; trust, confidentiality and privacy; the age and body image of the female patient; sexuality;

previous experiences of the patients; the patient's condition or level of acuity; and, the amount of control or choice held by the patient. The next section of the analysis was the factors that influence the provision of personal and intimate care with male nurses.

Factors Influencing the Provision of Personal and Intimate Care With Male Nurses

In this section of the analysis the participant's own beliefs, values, perceptions, self reflection and characteristics come into play in the overall understanding of providing personal and intimate care with female patients. In this section, I discuss the personhood of the professional male nurse that includes 1) the personal and professional comfort of the nurse; 2) his perceived role as a professional; and, 3) his competence. Threaded throughout this section of the analysis is the concept of sexuality of both the patient and of the nurse. The analysis will demonstrate how sexuality affects the nurse patient relationship, and plays a role with the provision of personal and intimate care.

I will also identify the nursing interventions and strategies that the participants utilize when providing personal and intimate care with female patients which include: 1) communicative; 2) cognitive; 3) emotional; and, 4) behavioural aspects. As well a separate aspect entitled workplace setting or situational factors will also be identified. The first area of discussion is the personhood of the professional male nurse.

The Personhood of the Professional Male Nurse

Personal and Professional Comfort or (Am I Really Supposed to Do This!?)

In the previous section, the comfort of the patient was identified as the major focus of the participants when they provided personal and intimate care. The nurse-patient relationship needs an element of trust to be able to develop into a therapeutic relationship. One aspect that allowed this trust to develop was ensuring the physical, emotional and

psychological comfort of the patient.

The nurse's comfort, however, is also important when considering the nurse-patient relationship and the provision of personal and intimate care. If the male nurse is uncomfortable providing personal and intimate care, then the nurse-patient relationship is affected and ultimately the comfort level of the patient may also be affected. The participants were asked how they felt or what they were thinking the first time they had to perform personal and intimate care with a female patient. The following statements provide some insight into the perceptions, feelings, and thought processes of male nurses during their initial exposure to providing personal and intimate care with female patients.

> I was scared, I was really nervous. Just seeing a naked body. It was something totally new and I didn't know what to expect. I'd never really seen a naked body and I think it was embarrassment. The anticipation of being in a very embarrassing situation. The whole thing about being embarrassed. I don't know what's the word, embarrassing or being very uncomfortable. I guess washing a female patient, there's something about that that was very hard to do at first. (7, 450)

> I think I probably sweated away half my body weight and it was very awkward. I think in some respects my own lack of experience with seeing women naked would have been strictly the sexual nature in the form of a relationship (sic). And I think I was, and the patient seemed to be a little bit uncomfortable. But they tend to see how uncomfortable you are and suddenly it becomes this whole issue of both people being uncomfortable with what's going on. It's extremely difficult and I don't know if there's any way to get past it except just keep plugging away and getting comfortable with it yourself. Yes, I remember as a student it was weird. It's certainly not second nature to do that. (11, 519)

> Oh, my God! That wasn't one of the things I was thinking when I was going into nursing that I would have to be doing. The very first bed bath I ever had to do just sort of blew me away. It was a tough struggle the first couple months getting used to providing intimate care to patients. Doing complete care on males and females. It's something that you don't do. I mean this is an unusual thing. I never babysat, I never looked after children so I never had to do any of that. I mean the closest I ever got to providing care was handing out meals to people and then they asked me to go wash someone head to toe. Well I can do my own body thank you very much but getting to do someone else's, that's something that you kind of have to adjust into. You can't just jump in and say, 'Okay I can do this'. I think that part of

> that is upbringing. You know, you look after yourself and you look after your own body and that's it. You don't go out and wash anybody else, or look after anybody else. (13, 275)

As the above quotes illustrate, the provision of personal and intimate care does not come easily or naturally to male nurses. Part of the reason for this is that the care is personal and intimate for both the nurse and the patient. Because of this, the male nurse's own beliefs, values, morals, ethics and upbringing play a factor in how the male will feel about and deal with the innate sexuality that is a part of the provision of personal and intimate care with a female patient.

One of the ways that the participants dealt with this issue was by having a good understanding of their role as a professional. This understanding was based on their own perceptions, feelings and attitudes towards the provision of personal and intimate care with female patients. It was also based on the understanding that sexuality and the sexualizing of personal and intimate care needs to be acknowledged and dealt with.

Professionalism and the Sexualizing of Personal and Intimate Care

The participants were candid in their responses regarding this aspect of nursing. Their responses potentially could give rise to concern regarding the appropriateness of male nurses providing personal and intimate care with female patients, however, as the analysis will demonstrate it is their very professionalism that ensures the patient receives only the most moral, ethical and professional care. The following quotations provide an idea as to the range of thoughts, feelings and emotions that male nurses have when providing personal and intimate care with female patients. What will also be readily identified is the commitment that male nurses have to ensure that their patients receive the care that they deserve.

> You're glad to be there for them. And to me that is intimate care. It's not physical hands on stuff. It might be rewarding in the sense that you see that they're glad that they're able to tell somebody whatever it may be. Whatever is bothering them or concerning them. (3, 341)

The above quote demonstrates that it is not just the provision of physical care that the male nurses perceive to be personal and intimate, but rather the overall care that is required to address a patient's health needs. However, the same nurse also identifies the need to provide personal and intimate physical care and how the concept of sexualizing this care has to be dealt with. He continues as follows:

> Intimate care could also be perineal care. Now, here age would make a difference. I mean, providing intimate care to a young attractive female patient. Yes sure I mean (pause) you know, well sexual feelings. I mean I don't know how crude that sounds. But for lack of better words yes sure you get turned on. But as long as that does not get in the way of professional care. I've talked to a lot of male nurses and you know they take care of attractive females and yes sure the male nurses would get turned on. But again as long as that doesn't get in the way of your professional care. Sure I have been turned on, but as soon as it starts interfering with my care then I will refuse to take care of this female patient. Now, I felt it's never gotten in the way. I felt I've maintained professionalism. Who's to judge whether I did maintain it or not. I think I did. Therefore, I continued on giving care. But if I felt that it would get in the way of professional care then I would not take care of this patient. I mean intimate care is not just one thing, it's on a continuum. It's all aspects of this person's life that you're dealing with. As far as my definition goes when you touch on something that's private to them you become intimate with them and if you're helping them in any which way, then you're giving intimate care. I mean it's a big continuum. It's not just one thing specifically. (3, 356)

This same nurse reiterates how sexualizing personal and intimate care plays a factor in the provision of the care that is provided.

> Well let's go to the turned on thing. I've taken care of a young female patient and she was good looking. I did not insert the urinary catheter but I was helping. Yes sure you get turned on. But I make a point of it not getting in the way of my professionalism. I mean to me they're natural feelings and if I were to deny them I think I'd be a liar. It's probably common that male nurses do feel to a certain extent some attraction for whoever they are attracted to. It's not just necessarily young female patients. I mean a young male nurse could be attracted to an elderly female patient. But there might be certain attractions, whether they're emotional, sexual or

whatever kind of attraction. (3, 400)

The participant identifies and acknowledges that physical attractiveness and the concept of sexuality plays a factor in the provision of personal and intimate care with female patients. What he is adamant about, however, is the need to maintain a professional commitment to the nurse-patient relationship.

The need to acknowledge the feelings surrounding the sexualizing of providing personal and intimate care with female patients was also identified by other participants as well. One of the participants commented that:

> Physical attractiveness is always a difficulty. We have a memory you know. And we have probably a stereotype of what is beauty, of what is the firmness of the flesh. If you're mind is wandering to those channels then of course it's going to be more difficult. I mean then it's a matter of knowing your own state. And it does change. I mean, I'm sure there's some people who completely overcome those things but I'm not one of them. (14, 222)

As the above quote demonstrates, this particular participant had a good understanding of his ability to deal with the provision of personal and intimate care. He went on to say that:

> I don't think a nurse is a nurse is a nurse. I mean I think people have different skills, different abilities to deal with things. I think you're always pushing or tempting if you put especially young males and females and doing intimate care with male nurse to a female patient(sic). Because there's a sort of an attraction that always happens. And I think it could take many different forms. And of course, the more intimate the care that's going on, the more the chances are that it can go across boundaries that'd be unethical. I think ultimately we have to judge those boundaries ourselves. (14, 129)

He continued with:

> When you're dealing with other people's feelings you're dealing with your own at the same time. You always are. So the better handle you have on your own feelings the better it is. And sometimes I don't have a good handle on my feelings. (14, 579)

What this participant identified was the difficulty that a male nurse may have in dealing with the sexualizing of providing personal and intimate care. This sexualizing of the provision of personal and intimate care can create a feeling of discomfort. As one of the

other participants commented:

> Sometimes I guess when it's a really young lady let's say in her early twenties or your own age. For me it's a bit more difficult. It just, it's closer to home, to my age I guess. And that's probably the only time I ever get a little bit embarrassed. I'm not sure exactly why that is. I guess I'm scared and nervous that they might think I'm thinking something about them. If I'm supposed to give someone a post op bath and I'm supposed to give it and it's a 25 year old young lady I wonder if she's thinking, 'I wonder what he's looking at?' or 'Oh is he looking at my boobs?' or 'I wonder what he's thinking?' I feel self-conscious doing it. (7, 262)

Another participant acknowledged that he too could feel uncomfortable when providing personal and intimate care with a female patient.

> I think the most uncomfortable situation you can get to is actually encountering someone who is fairly close to your own age of the opposite sex. Because apart from the work situation this may be technically a person that you might have dated or have found attractive in a social setting. So I guess for me personally that might be the only time that you would actually feel in the back of your brain a bit self-conscious. (11, 301)

Another participant identified how he at first had difficulties with the provision of personal and intimate care with female patients but had resolved those issues:

> In general. I don't have any hang ups with providing any type of care to any females. I did at first because being new and not having to do a lot of that in the past. I mean when you grow up you're a teenager and a lot of the stuff, anything to do with females is generally sexually related in a lot of ways because you're going through that transition period. (10, 267)

Although "dealing" with the issue of the provision of personal and intimate care may indeed be something that has to be overcome by male nurses, one participant addressed the issue from a different perspective. He stated that:

> If a male nurse ever feels that the relationship developing with the patient is anything but professional they should recognize that there's a conflict there and bow out. But unless they encounter something of that nature, either initiated by their own feelings or coming from the patient's side, there's no reason why they shouldn't provide intimate care. If they have some problems along those lines, if they find themselves I don't know, having thoughts that are less than professional then they should excuse themselves from caring for that patient. If they find it's becoming a

> chronic problem they should seek counselling. But those types of people don't usually get too far into nursing. I guess the possibility exists but I think the fact that they've actually gone into nursing probably would suggest to me at least that they're somewhat mature enough to handle all those types of experiences and so it shouldn't be a problem (11, 326)

This same participant took the concept of the nurse-patient relationship one step further and acknowledged that if indeed a relationship appears to be developing that is anything other than professional then the nurse needs to deal with that situation appropriately. His comment is as follows:

> Well I think the worst thing you can do is probably deny that it's there. I think you need to acknowledge that these thoughts are in your head and then, if anything pay scrupulous attention to the professional aspect of your relationship and make sure it doesn't interfere. I think to not be aware of it and to not acknowledge it could steer you into situations where you might be compromising your job. Compromising the nurse-patient trust relationship. So the minute you start acting in ways that aren't, have nothing to do with what you are as a nurse, then you're walking on dangerous ground.
> I think at the very least if you are a male nurse and you find you're attracted to a female patient you should definitely get out of that assignment ASAP. If you plan at all to take up that experience make it very clear to the other individual that you cannot have a relationship within the hospital setting. I've worked with nurses that have married patients later. You know, after they've been out of hospital, so it does happen. I mean I'm not about to say that you can never ever have a relationship with a patient. But I think you have to be very clear that it cannot happen within the balance of the hospital. (11, 616)

Just as the male nurse brings his sexuality to the situation so too does the female patient. As one of the participants commented:

> One time, I guess its sort of reverse sexism, when I had just graduated a woman had made a comment about my bum (laughs). 'What a cute ass he has.' and this type of thing. So it's sort of like the construction workers looking at the cute girl walking by. That sort of struck me, I mean I didn't think too much about it at the time, but in retrospect its something that I think about and now I can understand how a female would feel given the same situation with men. There was an older woman I remember who tried to grab my penis but she was confused and hallucinating. So that was sort of a real strange kind of experience as well. (2, 261)

Another participant brought in both the male nurse's perspective and the female patient's

perspective with his comment.

> An older woman knows that you're not looking at them that way and that you don't expect them to be looking at you that way. Working with somebody in your own age group, it's like, she might be 'Geez you know this is some hot looking male nurse.' and you might be looking like 'Oh, this is real nice looking young girl'. (12, 337)

One of the participants commented how allowing male nurses to provide personal and intimate care with female patients might create unnecessary discomfort for the patient.

> I think it's just what the female patients have to go through psychologically in having a male when it has to do with your reproductive system and that. You know doing breast exams and all that sort of thing. Asking those questions and I think a lot of females are uncomfortable with it. (7, 409)

One of the ways that nurses have dealt with the need to provide personal and intimate care with female patients is by de-sexualizing the situation. However, if the patient sexualizes the provision of personal and intimate care then the nurse has to deal with that issue also. As one of the participants stated:

> And you know that they're kind of uncomfortable but you know if you do your job professionally that can often pass. For example when you have to listen to their lungs or observe their abdomen or whatever, they're very careful to make sure their private areas are covered to the last possible second. That kind of amuses me because I haven't even thought of them as a sexual being to that point and you have to sometimes remind yourself that to them this might be a very in a sense sexual encounter even though to you it's not. But for them sexual in the sense that 'I'm covering my private parts. I don't let just anybody see that part of intimate care.' So different things like that can show that they're slightly uncomfortable with it. (4, 507)

One of the ways in which the participants dealt with sexuality and the sexualizing of the provision of personal and intimate care with female patients was to identify the need to provide this care as being a requirement of the job. This Perceived Role or (A Man's Got to Do What A Man's Got to Do) section of the analysis identifies the male nurses' perception that the provision of personal and intimate care is an important aspect of the job.

Perceived Role (A Man's Got To Do What A Man's Got To Do)

As the previous section identified, there is a belief or perception that providing personal and intimate care with female patients has a sexual connotation to it, and is therefore something that cannot be denied. What is also important however is how the participants deal with the sexual connotation behind the care that is provided. One of the ways that they do this is by knowing and understanding that everything they do is based on the fact that it is part of their role as a nurse. The nurses do not try and deny the sexuality of the situation, but rather understand that it is their awareness of their feelings and their responsibility to provide the necessary care that allows them to do their job. As one participant stated:

> I mean if there's some 25 year-old girl that's very beautiful and shapely or whatever, somebody might think you know, why are you doing this intimate care with this person? But to me it's part of my job. It depends on someone's perception of a situation that they think that there's some sexual connotation to doing something like this. Or having exposure of their bodies to somebody that's similar in age or just a bit older and that they might see it in that sense. That's the only thing I can really tie together. (10, 203)

Another participant introduced the fact that male nurses may not always be thinking professional thoughts, but then provides an idea as to how males deal with sexualizing the provision of personal and intimate care with female patients.

> I've had occasions where people have made comments and you end up joking about somebody after you've provided personal care. I think that's a very poor way of sharing things and thoughts that you've had. For example somebody mentions the lady who you've just provided personal care with, a very attractive lady, or makes some sort of comment about that and you might agree. I guess that's one way of saying that you've noticed these things. That you're not just a machine. Because you can't ever be a machine. You can't help but notice these things. I mean if Cheryl Tiegs or the equivalent model came in and you had to provide care. You'd have to be a complete machine not to notice some of these things. And in some ways it's a recognition of the fact that you notice them that you're trying to deal with them internally, but at the same time you're having to kind of block out the fact that this is

> not considered to be acceptable. I mean you're supposed to block it out. You're not supposed to notice these things. You're there to do a job you're not there to notice anything else. And perhaps it's a healthy way of trying to maintain your professional distance. But a lot of people you know, you wouldn't be able to admit that to, that you notice these things. Because that would be rude, viewed as unprofessional. Even though it's kind of impossible not to notice these things. (4, 841)

This same participant also identified that it is not just caring for a young female patient and the underlying sexuality involved that can play a factor in the provision of personal and intimate care. But rather, a patient that reminds you of someone could also make the provision of the necessary care difficult, but it is done because it is part of the job.

> One of the scary parts is when you have to admit a 22 year-old patient who comes in that normally on the beach you'd be looking at her, gawking at her in her bikini. Then all of a sudden you're supposed to be providing intimate care. And you're supposed to treat this as something like an inanimate object almost without any of those typical types of male perspectives. You go about doing your job and you just more or less block it out. You just do your job and that's it. But I don't know if it's much different when you have somebody who's 85 years old and reminds you of your grandma. You have to go in there and do perineal care and stuff like that. But in both cases you have to kind of do some blocking out and treat this as just a job. (4, 173)

Most of the participants dealt with the need to provide personal and intimate care from a matter-of-fact mode of thinking. That is, they believed it was a part of their role and of being a professional. There was no need to turn the provision of personal and intimate care with female patients into anything other than it actually was, and that was, a necessary requirement to provide needed nursing interventions. As one participant commented:

> It's necessary for me to be present to observe the wound drainage and the condition of the burn. I have to be there so I'm mandated to be present at a time when patients are naked. (11, 138)

Another participant identified the situation in the context of delegated roles.

> When you're in there, when you're dealing with a patient it's supposed to be, and for most part is, on a professional level and there is no sexual orientation or overtones

> to it. It's just the nurse is doing a job and the patient is not well and they both respect that. One is there to get well and one is there to provide the care for him. (12, 70)

While yet another participant reiterated this idea.

> Because I'm a nurse. That's what I'm supposed to do and I do it with a professional manner. And I think as long as it's done with a professional manner and a proper approach, there shouldn't be any problem with it at all. (15, 172)

One of the participants described how he dealt with providing care to patients, when the care created an uncomfortable feeling within him self. He did this by not personalizing the situation. In essence he was able to detach himself from the situation. He provided insight into how difficult it can be for a nurse to provide care to an individual in a given situation, and how some nurses may deal with difficult situations.

> What you're doing is you're taking care of somebody. It's not a male or a female. It's not a young person or an old person. It's a person that requires something to be done that you as a nurse are knowledgeable about and you have to go in there and do it. Over time you get better at being able to realize that what you're doing is important and not the person behind this. Kind of a depersonalization. And this probably goes against a whole lot of things that you're supposed to be talking about in terms of caring for the person. But I think in a lot of ways by depersonalizing the person to an extent you can often care for them better. Because if you're not so worried about what they might think or feel, it means sometimes being able to do what's necessary a little bit better. This issue goes beyond providing personal care in that sense. For example when we turn the ventilator off on a lady who was watching soaps in the morning and we couldn't wean her from the ventilator. She couldn't go home so she decided that's enough. I mean if you can't depersonalize that to an extent, I personally have to because I can't imagine what it would be like to be cogent to have the machine turned off. I can't imagine what that would be like. So that kind of goes all the way down to some of the smaller things. If you felt the modesty of every person that you did perineal care to you'd be worrying about that more than making sure that people got the kind of care that they needed. (4, 692)

This nurse understood the necessity to acknowledge one's thoughts and feelings about the provision of any type of care. He expressed how he personally and perhaps many other nurses, male or female deal with situations that for the most part are not an everyday

occurrence for the majority of the population. This could include something as serious as turning off a ventilator on a cogent patient who has decided that this would be better than living on the ventilator, to providing personal and intimate care with a member of the opposite gender.

The next participant summed up the concept of providing personal and intimate care with patients.

> My way of looking at it is I think there is far too big of an issue being made about it. I mean, there's too much stigma on this sexual thing like male-female. We're not male and female. We are registered nurses. We've been trained for that, hopefully very well. We take our job and our responsibility seriously and that's it. (12, 627)

It is that belief and value that we have as male nurses that provide us with the necessary determination to continue in our role as a nurse. Another way that we deal with the provision of personal and intimate care with female patients is by being knowledgeable and competent in our practice. This brings us to the last section in the personhood of the professional male nurse and that is competency.

Competency (I know how, I just need a chance)

Nursing is a hands-on profession. To provide safe, effective, competent and holistic care requires the nurse to be knowledgeable and technically competent. It is an applied profession that requires technical expertise and theoretical knowledge in conjunction with empathetic and compassionate understanding of the feelings, attitudes, fears and worries of people when they are ill and most vulnerable. Patients deserve care that is appropriate and safe. They expect their caregivers to have the necessary skills, knowledge and expertise to provide the care that is their right to receive.

Participants expressed this professional need, and personal desire, to be competent

particularly in the area of providing personal and intimate care. The participants expressed that their competency with the skills necessary to provide personal and intimate care helped determine their own comfort level. This in turn had a direct impact on the patient's comfort and trust in their nurse. One of the participants commented about the provision of personal and intimate care with female patients as follows:

> I think that it's an area where male nurses have to be very comfortable with women and sexuality and also have to be very comfortable with the procedures of intimate care, be it washing or catheterization or anything. If you get into a skill that you're not comfortable or adept at and then you start trying to practice or perform the skill and you're not comfortable with the whole situation to begin with then it becomes a disaster. So I think that it's important to realize the importance of having skill, of knowing what we're doing and how we feel about it. (2, 547)

Another participant also expressed the importance of feeling comfortable with the provision of personal and intimate care. By being comfortable with providing personal and intimate care the nurse is able to "normalize" the situation and in so doing increase the emotional and psychological comfort of the patient.

> A big thing is that you yourself have to be comfortable in giving that care. Once you're comfortable with it yourself, you show a different viewpoint on doing that aspect of care. You know what I mean? Like if you'd be really nervous about doing it and you are thinking you know, 'Is this person thinking it's sexual?' you might seem really nervous and kind of jittery about doing something. And I think right there you're setting off feelings in this person about you doing it. But when you're really comfortable and explaining it and it doesn't sound like a big deal to this person, well they'll think it's not that big a deal. It's how you present yourself to the patient. If you exude confidence and that this is just part of work and it's something that you do, I think that the patient sees it differently. (10, 650)

In the "Old Wild West" there was a saying among gunslingers 'First you get good, and then you get fast'. The thought behind this was that no matter how fast you were, if you could not hit the target that you were aiming for, that is if you were not competent, then all the speed in the world would not help you. That same concept applies to providing any

nursing skill. If the nurse does not know how to perform a skill accurately and correctly they will be unsafe no matter how quick or efficient they are at performing the skill. One of the participants identified the importance of being quick and efficient in the performance of skills of a personal and intimate nature, but also commented on the need to be comfortable and competent. The participant stated that it was important to:

> Be comfortable and adept at giving physical care quickly and efficiently. Having excellent skills in terms of, like if you need to do a PV exam or if you have to assist with a PV exam or if you have to do a catheterization. Having had the experience of actually doing that and doing it easily and comfortably really makes it easier. I mean if you come in and you look anxious, you look nervous, you're kind of already giving messages that you don't want to do this, you haven't done it very often, you don't know if its going to work and its a bother and all that kind of stuff. But if you can focus on the patient, their needs, what's going on and know how to problem solve yourself a skill that may be complicated such as the catheterization of a pregnant woman who's about to deliver and is in retention. Those are the things that are going to make giving intimate care easier. (8, 464)

Later in the analysis the importance of communication will be dealt with extensively. However, at this time it must be pointed out that communication between the nurse and the patient is of the utmost importance. The participants expressed that it is not just personal and intimate care of a physical nature that they have to deal with. The participants also have to communicate with the patient about personal and intimate details of their lives. As one of the participants commented: "Once I introduce myself to that patient that to me is personal care. So once I'm introduced to that person it becomes intimate because I'm accessed and privy to all the information" (9, 121). Another participant stated:

> There is a lot of things we talk and deal with that could be regarded as intimate and personal. Sometimes people explain their marital problems to you or problems with their past life and what's going to be happening in the future. You know all sorts of things. Their death wishes. (12, 119)

The information and situations that nurses are privileged to can be overwhelming if one

actually considers for a moment just how personal and intimate health care situations can be. It is only the ability of the nurse to develop a rapport with their patient that allows for these extremely personal or intimate moments to be shared with someone who only a short time earlier was a complete stranger. And it is during those times that nurses have to be competent in their ability to develop the necessary rapport. One of the participants described a situation that he had experienced that encompasses the concept of rapport building and intimate sharing between a nurse and his patient.

> I have one that really sticks out in my mind. It was a patient who was going through transplant and was very sick. Or just before they got very sick and they knew their prognosis was not that great and we were talking and I had looked after her for a number of days already in that week and we had done the rectal swabs and all that kind of thing. And it was no big deal. But during that period of time we seemed to really connect for whatever reason just in talking in general and she started to share her fears and different things like that. And I was there able to listen to her and to support her through this very difficult time. She didn't have a lot of family around. The following week, she came back to me and said how much she had appreciated that I was there for her and able to talk and just be a friend and share in that intimate moment of connecting with something that's very serious in her life. That she could possibly die from the treatment that she was receiving because of just the circumstance that she was in. To me that was very rewarding, like a pat on the back that I am able to care for female patients and to provide them with excellent care. Regardless of the gender, just that I'm able to do that. It'll always stick out to me, cause I just started nursing and that was a tremendous boost. (10, 327)

As the above comment illustrates, male nurses need to be comfortable with communicating with the patient about personal and intimate information or situations and not just the provision of personal and intimate care of a physical nature. Another participant described this aspect by stating:

> You have to be fairly confident about how you're going to deal with asking those questions whether it be about their sexuality, about events that occurred to them, and what your comfort level is and what their response is. So I think it's doing a lot of assessing, deciding where this person is at, where you're at, what the information is that you need and how badly it has to be gotten. If it's in terms of like you know needing to find out if this person has been in contact with someone with a sexually

> transmitted disease and that it's been transferred or something like that. So I think you have to have all those things lined up in your mind in terms of where you're going to go. (8, 337)

The ability to feel comfortable providing personal and intimate care with female patients, was directly related to the participant's experience. The more experience the participants had in providing personal and intimate care of any type, the more confident and comfortable they were. The participants were asked to remember back to their student days and describe what it was like when they had to provide personal and intimate care. As students, the participants remembered focusing on the task rather than the patient. As one participant expressed:

> I mean you're so involved in 'Okay, am I doing this properly? Okay this is what we got taught.' so I mean you're not even thinking about intimate care. All you're doing is being like a robot and doing what you were taught and that doesn't even come into your head. I was thinking about other stuff. (3, 560)

This thinking about "other stuff" had to do with the student wanting to do things right. As students, all skills are important and getting them right is a requirement to pass. This need for competency is important for all skills, but when you factor in the gender issue and relate it to the provision of personal and intimate care it is important to be competent. As another participant stated:

> I guess the worst part was trying to get it correct. Thinking of the procedure itself. That was about it actually. I don't now have qualms or quirks about it at all. I guess technique was my greatest concern. Doing it properly. Once we get passed it's okay with her it's okay with me that's the halfway point. Doing it properly is definitely it. (9, 295)

Another participant also focussed on the task, but even as a student he realized the need to ensure that the patient is comfortable with the care being provided.

> I just went about it in a focussed direct way and tried to demonstrate competence and security. If the patient was feeling insecure I did not want to feed that insecurity. (1, 208)

Even as a student with the added personal discomfort of being nervous, there was an innate understanding that providing personal and intimate care requires the nurse to deal with the patient's feelings and that many factors have to be considered during the provision of personal and intimate care. One participant handled providing personal and intimate care as a student by being quick and efficient. This participant remembered:

> Trying to do it as quickly and efficiently as I could. You know with limited embarrassment or uncomfortableness for the client. I tried to make sure that I had everything with me when I went in to do it. (6, 332)

While yet another participant remembered his student days as follows:

> I tried to provide as much privacy as possible. I tried to be as gentle possible. I think it had to do with the catheterization of a female patient. I was nervous. I felt quite nervous about it. I tried to be as informative as possible. I tried to be as professional as possible. I tried to be hopefully as quick as possible. (2, 315)

As mentioned earlier experience tends to provide nurses with the knowledge and expertise to deal with the provision of personal and intimate care. One of the participants expressed how he would have done things differently as a student if he had known then what he now knew.

> I would probably show a lot more confidence than I did then. Being one of the first times I probably appeared pretty unconfident. I approach it with a lot more confidence now than I did before. Each time you get more confidence I guess. And I'm more professional now than I was then. And I'm better at it. I can get it done quickly and get it over with and keep them covered up as much as possible so they don't feel that they're totally exposed to my maleness. (15, 281)

The last statement by the participant identifies the crux of the matter. It is the maleness of the nurse that may cause discomfort in the female patient when there is need for personal and intimate care or information to be provided. As one of the participants identified:

> Female patients have fears about what they're going into. And not all of them are at the same ease talking to a male as they are talking to a female about what's going to happen. Or they feel that we might not be as knowledgeable about these procedures because we don't have the same anatomy that they have. (13, 106)

If you factor in the above explanation along with the lack of experience and incompetence it is no wonder that some female patients may feel physically, emotionally or psychologically uncomfortable with a male nurse providing them with personal and intimate care. As one of the participants commented:

> It'll put a question into their mind you know, does this guy know what he's doing? Is he competent? And then I'm going to pick up on that anxiety and it is going to be a vicious circle. (9, 360)

And another participant suggested:

> If you can get the skill down it shows a certain level of competency on your part. It sets the person at ease. You know that they know that you know what you're doing. If you're blundering around with a Foley for two or three times, it's not going to make anybody happy. For me my main concern throughout was technique. (9, 539)

Continued experience allowed the participants to feel confident in their ability to provide personal and intimate care to the point that the provision of the care became "second nature". Once that comfort level is reached, the nurse is able to move on to other important aspects of nursing such as emotional and psychological care.

> I mean right now it's all mechanical it's something you do. It's no longer an issue. Okay I got to clean the right leg and now I got to clean the left. I mean, once you get good at something then it just becomes second nature, so providing physical care is not a problem with me. Now because I got my skills down, providing intimate care in the sense of emotional care or psychological care, I have more time for that. Because all the skills become second nature you have more time to discuss questions they have. Concerns that they have. Whether they are private concerns or social concerns or personal concerns. If they just want to shoot the breeze with you for whatever reason, you have more time to do that. Because all the other skills are second nature you have more time to provide intimate or personal care. (3, 635)

Nurses are empathetic toward their patient's feelings. They know that the provision of

personal and intimate care can cause emotional, psychological and even physical discomfort. They know this because of the nature of the care that's involved and how they themselves would feel in the situation. As one of the participants expressed:

> I mean if I was buck naked from the waste down with somebody putting the Foley in me, you know it's a personal thing. And I like to think that the person would act professionally and quickly and try to make it as less discomforting for me, so I like to think that's some of the things that the patient might be going through. Maybe some people feel embarrassment. You know some of the things that clients come in with, you know you see all sorts of things and sometimes it can be an embarrassing thing for a patient. (6, 550)

But it is not just empathy that provides the nurse with the knowledge that the patient appreciates competent care. Some of the participants expressed how the patients told them how important it is for them to be confident in the competence of their nurse.

> Patients have told me it many times, that they can see the differences in nurses. And they said they really appreciate when somebody comes across, not only exuding confidence, but showing that they know what they're doing and they know how to explain something to you. People really appreciate that. Especially on our ward where people get very sick. They really appreciate good continuity of care. That they know they're in good hands with whatever's being done. People want to know that they are safe. They want to have that comfort zone. And when you can show them that you care. That you know what to do, and you can explain why you want to do it, logically to this person and on their terms also, not just medically, but on their level, whatever it may be, I think that gives a person a great comfort in knowing, yes, everything's okay. You know there's no worries. (10, 669)

Another participant said it this way:

> You have to feel relaxed with what you're doing. If you're not comfortable doing that type of care, that person will not be comfortable, because they're going to sense it. I think that would be the most important thing. You have to be comfortable doing personal care. If you're not comfortable they are going to sense it. I've just heard it too many times. People can tell when somebody's nervous about something and they're not comfortable doing a certain aspect of something. I've had patients come and tell me that about other nurses that are new on the ward. And they said, 'Oh that nurse last night, she was really nervous about doing X and X Y Z or whatever and you can tell the difference in care'. And I think that's an important thing, and that's something that you don't just get overnight. That's something that comes with experience. You know that's something you have to build on. (10, 793)

It is important for the patient to think that their nurse is competent. If the patient believes that their nurse is competent it helps in the development of the nurse-patient relationship as well as the building of trust that the nurse is doing their job. As one of the participants explained:

> I think it leaves the patient or the client with the feeling that you're doing your job in a professional way. Also that you're knowledgeable. You know what you're doing, be it a dressing change or changing a Duoderm or something. You know the information you provide verbally to the patient as to what you're doing and you do your job efficiently and as fast as you can. No one wants to sit there with their legs up in the air or their backside exposed for a longer period than need be. You're just being courteous to them in the sense that they realize you have to do it and it has to be done. But you know we can do it as quickly as we can and then get them back and comfortable. To make them feel at ease. (6, 514)

By demonstrating competency, knowledge, compassion, understanding, empathy and professionalism the male nurse can demonstrate to his patient that the provision of personal and intimate care in just one facet of his job and there is nothing about the actual doing of his job that is in any way inappropriate. When describing how he would handle providing personal and intimate care with a female patient one of the participants expressed it this way.

> I would establish the relationship and of course you learn to do that quickly. The next thing I would do would be to demonstrate competence and security. So that the person can have confidence in me. And when you get those things going you can carry out the care, because then the patient and you are looking past a gender thing. (1, 267)

Another participant expanded on the above by commenting:

> When you deal with a patient of the other sex, professionalism and confidence in what you're doing, and being able to do it efficiently, helps the patient get through the procedure a lot easier than if you were fumble fingers or dropping stuff on the floor. And I think the rapport that you have to establish helps put the patient into a state of mind where they're willing to accept you as the nurse that's doing it and not as a male or female. (15, 294)

Throughout this section on competency the importance of being competent and knowing what you are doing as a nurse appears to be the focus of male nurses when providing personal and intimate care. However, what I hope has also come through was the importance placed on the patient's comfort. Also the importance of developing a nurse-patient relationship cannot be minimized. The need to be competent is important but it is the overall relationship that is required to be developed to enable male nurses to provide personal and intimate care with female patients Perhaps it was said best by one of the participants:

> But in my experience now, over three years, I've realized that anybody can be taught how to do this. It's caring that comes into play. It's that personal relationship that you develop and the rapport you develop with each patient. And I think it's a good thing because you realize that there's much more to nursing than doing skills. It becomes relationships really with the person that you do help. And that's where the caring comes in and I think all those barriers can disappear very quickly if the person realizes that this is a caring role and that you care for them. It's not just doing something. You care about this person and you're helping them through something. It kind of changes the aspect of care. (10, 446)

It is the fact that male nurses care for their patients that is important to understand. The development of the nurse-patient relationship provides the nurse with the ability to overcome barriers that may arise when providing personal and intimate care with female patients. These barriers can result from the patient's perception and feelings about the situation or the nurse's perception and feelings about the situation.

In this section the personhood of the nurse included the nurse's personal and professional comfort, the professional role of the nurse, and the nurse's competency in the provision of personal and intimate care. Threaded throughout the section was how the sexuality of the patient and nurse and the sexualizing of the provision of personal and intimate care affected the nurse patient relationship. The next section of the analysis deals

with the strategies and interventions utilized by male nurses when they provide personal and intimate care with female patients.

Nursing Interventions and Strategies Used by Male Nurses When Providing Personal and Intimate Care With Female Patients

In this section I identify strategies and interventions used by the participants when providing personal and intimate care with female patients. After the strategies and interventions are identified I will describe the consequences that can result from the participants not attending to the patient's comfort during the provision of personal and intimate care with a male nurse.

The participants believed that the strategies and interventions they utilized enabled them to provide the necessary personal and intimate care required, while ensuring that their female patients' emotional, psychological and physical comfort were maintained. In addition to the comfort of the female patients, some of the strategies and interventions were used so that the participants themselves felt comfortable when providing personal and intimate care with female patients. The strategies or interventions have been categorized into four main sections: communication, cognitive, emotive, and behavioural. A fifth separate and distinct, yet pertinent section will also be presented, and that is, workplace setting or situational factors. (see Figure 1). Each section is presented separately.

Communication Strategies and Interventions
- a) Rapport Building and Explanation Giving
- b) Seeking Permission
- c) Humor Utilization

Cognitive Strategies
- a) Detachment
- b) Distraction

Emotive Strategies and Interventions
- a) Respect
- b) Empathy and Caring

Behavioural Strategies and Interventions
- a) Maintaining Privacy
- b) Trading Assignments or Providing a Female Alternative

Workplace Setting or Situational Factors

Figure 1 Categories of Strategies

Communication Strategies and Interventions

Many of the participants commented on the importance of communication. My analysis revealed three main components of communication as a strategy or intervention when male nurses provided personal and intimate care with female patients. The three components were rapport building and explanation giving, permission seeking, and humor utilization.

Rapport Building and Explanation Giving

All of the participants commented on the importance of developing a rapport with their female patients. To be able to develop a trusting nurse-patient relationship, building rapport is a prerequisite. As one of the participants stated, "You have to establish a bit of rapport first before the patient will accept you as being their caregiver" (10, 114). Developing rapport is even more important when personal and intimate care needs to be accomplished. The same participant expressed the need to develop rapport before attempting personal and intimate care.

Female patients may be at first, a bit timid, but once they get to know you and you

> develop a rapport, I think it's with anybody, even a male patient, comes that trust between you. And that to me is a really important thing to have before something like that takes place. (10, 171)

Another participant also commented on the importance of developing rapport and how that can help in their assessment of what the patient may be feeling or thinking about the situation.

> I use a very friendly approach technique. I just try to build rapport before I initiate anything. I just get to know them. You get a sense of where you can go and where you can't go with them. And then just go from there. (9, 372)

The dynamics of male and female interactions play a factor in the interventions used by the male nurses. Participants were asked how they dealt with having to intrude into the personal space of their female patients. One of the participants explained it this way.

> Mostly a lot of talking. Trying to tell them that you can appreciate their concern. Just by giving them the option. 'Do you need a hand getting into that gown? Should I come back in a few minutes after you've got your gown on? I'm just going to take a look.' Telling them ahead of times what you're going to do so that they know what's happening so that it's not like an unexpected intrusion. It's something that they can say 'Okay, I'm doing this because I have to listen to your to your lungs'. You can only hear the middle lobes from the front so you tell them what to expect and why you're doing things. Explanations, so that it's an expected event, as part of a task, as opposed to an intrusion. I think that is kind of a significant way of trying to help deal with it. (4, 556)

As the above quote illustrates the importance of communicating and providing choice is important. Providing rationales and education is also an important strategy for the male nurse to use. Another participant also identified communication and rapport building as important.

> You can talk to them about being a male and that you can let them know that you looked after many female patients. You can right away see if people are anxious or whatever. It's not hard to tell, generally you know, at least I've found that people when they're anxious they show it all over, it's like, 'Get away!' (laughs). So I think for me the biggest thing would be is to try and develop a rapport with them before, talk to them about what's going to happen. Don't even bring anything in the room.

> Just say 'Look, this is what we're going to do'. Explain it to them properly and then kind of get a read on them to see what they're like and talk to them about it. Say, 'I've done this many times and if you're uncomfortable I'd like to talk about it'. You know, 'What are your thoughts or whatever'. And build again that relationship that you can build with the rapport of the patient. (10, 480)

In addition to rapport building another important communication technique used by the participants was providing information to the patients. This information or explanation giving enabled the participant to provide the female patient with the necessary knowledge to make an informed choice as to whether or not she would "allow" the male nurse to provide the necessary personal and intimate care. As one of the participants expressed,

> What makes it easier is if you develop a rapport with the patient prior to the experience. What makes it easier is to explain what you're doing and why you're doing it. Always explain what you're going to do before you touch a patient in any respect. 'We're going to wash this area now.' Or, 'I'm going to examine, for example a patient had a breast reduction, I'm going to undo the top off your gown. I'm going to check for bleeding and make sure your dressing is okay.' Always explaining what you're doing. You're not just going to take off a patient's gown and start staring at them and them have no idea what you're doing. I think it's very important you explain what you're going to do step by step. Certainly the same goes with a catheterization or any other experience. (11, 198)

Once again the importance of ensuring that the patient's feelings are taken into account and that the patient remains comfortable during the procedures was demonstrated as important to the male nurses.

> I think if you can make them feel at ease. Try to develop that even though it might be the first time you've met them. Try to develop that personal contact with them through talking. Acting in a professional manner. Explaining what you are going to do and the purpose. Why you have to do these things. Provide information to the client like, 'Your urine output has not been what we'd like to see. Are you having trouble voiding? We are going to put a catheter in. This is what we are going to do. Have you ever had one before? We will be doing this.' And giving them information and acting in a professional manner. (6, 156)

This same participant went on to explain the importance of talking with the patient, getting to know them and preparing them for what will be happening to them.

> Just be open and provide the patient with information as to why and what you're going to do. And act in a professional manner. And if you can, develop a bit of a communication with them, be it on a personal level or you know just in generalities about the weather. Trying anything to just put them at ease. Explain to them that 'I'm the nurse I'll be on tonight. We work 12-hour shifts so I'll be here seven to seven. I'll be in every hour to check on you. If there's anything you need the call bell is here, don't hesitate to call. I'll be back in 20 minutes after I see everybody to have a look at your incisions and listen to your chest'. And then follow up on that. Come back in 20 minutes and go proceed with your assessment. You've sort of prepared them for it when you come in to do the assessment you are not the stranger you were the first time. So maybe they feel a little better. (6, 456)

The participants believed that just as it is important to present oneself professionally, it is also important to explain what is going to happen and to follow through on what they said they would do. Another participant explained it this way.

> I think the biggest thing is just explaining what you're doing properly. And that it's something that needs to be done. And if you're professional and caring in the way you're saying it and you tell them everything that's going to happen, then a person understands what's being done and why it needs to be done, I think that's an important thing. Like that learning aspect of the patient knowing, okay this is what's going to happen, this is what you're going to do, and you know, if it doesn't involve pain often, that's another good thing (laughs). (10, 639)

Another participant expressed the importance of being truthful with what had to be done particularly if it was going to be an intrusive nursing intervention.

> You have to identify that you're going to be intrusive. You have to already have had a feeling of what's going on. And in what space the person is at already. I think you have to identify that the situation is going to be intrusive if its not clear that you're going to be either asking intimate questions or touching someone in an intimate way. So I think that the most important thing is that you have to let them know right off the bat exactly what's going to be happening. (8, 332)

Another strategy or intervention that the participants used when providing personal and intimate care with female patients was seeking the patient's permission to perform the necessary care.

Permission Seeking

Asking the patient's permission to perform personal and intimate care was an important strategy or intervention. Along with asking permission to perform the nursing interventions, the participants also incorporated other communication strategies at the same time.

> I go in there and I explain what's going to take place over the day, what's going to be happening. I ask them right up front if that's okay. I know that I'm a male nurse. I give that opportunity to refuse, and then just go from there. It becomes technical and most of the time I'll come back later and try to get a personal aspect. Get that psychosocial thing going. (9, 378)

Another participant stated it this way: "What does help is just asking permission whenever you're about to do something" (4, 92). However, another participant indicated that it was not always possible to obtain permission. He described how he tried to get permission whenever possible, but at times he was unable to do so. He still maintained, however, the importance of continuing to communicate with his patient.

> I would try to make it a point of telling them what I was going to do before I did it. Asking permission before I did it. I tried to make a point of it. I would not always do that just because sometimes it gets busy. You know it's busy, you don't really have time to, you should make time but in real life you don't always. Or you don't think you have time so you just go ahead and do it. Where I work now, these people are ventilated, they're sedated and that kind of thing. You just don't talk with these people. I mean you talk with them but there's no social conversation. You, don't ask permission to do that. You just do it because it wouldn't make sense. I mean a lot of the times I try to make a point of telling them what I'm doing, while I'm doing it. Whether it's perineal care or whether I'm suctioning or something like that. You tell them what you're going to do. Even if they are comatose. It has kind of become second nature to tell them what you're doing while you're doing it. Even if they're ventilated, even if they're heavily sedated and they're not aware, you just kind of talk to somebody who's lying on the bed. Even if there's no actual physical talking, you just talk to them. While you're caring for them. That's become second nature now. (3, 663)

> Another participant did not actually state that permission was sought, but rather

indicated that permission was received by being "invited" into a situation. This was particularly important when the nurse needed to attend to the patient's "emotional space".

> In terms of invading emotional space like for example where the patient was having a difficult time with appearance. I think you have to let the patient know that you are available to do that. I don't think you enter into these areas uninvited. Sometimes you find yourself having a very deep conversation with a patient. But that normally evolves naturally, you don't force it. And you let the patient know, 'Hey listen, you know, you're awfully quiet, you need to talk about this'. Or 'I'm here, you know, I've got some time this afternoon'. You need to be available to that. In terms of physical space, I guess I'd explain what you're going to do, why you're doing it, so that there is no surprises, and it goes a lot smoother. But like I say, for the emotional and psychological, you've got to invite yourself in or you have to let it evolve naturally, you can't force yourself into situations. (11, 666)

Another strategy related to permission seeking is contracting. By contracting with the patient, and the patient agreeing to the "contract", there is the presumed consent or permission to carry out the nursing procedure.

> I think the strategy would be contracting with patients and trying to decide what did they see as being important, as a priority. What I saw as being a priority and needing to be done and then trying to come to agreement about how things needed to be done. What would make them feel better? How would the situation work better for them? How the situation is working for me right now in the context of like you know, where I can fit this in. If they just don't feel comfortable right now and want me to come back in 15 minutes after they've thought about it or if they just really need to have somebody else do it. (8, 494)

One of the participants spoke to the need for both the patient and the nurse to be comfortable with the situation. This particular nurse indicated the importance of reassuring the patient, but in doing so he was also able to reassure himself.

> Okay, first of all I give them some prior warning. That's important. That I'll be there and I try to do it on a casual basis. And then I always say is that okay? And that gives them an opening too. You know. And the other thing is that when I'm preparing things around there I usually talk, I talk to them and try to reassure them in different ways. And I suppose it's also reassuring myself because you pick up on the person's nervousness. But I've learned to pretty well walk through it now. But sometimes I get somebody else to do it. (14, 505)

Previously, many of the nurses indicated that their role as a nurse included the responsibility to provide whatever care the patient required, including personal and intimate care. There was, however, an unstated tension between their role as a professional, and the gender issue of being a male nurse. This "tension" was perhaps best illustrated, when one of the participants was asked what he would have done differently when he was first learning how to provide personal and intimate care with female patients, compared to what he did now. His comment was:

> Ask them. I never asked them. (pause) If it was okay if I did this. I would ask them if it was okay, if I as a nurse did something. But I never asked a patient if it was okay if I, as a male nurse, did something. Because that isn't the way I thought. I thought of myself as a nurse period. (1, 218)

Many of the nurses indicated that they used humor as a way to "lighten up" a situation where personal and intimate care needed to be provided. The last component of communication is humor utilization.

Humor Utilization

The last main communication strategy or intervention that was used by a number of the participants when providing personal and intimate care with female patients was humor. Humor "lightened" the situation, thereby making the provision of personal and intimate care easier.

> Sometimes I use humor to try and lighten the situation. I might have said something I might have seen on David Letterman or some sort of current event. Or if there was a newspaper lying on the table, say for example if there's a National Enquirer sitting there I'll say, 'Well its got to be true if they print it.' You know all that stuff. Giant Bat Kid on the front page. (2, 347)

The participants were asked to identify characteristics that they believed male nurses should possess to enable them to perform personal and intimate care. One of the participants

commented as follows:

> I think any nurse should be adaptable, should be flexible to deal with varying situations. I think they should have a good sense of humor. I think that's a very important thing to put patients at ease. (13, 620)

As the above quote demonstrates, humor was used to put the patients at ease. When the participants were asked what made the provision of personal and intimate care with a female patient easier humor was a common thread as evidenced by the following excerpts.

> What makes it easier? I find, what makes it easier for me is I tend to joke a lot with my patients. And I find this sets them at ease. (12, 145)

> Humor makes it easier. Humor. Humor (laughs) yeh. Definitely humor setting people at ease. (14, 189)

The participants, however, stressed that it was important to use humor appropriately. The humor was used as a strategy to enable them to perform certain nursing interventions while maintaining the physical, emotional and psychological comfort of their patients. They felt that using humor was a way to develop rapport with the patient.

> Myself I find that if I establish good rapport with them at the very beginning like, you know a little witty and joking type thing. And address them properly with madam or missus or miss or whatever they prefer. It tends to sort of relax them. Be very professional in your attitude towards them and there's no real problem with that part. (15, 121)

The same participant expanded on the need to develop rapport with the patient. He believed that he was able to develop this rapport by using humor. He also believed that it was humor that enabled him to provide personal and intimate care on people that he knew.

> Well first of all it's the rapport. You've got to establish the rapport. Speak to them, get them happy, smiling or laughing or something like that there. I've even done people that I know. Fellow employees have been in the hospital, in the emergency. I've taken care of them. I've had to help them get undressed. Protect their privacy as much as possible. If it was someone I know I might say 'Okay, go into the room, take off your clothes, I'll get your phone number later.' And the little joking thing, she laughs I laugh and that's fine. I don't do that with a regular patient but people I

> know yes. And that kind of joking type of attitude and at the same time remaining professional with what you do. It's all the same thing. It's rapport, it's professionalism, it's efficiency and it's respecting their privacy as much as possible. And that seems to work very well for me. Maybe not for other people but it works well for me. (15, 365)

Using humor demonstrated to the patient that the nurse was a person. However, it was also important to maintain their professionalism, but not at the expense of being seen as "too professional". As one participant stated:

> I don't know. Some people take their professionalism to a limit. To the point where you're almost not being professional, you're being snobbish. I like to go in there, and I'm just like off the wall, you know. I use a little bit of humor and comedy in there and joke around and try to be a person first. If they like you then, great, I showed you my side now I will show you how professional I am and they have no problem. Because if you show them that you're a person and that you are professional, hey, they have no problem. No matter what you want to do. If you explain things to them and treat them with respect. It makes the job a whole lot easier. (12, 403)

Another participant discussed the importance of having the ability to assess the patient and to know whether or not humor would be appropriate. His experience and "style" allowed him to be able to identify which patients he could use humor with.

> Well I use a lot of lightness, comedy type thing when I see them. Like 'How are you? And you're feeling really well. Then if you're feeling that good how come you're here?' type of thing. Things like that. And over the years I've developed I guess a bit of a sort of a idea when I walk in a room what I can say to a patient and what I can't say. Depending on the patient of course but a lot of times I've established the rapport very quickly. I guess its experience and what I've done over the years. And I've built up almost a sixth sense on how to speak to them and just how to sort of get on their good side right off the start. And it works most of the time. I don't know, I can't explain how I do it. I go in the room and other people go into the room and this patient will be growling and I go in and the patient will be happy. I don't know, it's just the way I am I guess. Smile, smiling nurse. (15, 326)

The participant suggested that he used a sixth sense to determine how to speak to his patients. He identified that he did not know how he did it, but he knew when, or if, he could use humor as a strategy, and that when he did, it usually worked. Another participant also

commented on the need to use humor appropriately and to properly assess the patient. If it appears that humor is not appropriate then using another intervention is required.

> Well I will say humor is by far most effective. For me it is anyway. And when I say humor I mean you have to size up the person. And sometimes that's not always the right way. Because sometimes you'd be very glib or superficial and or they can interpret it as being flippant. I'm quick to see how they respond to the humor. And if they don't, then if I think touch is appropriate and I think they're receptive to it, then I'll use touch. (14, 587)

As mentioned previously there can be an underlying sexual connotation to the provision of personal and intimate care. By using humor the participants try to "normalize or de-sexualize" the provision of personal and intimate care. As one participant stated when discussing how he handled providing personal and intimate care: "You know, joke around a little bit, like it's nothing I haven't seen before" (12, 442). By stating that it is nothing that he had not seen before, the participant was able to normalize the situation. By stating it this way, the patient would understand that it was a normal occurrence for the participant to partake in the particular nursing intervention and that it was nothing to become uncomfortable with.

A situation that another participant had recently been in illustrates how the utilization of humor can provide the necessary "ice breaker" required for the nurse to provide the care the patient needs.

> A couple weeks ago I had a patient and she had an ulcer on her coccyx and she was fairly alert and orientated. When she found out I was her nurse for the day, and I told her that I wanted to take a look at her coccyx area and I wanted to see how everything was developing there. And she says she wouldn't let me. I say wow, you know. I mean I'm rushed for the day and I need to see this, this is very important. Well she says 'You're a male.' I say 'Well dear, I mean, if you have something that I haven't seen I don't want to see it.' So that sort of broke the ice. (13, 452)

Although not mentioned by other participants, one participant identified that he used humor

when he himself was uncomfortable in a situation. This participant described a clinical situation he was in as a student. He had to insert a catheter into an obese female patient and his instructor had some of his classmates come in to observe the procedure.

> So it was a very, it was very public humiliation. Because it was extremely difficult, I think by the time I was done, I think she actually had about four or five catheters in her and the issue was no longer intimate care, the issue was 'My God let's just get this done and get me out of here!' So I tend to handle things with a bit of a sense of humor. (11, 570)

As the above quote illustrates, the male nurse used humor when he himself was uncomfortable with providing personal and intimate care. Both the patient and the nurse have to be comfortable with the provision of personal and intimate care.

Whether it is rapport building and explanation giving, permission seeking or humor utilization, communication with the patient is of the utmost importance. It is the male nurse's ability to communicate that enables him to carry out his responsibility of providing personal and intimate care. The following two excerpts can best express this:

> I have had some people who I wouldn't say strongly objected to me giving them a bath or doing care on them, but did object. And through a little bit of good solid communication, and setting them at ease I was eventually allowed to conduct my job and look after the patient's well being. And they had no problem with it after that. It's just that initial barrier. It's that first meeting. It's you know like the first impression lasts forever and if you go about it the right way and go in slowly and calmly and you know let that professionalism show, there's no problem usually. I mean if you go in and get rough and while you know I'm doing my job and that's all, don't give me such a rough time, you're going to have a hard time. But if you go in and remember that's a person there and you're not just going in to shovel dirt into the hole and get the job over with. It's a person you're dealing with. They have feelings and they have wants and needs and you have to look after those. (12, 464)

And, as one participant described how, as a student he observed an experienced male nurse provide personal and intimate care with a female patient:

> It was just - I found it unique. He had been working in this area for quite some time and I found it unique the way he did it. It was like his hands were detached from his

> body and he was doing this. And it was like his head was taken off and his head was sitting there talking to the patient and keeping them totally occupied while he's just washing. And before the patient ever knew it, they were washed, cleaned and had a nice conversation and nobody was aware of anything. And you know it was done very professionally and I never forgot that one lesson. That first time, I never forgot that. It comes down to the art of communication. If you can speak to the people, and I think a matter of fact that's the most important issue. If you can talk to them and relate to them and make them comfortable that way there is no problem with male and female gender. It's basically if they like you as a person it doesn't matter. (12, 354)

The next section addresses cognitive strategies and interventions used by male nurses while providing personal and intimate care with female patients.

Cognitive Strategies and Interventions

Some of the strategies and interventions that male nurses use when providing personal and intimate care with female patients have a cognitive aspect. Male nurses use techniques such as detachment and distraction when caring for their female patients. Each of these techniques will be presented separately.

Detachment

A number of the participants indicated that they occasionally felt uncomfortable with having to provide personal and intimate care with female patients. Alternately, on occasion, the participants' patients also felt uncomfortable with having personal and intimate care provided by a male nurse. This may result because of the male nurse's own history, beliefs and values, or the patients'. Or, it may be the situation in which the nurse and patient find themselves. Regardless of the reason for the discomfort, the participants needed to use a strategy or intervention that would enable them to complete the required care.

One of the strategies the participants utilized was detachment. Although the term

detachment could be construed as somewhat negative, as it can be an unconscious reaction to stress, in this situation the term detachment was chosen because the participants made a conscious decision to focus on the task or the intervention rather than the patient. That is, the participants did not detach themselves from the situation, but rather, detached the intervention from the patient, thereby bringing the skill or task to the foreground. One of the participants described using detachment by "blocking out" something whenever the patient or he himself felt uncomfortable.

> She's uncomfortable and it makes you a little bit uncomfortable and you just kind of block it out of your mind. Some of those things make a difference, at least to me. A lot of those things I think though that make it more or less difficult, I try and block out so it's not something that's actually an issue. I'm here to do a job. I'm doing it regardless of any emotions or anything I feel. I just block it out. It's not an issue. (4,160)

The participant identifies that he is there to do a job and that he has to perform the procedure because it is his job, regardless of how he feels about the situation. The same participant went on to describe how in addition to "blocking out", he "depersonalises" or detaches himself from the situation.

> I come in, I ask if I can do things and I do it. Again you notice that there is a difference but you just kind of block it off because you're there to do something and you do it. It's a person. It's not a male or a female. You know, like standing back of course you think, I mean a person can't help but notice sexual differences. They're pretty blatant. But when you go in there to do a job, you approach your task and the things that you have to do. As you're doing it at least to me it's a person. It's not a male or female. It's kind of like in some ways I guess almost detach yourself from it. You know it's kind of the example that (laughs). Can't use this part in your study but it's like when you tell your wife you know she sees you looking at a good looking girl in the bikini on the beach. And you say it's like looking at a nice car or something like that. You detach yourself from it. (4, 465)

The participants reported that many of the nursing interventions that are performed with patients have an emotional or psychological component. Because of this, some of the

participants believed that it was easier to perform the technical component of the skill rather than attempting to "deal with" the psychological or emotional component of the intervention.

> Though it all depends on how technical it is. You know. Providing comfort measures is much more difficult than providing a technical skill. I mean, if you're doing a catheterization that's easier because there's a certain detachment to doing the technique or whatever it is that occurs. But if it's providing a comfort measure, washing the perineal area, even rubbing a back. Matter of fact that's one of the most, probably the most intimate moment, the most I felt more out of control in that situation than in any other. (14, 104)

This same participant described how he handled providing personal and intimate care when he himself felt uncomfortable with having to perform the care. "Oh, well, I hurry it. I hurry it. I get myself into a state and say I got to get through this. And I just probably put it as object, you know. This is, or a task, task to be done" (14, 482). Another participant expressed how he felt when as a student he had to provide personal and intimate care. Even as a student the participant used the strategy of detachment in the situation.

> Well I panicked quietly inside and tried not to show too much fear or whatever. But I basically, I just went back to the basics. What we were taught in school and just thought in my mind, step by step what I wanted to do. And I wasn't, that person wasn't even there. You know it was just doing a task. That's what it became. (10, 423)

A previously quoted participant also identified how situations or factors during your life can affect how one handles the need to perform personal and intimate care with patients. Life experiences or events can affect us deeply and play a factor in how we perform the necessary interventions with our patients. This particular participant was aware that "blocking out" certain realities would enable him to provide care to anyone. However, it was the knowledge that even though the nurse in him could provide the care, it would not necessarily be appropriate in some situations for him to actually participate in the care.

> There are certain things that are associated just with being male and your position in life. For example, my grandmother died of stomach cancer and had problems with incontinence, and we had to help keep her clean. I mean that brings back certain memories and you feel certain things for people that are in certain situations because of your situation in life. A girl that I know, I was her camp counsellor for years, came in and I went to help with the log roll. And I was assigned to her and she was the victim of an accident and paraplegic. Well you have to go and, more for her sake probably than for yours, reassign yourself. Because again you get used to just blocking it out and you could, I could almost probably do that kind of care on my mother without thinking twice about it. You just learn to just do your job. So your situation in life sometimes brings about things or memories or associations that you have to kind of try and keep out of the way sometimes. (4, 181)

This same nurse also described how it is important to "block out" other types of personal and intimate care that nurses have to deal with.

> There seems to be recurring things when it comes to intimate care. A recurring thing in nursing is you block it off. You just say okay this is something I have to do and you do it. It's like the first few times when I started nursing, I mean within the first few months of nursing between working in emergency and elsewhere seeing people die regularly. I found that to be extremely difficult because I mean it was significant. You saw the families dying, you saw everything happening. And what happens is that if you felt that intimately with the family, you know empathy versus sympathy. If you were that involved I don't know if you could go on a long time if you really truly saw it as you would if you weren't doing it on a regular basis. It's like a normal person having to try and do an autopsy. I mean, it would blow the mind of a normal person but if you do it every day you kind of wall off the typically perceived enormity of what you're doing. And I think that's the same kind of thing that happens at least with me in nursing. For the most part you're there to try and do a job as sensitively as you can, as well as you can. And that's what you're going to do. (4, 391)

No matter what strategy or intervention the male nurse uses when providing personal and intimate care, it has to be done with caring and concern for the patient. As one of the participants said:

> I'm having a problem with professionalism lately. I see the major reason people use the word professional is a way of, I was almost going to say, not caring. But that's not it. Of detaching themselves. And you have to have a certain detachment but you have to have concern. And of course that always runs in a balance. Cause I mean you can't do everything. (14, 775)

Another strategy or intervention used by male nurses when providing personal and intimate care with female patients is distraction.

Distraction

By "distracting" the patient's focus away from what was actually being done, the participants were able to complete the necessary care without causing discomfort to the patient. The following excerpts illustrate the use of distraction.

> When you start, make them feel comfortable. Always talk to them. Always keep talking to them. It's, I guess you're sort of using what would be called distraction or whatever. You know you can sit there and you can work on them and distract them with your conversation and keep them comfortable that way. And before you know it, it's over. And they're like 'Wow, that wasn't so bad.' (12, 448)

> I talk. I have to explain it, explain exactly what I'm going to do first and then I basically talk to them. Try to put them at ease. Talk about different things. Talk about families. Where they're from. Try to get their mind off of what I'm doing. (1, 334)

By talking with the patients during the process of providing personal and intimate care the participants used distraction as a strategy. The participants believed that in so doing, they were able to perform personal and intimate care with their female patients, without having their female patients feeling uncomfortable.

The participants also expressed psychological or emotional components that were used as strategies or interventions when providing personal and intimate care with female patients. The next category highlights emotive strategies and interventions.

Emotional Strategies and Interventions

The participants believed that respect and, empathy and caring were important strategies and interventions when providing personal and intimate care with female patients.

Respect

The participants believed that it was important to have and demonstrate respect for their patients. Respect was viewed as important for building trust in the nurse-patient relationship. One of the participants commented how he would not consider having a patient refuse care from him as a negative experience, because of the need to respect a patient's wishes.

> So I wouldn't even view being refused to care for people as being a negative experience. That's just that's their own personal space. That's how they want to deal with it and I think you have to honor that. I think that's as much of the trust relationship, is stopping and listening to their wishes and not forcing the care upon them. (11, 485)

Another participant commented on how important it is for everyone connected with the health care system to demonstrate respect for everyone coming through the doors of a facility.

> I like to think that when a person comes in through the door of a facility they are treated equal from all the staff members. Be it medical staff or the housekeeping, the kitchen, whatever the staff. I hope that no matter what the gender or background or whatever it is of the patient. That when they come in the door it equalizes everything and we treat them all with the same and proper respect. And are open to their concerns and issues. (6, 103)

The participants also commented on how providing the patient some control over their health care illustrated respect for the patient's wishes. It was important, however, for the nurse to be able to "allow" that control only if the patient's health was not adversely affected by it.

> I mean you still have to respect their wishes. If they wish for whatever reason care not be provided to them, anything, giving pills or whatever, and it will not affect the safety of their being alive, assuming that these people want to stay alive. And it will not affect them, what's the word I'm looking for, in a negative way, then sure you've got to give them some control. If they don't want that medication and it's really not going to harm them then I won't intrude. I'll respect their wishes. (3, 701)

The importance of demonstrating respect towards patients is much more pertinent when the care that needs to be provided is personal and intimate. As one participant commented: "You have to respect their privacy. Respect their personal areas as much as you can" (15, 319). The participants believed that demonstrating respect also helped the patient feel more at ease or comfortable with the situation.

> When there was Foley catheters to be put in on the wards, the nurses would ask me to do it, to put in the catheters for males. And I would ask if they weren't busy for a female to do it. Just out of respect for the person. And not respect but just so they wouldn't have to feel uncomfortable (7, 323)

> On the ward that I primarily worked on it hasn't been a very big issue. There have been times when female patients have requested that certain things be done by a female nurse. And I've respected that. Just because people are comfortable with some things and some others aren't. And I try to respect that and give them the option, not that I would force the issue. I mean I can tell them that I've done this to many other female patients and I if they start himming and hawing I'll let them know that 'Hey, you know this isn't that big a deal. That somebody else can do it.' But if it can't be done then I guess I have to try and work around it. But, it hasn't been the case so far. (10, 65)

The importance of demonstrating respect for the patient was perhaps best stated by one of the participants when discussing personal and intimate care. This particular participant identified the body as a temple and that some aspects of personal and intimate care invade the patient's temple.

> To me the most intimate thing is when you're invading somebody's body. I don't care whether it's with a needle through the skin or through an opening in their body. That is, that's like they're showing their temple that you're entering. You're going into their church. And you know it should be done with respect, with caring and tenderness. I know some people just look at it as 'Aw geez, it's just another procedure.' you know. But you try to remember that this person you're sticking a tube into or you're finger, checking something, as in checking for stools or something like that. I mean, that's a person there. And you are entering their church. You know. And you can't violate that. You have to have a lot of respect for it. (12, 384)

The respect that the participants have for their patients is important in the nurse-patient

relationship. What is also important is for the nurse to be able to demonstrate empathy and caring for the patient and their situation.

Empathy and Caring

The participants believed that it was important for a nurse to be empathetic and caring. Several participants stressed the importance of being empathetic and caring particularly when providing personal and intimate care. Being empathetic and caring enabled the nurse to properly assess the patient's feelings or comfort level regarding the procedure being performed.

> Again it's always valuable to as much as possible get to know the patient as a person before you start into the intimate areas of care. That way you can gauge, okay this morning this person was light and everything was relatively easy and quite conversational. Now they're suddenly very quiet and quite tense. You sort of get a feel for what they are as a person and if their demeanor changes then it's best to canvass 'You seem kind of quiet now, does this make you uncomfortable?' And it may be what you're doing and it may be something that's happened to them and it may have been a conversation they've had with the physician or it may have something run through their minds. So you need to be sensitive to what they're normally like and if that changes, make sure that it's not related to something that you're doing. And there's always a certain amount of natural tension involved anyway. You can insert a catheter or tube into my body, excuse me if I don't get a little bit uptight about this or, are you going to swab my cervix or anything else like that. You tend to have to be sensitive to that. (11, 696)

> I guess it's good to be empathetic. Be able to empathize with people. It's good for a person to understand how the human mind works. It's good to have a psychological background. It's good to be a caring person, someone who really cares. If you don't care about the person it's just a duty to get the bed bath done. It's not going to come across very good you know. I think if you really care about what you're doing, if you're dedicated. I mean dedicated is committed to nursing. Committed to the principles of nursing, of caring. That makes a huge difference. (7, 859)

The above excerpts identify that nurses have to be continually assessing their patients on not just a physical level, but also on a psychological and emotional level as well. Nurses have to be compassionate, empathetic, sensitive, caring, understanding, respectful,

committed to nursing, and communicative so that the patients remain comfortable when having interventions such as personal and intimate care performed with them.

The participants were asked whether or not they believed that they were able to alleviate any psychological or emotional discomfort experienced by their female patients when providing personal and intimate care. One participant stated how he believed that he was able to do this because males working in nursing have a good understanding of women. And, it is this understanding or empathy that allows male nurses to care for female patients as well as they do.

> Yes I seem to be able to do that. I think a lot of what I do is probably now unconscious. I think in part, dealing with women is something you do on a daily basis, the male nurse. Chances are your unit manager or your boss may be a female. Certainly you're surrounded all day long by female co-workers. If you don't have a rapport with women you can't function effectively in many areas of nursing. So if you don't have respect for women, if you don't like women, I don't know why you'd work in nursing to tell you the truth. You're better to go into a different field. And so I think for that reason you're already sensitive to feminine issues. You already have your own philosophy and your own feelings about women. And for that reason I think it makes it easier, that you actually have your own definition and philosophy and your own rapport with women already. Based on the job and then basically what you do is you just tweak it a little bit and adjust it to women. So if I go in and talk about kids and talk about fashion and soap operas, you can sit and you quite often know what the common ground is. And you just basically use that to get to know the patient. And I think, as a result of being a male nurse, if you worked in the profession for any length of time, you probably genuinely like women. If you didn't before you certainly do after nursing for a while. You had to come to your own terms with the feminine gender and you've obviously got your own way of dealing with it. I think if you work with women day in and day out in situations that are sometimes very tense, very stressful, I think you become quite adept at dealing with female patients that are also in situations that are very intense. Sometimes they're angry, sometimes they're upset and so you're very comfortable with the way that women deal with stress and so it doesn't make you uncomfortable and so I think that shows too. You basically are able to ride that wave. Sometimes I think, actually dealing with male patients might be more difficult. There's more extremes and more anger and sometimes you might find that actually your areas of contention are not with the female patients. It's well, the testosterone on both sides of the equation kicks in, that there's a more volatile mix for patient care than the male-female one. Actually that sometimes goes a lot better naturally, I would suspect. (11, 793)

This particular participant identified an important component of being a male nurse. And that is that by working with women on a daily basis one has a tendency to develop a better understanding of how a woman may react in a given situation. The male nurse, because he works in a stressful environment with females, is often privy to observing how females react in different situations. Also by continually communicating with his cohorts, the male nurse is also able to develop the ability to communicate effectively with women. Male nurses utilize this knowledge to provide the necessary care that their patients require, while maintaining the psychological and emotional comfort of the patient.

In order for male nurses to provide personal and intimate care with female patients appropriately, gender differences and sexuality issues surrounding personal and intimate care have to be considered. The participants were asked what made the provision of personal and intimate care with female patients easier. One of the participants identified that developing rapport is the most important consideration to make the provision of personal and intimate care easier. Developing rapport was seen by the participant as a means to show the patient that he too was just a person. And that he was there because it was his job to be there and to care for that person.

> What makes it easier? I think the biggest is rapport with the patient. If there is a rapport and understanding that I am just a person, this is my job to care for you and I can show this person that I am a caring person and want to look after them to the best of my ability. Once that is established, I think a lot of these fears can be alleviated because the role shifts. It's not me as a male, it's me as a caregiver. It changes. It doesn't matter what gender, it's a care giver role. (10, 257)

This same participant summed up the importance of caring. And how caring can overcome gender issues related to personal and intimate care.

> A gentle caring attitude, I think to me that wraps it up in a nut shell. You have to show that you're caring. You have to surpass that gender thing and show that you

> genuinely care for this person and that you're concerned about their welfare and their wellbeing. It's not just a job or task which involves something that may be perceived as sexual or with the opposite sex. But that transcends that. Like you just float over top, you don't have to worry about that. Because once that relationship is built, that you are a caregiver, and that you really genuinely care about their wellbeing. And that you're looking after them, and you do the job to the best of your ability. I think that transcends all those other issues. Once that is established. (10, 910)

The last category of strategies and interventions used by male nurses is the behavioural strategies and interventions.

Behavioural Strategies and Interventions

This final category of strategies and interventions includes the behavioural components of maintaining privacy and trading assignments or providing a female alternative. Each component will be discussed separately.

Maintaining Privacy

The participants believed that maintaining privacy was an important strategy or intervention when providing personal and intimate care with female patients. One of the ways privacy was maintained was by physically ensuring the patients were exposed as little as possible. The following statements illustrate the importance placed on providing privacy.

> Discretion is very important. So that if you're changing someone's gown you put the other one on top and slip the other one off. Or if you're doing a bed bath, you don't strip everything off and let a naked patient lie there. You cover everything up except for what you're doing and then you always cover it up and that sort of thing. But just covering up has a lot to do with it. Just being really thoughtful in what you're doing. (7, 528)

> Try to maintain as much coverage over the patient. Allowing for sterility and stuff like that, asepsis, keep them so they feel that they're not lying out there with all their clothes off in the middle of nowhere with you know some guy in the room and they're just lying there totally naked. Coverage as much as possible even when putting a gown on a female patient. Even slipping her arms out of the bras, I have the blue coat over top of her chest anyway so you can just put her arms through after. Things like that there you have to respect their privacy. Respect their personal

> areas as much as you can. And try and show that to them, that you do that kind of thing and I think they accept that better. (15, 319)

As the above comments illustrate, male nurses believe not just in the importance of privacy, but also are keenly aware of the role that gender plays in the provision of personal and intimate care. But it was not just physical care that male nurses consider when discussing privacy. One of the participants expressed the importance of maintaining privacy when it was related to situations other than the physical exposure of the body.

> Some people feel embarrassment. You know some of the clients that come in, you see all sorts of things, and sometimes it can be an embarrassing thing for a patient. You know what has happened to them or you know what caused their problem. And so, acting in a professional manner and respecting their privacy and the confidentiality of the situations hopefully will put them at ease. (6, 560)

The above excerpt illustrates that it is not just physically viewing or manipulating a person's body that requires privacy. People being people occasionally create certain life events or situations that on occasion result in a need for medical intervention. In these circumstances it is important that the patient know and understand that their privacy will be maintained. Another participant expressed it best when he discussed the importance of maintaining privacy while once again expressing how important it is for male nurses to be sensitive to the patient's feelings surrounding personal and intimate care.

> Always be sensitive to what the patient's needs are. Recognize that they may be different from your own. I mean some people they get home, they chuck their clothes and they may walk around the apartment naked. For some people, they may undress in the dark. I mean all patients have their own level of comfort with intimate care. Some people are very confident about their bodies. Some people are extremely self-conscious about their body image. And it may not always be the people you think should be. You know you're beautiful or you're handsome or you're totally buff or whatever. Why would you be worried about it? It's basically the patient's concept of how comfortable they are with their body and with intimate care or with any portion. I mean some people are quite verbal about you know, or quite honest about their emotions as well. Everyone holds back a certain amount. So you have to respect what the patient's level of comfort is with intimate care. And then respond

> accordingly. Not to the point that you can't provide care at all because if some people had their choice they would not be in hospital. So I think if you're comfortable with that, I think if you're sensitive to that and honor their need for privacy as much as possible. Regardless of whether you think it's ridiculous or not. It doesn't matter what you think, quite frankly. It's sort of like the pain concept. I mean the patient's pain is what they say it is. I think you have to recognize that the patient's need for privacy is what they say it is as well. And you have to act corresponding to that. You can't ridicule it. You can't downplay it. You have to be sensitive to it and respect it and try and make the experience as comfortable for them as possible. For some people, I mean they're in hospital, and they're scared. Their life's been turned upside down. And then for you not to give them some control and some acknowledgement how they feel just makes matters worse. I think the type of person that you need to be is someone who's sensitive to what the patient's going through. (11, 1004)

The above excerpt illustrates an important aspect about people. And that is, that everyone is different. And because of these differences one can never assume how a patient will act or react in a given situation. Because of this it is important for the nurse to properly assess the patient's level of comfort in a given situation and utilize the appropriate strategy to be able to complete the necessary intervention. Another strategy or intervention used by the male nurses was to exchange assignments or to provide a female alternative if requested by the female patients.

Trading Assignments or Providing a Female Alternative

One of the many strategies or interventions that the participants used when providing personal and intimate care with female patients was to have a female nurse provide the necessary care. The participants did this by either outright changing assignments or by trading nursing tasks with female nurses.

Participants expressed an understanding that some female patients felt uncomfortable with having a male nurse provide certain personal and intimate nursing interventions. It should be noted, however, that not one participant felt that it would be

inappropriate for a male nurse to provide care of a personal and intimate nature with female patients. As one participant stated:

> To me there's nothing wrong with a male giving care to a female. If the female patient doesn't want that then that's okay, then make arrangements to have a female nurse take care of a female patient. I mean it's all how the patient feels. If they feel uncomfortable, then make arrangements in order to make them feel as comfortable as possible. (3, 232)

Occasionally, a participant would encounter a patient who did not want to receive personal and intimate care from a male nurse. Although these situations were infrequent the participants acknowledged the patient's feelings and respected their wishes. One of the participant's comments expressed how he dealt with the situation, but also demonstrated how infrequently this situation had occurred for him.

> If the patient then said I don't want you, then I would indeed respond to that in a supportive way. And that's probably happened. I just don't have any recollection of it. It probably happened. There would be patients who'd say you know, 'I'd rather get somebody else doing it'. And I would say fine. And I would go trade some responsibility with a colleague. At least that's the approach I would take. And I'm sure it happened, I just don't recall. (1, 236)

Another participant, when asked how he felt after having a female patient request a female nurse, described how he believed he could have provided the care himself with respect and professionalism but that the patient's comfort level was more important than his feelings on the topic.

> I felt that I could have sufficed and done the job properly and respectfully. But I respected her wishes and didn't want to make her feel too uncomfortable with her hospital stay, so I'd ask one of my cohorts to wash this patient for me. (2, 285)

When providing personal and intimate care with female patients, male nurses are always assessing the patients' comfort level with the care that is being provided. As mentioned previously, the male nurse watches for behaviours or mannerisms that would

indicate discomfort on the part of the patient. One of the participants expressed it this way while also acknowledging how infrequently this occurred.

> Occasionally I've had a patient that will display behaviours that tell you that the female patient is uncomfortable with the care. In which case I would have a colleague, a female colleague you know, take over or be present. But it's usually a non-issue. In all my years in intensive care, that rarely happened. Very rarely was there a situation where there was a problem. (5, 87)

This same participant went on to express that not all patients express their discomfort clearly so it is important to be aware of the patient's comfort level.

> I have been in situations where the patient perhaps didn't express clearly that they didn't want the care. But they looked uncomfortable with a perineal exam or catheterization that sort of thing. And because there was another caregiver available, a woman, I would call on them to do that and try and do a task for them. I can't remember any specific instances where a patient had a particular reason, although in training I remember in obstetrics and gynecology the first patient that I sort of went in to do an examination on, told me to get lost. But I think that was just frustration with being seen by so many people, being in a teaching centre. Maybe not so much the fact that I was male. (5, 226)

Other participants expressed the importance of not only assessing the female patients for discomfort, but also reinforced what has previously been mentioned regarding the importance of providing the patient some choice in their care. By doing this, once again, the trust issue is addressed. The following two comments illustrate what the participants believed to be important.

> If I detect that somebody is very leery about me doing swabs, you know I can sense the distancing quite easily with most people. At that point I usually say 'Look, if you're really uncomfortable with this, for me doing this, I can have someone else come and do it'. And then it's their choice. I think people should have a choice if you see that they're squirming about something and they feel very uncomfortable with you doing something. Then I'd like to give them the option because that builds the trust again. Because you're putting it into their hands, not that you're forcing something that they have to do. (10, 178)

> If you find yourself where you feel you have a conflict of interest or there's a conflict where the patient is uncomfortable, give them the option if at all possible, of

> providing a same sex nurse. Sometimes giving them the option is enough. That they'll say you know, you give me the option and on that basis I now trust you. Sometimes that's enough to get it done. That option is available to them and if at any point during the procedure they get uncomfortable with what you're doing then somebody else can come in and usually the rest looks after itself. (11, 759)

The participants identified that trust was important to develop between the patient and nurse. By properly assessing the patient's comfort level and providing the patient with a choice of care giver, the male nurse was able to strengthen the trust the patient had for the nurse and therefore was able to perform his duties as a nurse. The participants also expressed that sometimes the trading of assignments or providing a female alternative depended on the task to be performed. It appears that the more personal or intimate tasks are the ones that male nurses would trade off. As one participant expressed:

> The nurse has to be flexible. You can't just be rigid and say, 'Well this is what's going to happen'. I mean you have to allow for a certain amount of adaptability I guess. If the patient doesn't want a certain thing done then fine, I'll have someone else come in and do that certain aspect. (13, 149)

Another participant was more specific as to the type of intervention that may make him find a female alternative. He stated that it was during a catheterization and usually a vaginal packing that he would have a female do it. Take it out and repack it or whatever needs to be done. (14, 532)

The final section is workplace setting or situational factors.

Workplace Setting or Situational Factors

This component is somewhat different from the other sections discussed previously. The reason for this is that the workplace setting or situational factors in and of themselves are not actual strategies or interventions. But rather, they are one rationale as to why female patients may receive personal and intimate care by male nurses. The need for particular

nursing interventions to be accomplished in these settings and situations is understood and therefore is justified when a male nurse is the one performing the care.

Some of the participants discussed how the setting, patient's condition, or, context of the situation, made the provision of personal and intimate care with female patients easier to accomplish. These factors either made the provision of the care psychologically or emotionally easier or, made it logistically easier for the nurse to complete the care. For example, one participant suggested how the setting's routine made the provision of personal and intimate care easier.

> I guess the decision when to do certain things with patients that are personal and intimate has the onus on the nurse when they're in ICU. It's easier in ICU because it was your schedule. You were the director of how things were supposed to go. It almost became part of a routine. For example on nightshift, part of our routine was to bathe all the patients. You usually liked to do it before midnight. So we would be giving patients baths at around eleven o'clock eleven thirty at night. Before we would go off on our first break. So you didn't want to stray too far away from that type of routine in order to complete all your tasks for the rest of your night shift. And that had to be done at that certain time. So to me that was easier than if the patient was on the ward and they've gone off for a cigarette or their family's visiting with them and there's a lot of intrusions and other things going on that can delay or alter the experience with the patient. (2, 394)

This same participant went on to discuss how the patient's condition or factors surrounding the patient made it easier or more difficult for him to perform personal and intimate care with his patients.

> A lot of the patients that I've looked after were unconscious so there would be no facial expression. There'd be no sort of body language to sort of say 'I don't like what you're doing.' or, 'Can you wash my back?' or, 'Can you get my foot?' or whatever the case was there. On the ward it's quite a bit different because the patients are quite a bit more animated. And I think there's a lot of extrinsic factors on the wards that contribute to what goes on. You know if the patient's family members have come in and they've had a fight. The wife's had a fight with the male patient. We had an incident this past week where a husband and wife were having an argument and the fellow had bypass surgery three days prior. And he had an anxiety attack and so on and so forth. So these types of things can occur. Whereas I

> guess the ICU is a bit more controlled. So that it made it easier for me to go and do these types of things. You had your list of things to do and this is the time to do it so let's get it done. (2, 431)

Another participant discussed how certain characteristics of the patient, or the busyness of the area, made the provision of personal and intimate care easier. This particular participant's comments also allude to the previously discussed idea that the sexuality of providing personal and intimate care has to be considered and dealt with.

> I find intimate care easier right now in my area of surgical intensive care. Intimate care is much easier if it's very busy. To be honest I would find it easier if the female patient was married or if the female patient was elderly. I find intimate care more difficult, not physically difficult but emotionally difficult if the person is younger, if the person is single, and if it's not busy. Because when you're busy you don't have time, you don't really have time to let personal feelings get in the way. You're just busy. You don't think of that. You get the job done and that's it. But when its more laid back you have time to let your feelings kind of interfere a little bit more with your care. Well, not interfere, but the feelings come out more. (3, 193)

The participants also discussed how at times they just had to get the intervention done. That is, the need to perform the care was what was important. The following excerpt describes how one participant handles situations requiring caring for confused patients who do not want personal and intimate care performed.

> I've had confused patients tell me to get out of the room and this and that. And then I try to calm them down and I explain to them that we'll we do this to the minimum. 'We'll do your bed bath, and the procedure that we're doing is a necessary thing that the doctor's ordered. And that whether I do it or another nurse does it doesn't matter it's still going to get done'. And usually in those situations it's not so much the person, it's the procedure that's happening that the patient's objecting to. (13, 263)

Another participant described how it was important for the procedure to be accomplished and that unfortunately there are times and situations where it is more important to perform the procedure rather than worry about the patient's permission or comfort level.

> I mean, sometimes you have to intrude. Whether they like it or not. You try to be compassionate. You try and get their permission. I don't think intruding on

> somebody who doesn't want to be intruded upon is okay in any respect. But sometimes you just have to do it. And I mean you just try and make a point of making sure that it's okay with the patient prior to you doing anything. Whether it is personal or intimate care. That's how I deal with it. And if they're not comfortable with it you deal with that when it comes out. But, intruding on someone's privacy I personally don't have any problems with that. (3, 717)

Another participant described a situation that illustrates how sometimes pharmaceutical intervention is the only alternative to be able to provide the necessary personal and intimate care.

> I've had agitated patients upstairs in the intensive care who you do use sedating drugs. They're agitated about them being touched in a certain place or something like that. When you're wiping them up or whatever. It's part of their general thing and if it's a closed head injury you use sedation. And so in that sense it's part of a more general trying to relax things. But that is something that I guess could be viewed as a technique. (4, 604)

Perhaps the most frequently expressed aspect relating to situational considerations when providing personal and intimate care with female patients was when there was not enough time or staff to be able to provide a female alternative. It was during these times that the participants acknowledged the patients' feelings, but the necessity of the intervention had to take priority over the patient's feelings. As one participant expressed when discussing finding a female alternative:

> It's not always possible. Like for example when there's a trauma and you're in emergency and we've got three people and a possible spinal situation. I mean there's nobody else and we're doing the intimate care. Like it or not that's going to be done because we have to do it. If you can't give them the option to have something different, you try and preserve their modesty whenever possible. You know, like giving them a towel to cover up when you're checking something. You try and maintain their modesty as much as possible. Kind of recognizing that for them this is something that's happening even though it's not anything like that for you. (4, 529)

Another participant discussed how at times the male nurse has to be assertive in his need to provide the necessary personal and intimate care. When asked what types of strategies or

interventions he had used in the past his response was:

> Sometimes just being very firm and business like with situations. Again it comes down to kind of the necessity of the situation. I mean we had a lady that came into the hospital. She had been stabbed several times anteriorly with a paring knife. And we were worried about hemo and pneumothoraxes. And because of the time constraints or patient load you just go in there. And you're very busy. And this person is extremely agitated which is not hard to imagine, you know, being assaulted by your boyfriend, being stabbed. She was under the influence as well and extremely agitated. And you end up just being very business like saying 'I'm going to do this. I'm going to be listening to your chest here. I'm going to be taking a look at the wounds on your front here to see what's happening with them'. And you just don't even give them the option because that wouldn't be in their best interest. And well, it might even be in their best interest, but there are constraints that don't allow you to do that. So again, there's constraints on you that make you have to approach things differently than you would in an ideal world, where you ultimately respect every little feeling a person has. (4, 604)

The data analysis provided the strategies and interventions used by the participants when providing personal and intimate care with female patients. The analysis also identified the consequences resulting from not attending to the patient's feelings of discomfort when receiving personal and intimate care by a male nurse.

Consequences of Not Attending to the Patient's Comfort

The participants were asked how they knew if their female patients were uncomfortable with the care that was being provided. The responses fell into two main categories, verbal and non-verbal behaviours or responses.

Participants indicated how the verbal cues or behaviours expressed by the patients could be overt and easily interpreted. As one participant stated: "Verbally they could make comments like `Oh, I've never had a man do anything like this', and then you know that they're kind of a little bit uncomfortable" (4, 503). Alternatively, the verbal cues may be subtle, as one participant expressed how sometimes patients may say: "Do most male nurses do this?" (1, 245).

One participant, however, did acknowledge how difficult it is to assess something as subjective as a patient's level of comfort by stating that:

> Ultimately I don't know. Unless they come right out and tell me, 'I'm uncomfortable with what you're doing'. I mean interpreting body language you know, nervousness or that kind of thing. I mean that's my subjective reality so ultimately unless they come out and say it, then I don't know. (3, 731)

Verbal cues or behaviours appeared to make the assessment regarding patient comfort easier. However, it was not as prevalent an assessment tool as was the observation of the patient's non-verbal behaviours.

Many of the participants discussed how the patient "looked uncomfortable" when it came to identifying non-verbal behaviours exhibited by the female patients when personal and intimate care was being provided. As one participant stated: "I mean, sometimes you would assume that they are uncomfortable just because of the way they are reacting" (3, 736).

There was no singular non-verbal behaviour, reaction or response that could undeniably inform the nurse that the patient was uncomfortable with the care being provided. What was consistent throughout the interviews was the idea that the patients had a certain "look" about them that the participants were able to assess as discomfort. Some of the comments related to "the look" expressed by the participants are as follows:

> If they have that 'look' on them. (7, 542)

> Look at the expression on their faces. Where there's less time – look at the facial expressions. (8, 396)

> And you can see it. I can see it in their eyes and just the expression on their face. (10, 612)

> It's the physical presentation. And when you work with people as much as you do as a nurse you get there pretty fast. (11, 683)

> There's the typical facial expression. I look at the face and try to figure out what the patient's thinking. (13, 425)

The male nurse, very often assessed this look, intuitively. As one participant commented: "Look at the expression of their faces. You can tell immediately from people's responses whether or not this is something they feel comfortable with" (8, 371). While another participant stated: "You have to read the person. They way they look at you" (12, 414).

This intuitive understanding of the comfort level of the patient experiencing the provision of personal and intimate care by a male nurse is based on the assessment of the non-verbal behaviours and responses of the patients. The behaviours or responses that the participants perceived as being an indication of patient discomfort with the care being provided have been categorized as facial cues, emotional/psychological cues, withdrawing cues, and protective motions cues. Table 1 lists the behaviours or responses that reveal the discomfort experienced by the participant's female patients.

Table 1 Cues Perceived as Being an Indication of Patient Discomfort

Facial Cues	Emotional/ Psychological Cues	Withdrawing Cues	Protective Motions Cues
• The eyebrows go up • Shifting of their eyes • Turn their head away – they try to look away but still watch you from the corner of their eyes. • Lack of eye contact	• Flat affect • Jitteriness • They may cry • Fidgeting • If they are talkative	• A change in how receptive they seem • Reluctance • If they don't talk to the nurse, if they don't verbally respond • If they are quiet • You can sense the distancing quite easily, they pull back from you, they make a greater space between you and them. • Some will just lay there and not say anything • Being withdrawn	• They hug their arms to their body • They will not assist with loosening the gown or by only pulling it down part way • They stiffen up • Holding onto their sheets • They push your hands away • They hold on to their clothes • Clench their fists on the side of the thing • Being careful to keep their "private areas" covered

The comfort of the patient is of utmost importance to nursing and nurses regardless of the type of care being provided to patients. The consequences of not attending to the female patient's comfort results in psychological, emotional and physical manifestations that ultimately can affect the nurse-patient relationship. If the care received creates or results in an emotional, psychological or physical discomfort, then it is of paramount importance to identify the source of the discomfort and take measures to either alleviate the discomfort or to prevent its occurrence in the first place.

This section of the analysis presented the behavioural strategies or interventions

used by male nurses when providing personal and intimate care with female patients. The components of maintaining privacy, trading assignments or providing female alternatives and workplace setting or situational factors were presented. Consequences of not attending to the female patient's feelings of discomfort during the provision of personal and intimate care were also presented.

This completes the analysis of the nursing interventions or strategies used by male nurses when providing personal and intimate care with female patients. In this section the participants identified communication, cognitive, emotive and behavioral strategies or interventions as important tools in the provision of personal and intimate care with female patients. Also identified were the consequences of not attending to female patients' discomfort when receiving personal and intimate care with a male nurse. The next section of the analysis discusses factors dealing with societal considerations and expectations relating to the provision of personal and intimate care.

Societal Forces Relating to the Provision of Personal and Intimate Care

In this section I present factors addressing societal considerations and expectations regarding the provision of personal and intimate care by male nurses. This section is divided into three sections. The first section highlights participants' societal beliefs surrounding the provision of personal and intimate care to female patients. The second section addresses societal considerations influencing male nurses in this regard. The impact of nursing education on the provision of personal and intimate care is reviewed in the final section.

Societal Beliefs Surrounding the Provision of Personal and Intimate Care With Female Patients

Societal beliefs, values, mores and expectations influence how one acts and or

responds to social "rules". Because males in general are not generally seen to be the caregivers in society, male nurses might be perceived by some people within society as bending or breaking the rules of role expectations. Participants were asked if there was an issue or concern with male nurses providing personal and intimate care with female patients. The participants themselves had no substantial issues or concerns with the provision of personal and intimate care with female patients as evidenced by the following excerpts:

> I don't think there's much of a concern. Occasionally I've had a patient that will display behaviours that tell you that the female patient's uncomfortable with care. In which case I would have a female colleague take over or be present. But it's usually a non-issue. In all the years in intensive care that rarely happened. Very rarely was there a situation where there was a problem. (5, 83)

> I haven't encountered anything like that. I've been receptive I think to patient concerns and their wishes. But on the other hand I've never felt out of place doing things with female patients. I always think I've been a professional, and I've never heard contrary to that. Just on my experience I don't think it's a big issue. (6, 83)

> I think it's acceptable. I don't have a problem with it. I think it's a valuable time and opportunity for you to share with patients that males can look after females and provide a good example of it. And make it less of an issue for people. Just by doing it you know, just by being the best you can. Try and set an example for them to be left with the thought 'I had male nurse which hasn't happened to me and I really enjoyed it.' You know, to leave a good impression. (7, 290)

Because society in general can influence our thinking, values and behaviours there is always the possibility that someone may not agree with the participants' perception that there is no substantial concern with male nurses providing personal and intimate care with female patients. One participant identified that not only should it be a concern, but the issue of privacy is of importance regardless of the gender of the care giver.

> It should be a concern because when you're in the hospital you're sick. Your privacy is in the hands of other people. So yes it is a concern because your privacy is encroached upon. Yes it should be a concern because basically you're invading

> someone's privacy whether it's a male or female patient. It should be looked at because it's part of nursing care and it affects people's lives. I mean, they are in a hospital, you invade their privacy and it should be a concern. (3, 106)

Sometimes it was not the patients who had an issue or concern with a male providing them with personal and intimate care but rather, a family member expressed the concern.

> I know that in some cases there are some patients who are on the receiving end of that care who have concerns about it. In my experience it's been predominantly the family who have concerns about it. But I do believe those concerns can be effectively addressed. (1, 71)

This same participant described a situation when he was a student caring for a young woman during his obstetrical clinical rotation.

> I would have to go back to the same incident with the young unwed mother when I was a student. I believe that her mother initially had some trepidation about my performing that kind of intimate physical care. But I went ahead in a business like and competent way and then at the same time was able to deal with some of the psychological and psychosocial issues with this patient. The response that I got afterwards and the feedback I got was extremely positive from the patient, but particularly from the family member. (1, 161)

Another participant stated that it was not so much the fact that he was male that the patient had a concern with him providing personal and intimate care. Sometimes not all patients and nurses like each other.

> And it's all part of intimate care. Personal care, I mean, because they're female. Sometimes you just don't get along with the patient. They don't like you for whatever reason. It's never been an issue whether they're male or female. It's just sometimes you and the patients just don't get along for whatever reason. They don't like the look of you. They don't like your voice or whatever reason. They don't like the care that you're giving them for whatever reason. (3, 498)

One participant acknowledged that some female patients have a concern with male nurses providing personal and intimate care and feel uncomfortable having a male nurse care for them. However, the same participant also identified that some female patients

prefer having a male nurse.

> Some patients feel uncomfortable having male nurses because they're just not used to the idea of having a male in that role. I think that's changing. I found through my experience that a lot of female patients after they've had a male nurse, would rather have another male nurse look after them. I don't know why that is, but, it's been my experience that the one's who have previously had male nurses don't have a problem with it afterwards. (13, 52)

Although the participant indicated that some female patients prefer being cared for by male nurses, he stated that he did not know the reason for this preference. The following excerpts may provide a possible explanation for this preference.

> We're new into it so I think we still have to prove ourselves. We're still sort of walking on thin ice. So we sort of have to tread softly and do everything a little bit more with kid gloves. And because they expect men to be so rugged and rough and man handle everything, we try to be a little bit more gentle I guess. Plus I think men have a better sense of humor (laughs). (12, 223)

> I've heard from a vast amount of patients that males tend to give more compassionate care. Caring care, sort of thing. Whereas the females have a tendency to make it a routine or something like that. But in my sense, I have no problems with it. I guess it's more my personality. I'm a caring person. I don't care if you're black, white, male or female. If you need help, if there's any way that I am able to help, I'll do it, within my broad scope of practice. (9, 175)

> I mean from the feedback I've gotten from female patients, and not belittling my female counterparts, but for the most part I've heard of a lot of females after they've had a male nurse, say that they prefer the male nurses to the females. Where they find the men sometimes seem a little bit more patient and caring and tender than the females. That the females tend to be a little bit rough on the handling. (12, 213)

The participants were asked what their thoughts were about male nurses working in areas specifically requiring the provision of personal and intimate care with female patients, for example, in labour and delivery. A previously quoted participant answered this way:

> I've never had any problem when I did a rotation in there. I think guys can do just as good as women given the chance and making sure the client is comfortable with it. Never really thought of it. I think that the guys can do just as good if not better. From what I heard from the women, that I've talked to in regards to male care. They sense that there is a little bit more caring, sensitivity. Males were a little bit more sensitive when it came down to caring. (9, 228)

While another participant responded it this way:

> In a setting like obstetrics and gynecology I don't think that there should be a specific restriction. I think for the most part my experiences have been, that, female patients in those areas just want good care. Going back to training I actually can't remember one of the specific instances. I've had females express that they prefer male care over female care. For some reason males are more compassionate. There was some sort of a comment like that. We had a different perspective. Maybe we didn't have the same types of symptoms and the same anatomy. Maybe that was a reason that they felt that males actually provided a different type of care. Comments like that of course make you feel good about giving care to female patients (5, 258)

One participant suggested that, in general, the public is becoming more accustomed to being cared for by male nurses. However, the participant went on to suggest that it depends on what point in the labour and delivery experience that a male nurse cares for a female patient, that will determine if there is a concern expressed or not.

> I think the public is getting more and more use to the idea that there are male nurses and they will be caring for female patients. I think the one exception might be I know that some women have refused to have male nurses involved in the early part of their L&D admissions. But once they get advanced into labour and there's X number of residents examining them then it becomes a non-issue. I think there's been a long social understanding that women care for men in a hospital setting as nurses. Having said that, there are still some men that are uncomfortable with women doing certain procedures on them. But until the last few years when male nurses have actually entered into the hospital situation, there often wasn't a choice. So they didn't make an issue of it because they realized that I'm going to have this procedure done, the chances are about 99% that I'm going to have it done by a female. In some hospitals only male orderlies will perform catheterizations or certain procedures on men but I think that that's probably an exception now and unusual. (11, 100)

Although the participants believed that it was acceptable and appropriate that male nurses be able to work in any area of nursing, one of the participants acknowledged that for he himself, the labour and delivery area would not be an area that he would choose.

> I think it's okay for males to be there. Often a woman in that situation is in need and they don't care who it is. I've heard that so many times from different people. For me I don't think it's the most appropriate place to be. But then again I don't have an

> interest in that area personally and I missed that rotation because of the nursing strike six years ago. I never got that rotation, obstetrics and gynecology. I think there probably would be more appropriate places for males to be and we'd leave that one for the females. That's my opinion. (7, 394)

All of the participants believed that there was no reason for male nurses to not provide personal and intimate care with female patients. They did, however, acknowledge that there was a possibility that the provision of personal and intimate care could become a concern or issue for some patients and their families.

Societal Considerations Influencing Male Nurses Provision of Personal and Intimate Care With Female Patients

In this section I present societal considerations that influence male nurses when providing care with female patients. Areas addressed include stereotyping; legalities; and; culture, upbringing and religion.

> I don't think it should really be a concern because here is somebody that needs care, and this is your assignment at work and these are your duties and your tasks that need to be done. And I think a lot of people when they're in that sick role, it becomes a different modality. When you look at who's caring for me, does it really matter? I mean now that there are so many male and female doctors and more males coming into nursing I think that it's changing. People's attitudes are changing towards who cares for you. They don't make as big a deal about it. (10, 93)

> I have not experienced any negative reactions towards it. It's the nineties. Times are changing. People have to realize as women are getting into men's areas of work it's vice versa where men are starting to explore some of the areas that were traditionally women's jobs. (12, 53)

The above two excerpts provide some insight as to why male nurses believe there is little concern if they provide personal and intimate care with female patients. Although times are changing, the reality of the situation is that for the most part males entering nursing are still going against the traditional societal expectation of who performs what role.

> Because that's something that when somebody asks you why are you going into nursing. Like I was a truck driver before this, part time, and you tell them, a truck driver, that you're going into nursing. I mean look at the huge chasm you're crossing there, from this rough tough image to being a nurse and doing these intimate things. I think that was part of it, is that I had to get over that, get out of this male stereotype and get into almost a neutral role of being a care giver. Like I never thought about it that way but it's kind of become that where you're a care giver and yes you are male, but that doesn't mean you can't perform these things and do it professionally and caringly to whoever it is. (10, 511)

In this section I present data that demonstrate how societal stereotypes of traditional roles and expectations influence a male nurse when providing personal and intimate care with female patients. As previously mentioned males in nursing are to some extent still considered a novelty. Previously quoted participants indicated that males are "new" to nursing and people are just not used to the idea of a male nurse. One stereotypical societal belief is that for a man to enter nursing he must be homosexual. As one participant commented.

> And especially in the context of health care, but also building from a background of North American society and what the expectations are. I think that frequently in my early practice people were more suspicious or more questioning of male nurses' sexuality and what was going on. There was kind of anything from the fact well you could be homosexual or you could be totally safe with a female patient because obviously you were gay. Whereas male patients weren't quite too sure what to make of you. And female nurses weren't quite too sure what to make of you. So I think there's that whole spectrum of trying to understand. (8, 748)

Another participant, when asked if there should be a concern by male or female patients in being cared for by a male nurse expressed it this way.

> For myself it's not a concern. I can't say it shouldn't be a concern for someone if it is. From my perspective it shouldn't matter to me if it's a male or female taking care of me. I think I'm more open to it. I've had a lot of exposure working with people. It's not a big deal to have females or males look after you. At work here I was working with males and females. Whereas a lot of my friends are in construction or whatever and I think it would be harder for them. I think they would have difficulty with a

> male looking after them, just the macho image kind of thing. And they're not used to even dealing with any of these issues. When I talk about this male-female thing, it doesn't have to do with interacting it has to do with when there's a bath and all that sort of stuff. The other stuff, interaction and that, doesn't matter so much. But when it has to do with the physical body I think that the macho image they would have a hard time with that. (7, 121)

If the male entering nursing is not homosexual then the "alternate" societal expectation is that whenever males work with females, an environment is created which is conducive to flirting. The same participant went on to say:

> You can't come from a Western society where men and women's interactions can be quite stereotyped in terms of like you know, men are on the make and women are flirting and that kind of stuff. But obviously as men working in a profession which is mainly women, you can't work in a day to day environment with the dynamics where you're working with women and people are flirting with each other and men are making a come on with people. I mean obviously it has to be a level playing field where everybody understands why you're there and what you're doing and what the job is. And I think a lot of those things don't get sorted out sometimes before people start work. And those can be issues which then can cause problems for some people in terms of their work dynamics. And they can also cause problems with patient dynamics and care dynamics if they don't feel comfortable with where they are at work and their relationships with women and with themselves and then have to go and give intimate care to the opposite sex. Even for women it's a big problem. (8, 759)

The participants were asked if there was less of an issue or concern, when female nurses provided personal and intimate care with male patients. Some of their responses are as follows:

> Yes, I do believe that, because it's been the standard. I mean for as long as anyone can remember there's always been female nurses. That's just the way it's been. I mean you go into a hospital, you have a female nurse there. That's who's going to take care of you. (13, 64)

> It's an area that males are moving into and they haven't traditionally been in that area. Whenever you move into a new area it's kind of suspicious. It's the same as when females move into an area that's been a male domain like engineering or anything or a sports reporter or something. (14, 83)

The following excerpts reinforce the above statements while providing a possible

explanation for these stereotypical considerations.

> I think women, especially the older women, are more conservative and it's an expectation that they wouldn't have a male nurse. That's just from my experience what I've noticed. Because several patients have come up to me and said, "Oh my, a male nurse. This has never happened to me and I didn't even know it existed." and that sort of thing. People don't know out there. Just like I didn't know when I went into nursing. (7, 104)

> I think men frequently haven't been involved with giving physical care to people period. Whereas women, young women frequently have been involved in giving child-care such as babysitting, so they're sometimes more used to giving physical care to people. (8, 313)

North American society still has expectations as to what are considered appropriate gender roles. Because of this, the participants also had to contend with their being considered something other than a nurse. Males working in the health care system have traditionally been seen in the roles of porters and orderlies or doctors. It is only when we identify ourselves as nurses that the patients realize that the male in front of them may not be in the role that they expected. The following two excerpts illustrate the roles that the participants have been identified with.

> To this day I still get a lot of people who think I'm the orderly. And then when I tell them I'm the nurse it's like disbelief. Like "Yeh, but you're a guy. You can't be the nurse, you're supposed to be the orderly". I say, "No, no, I'm the nurse". And "Oh, okay, well then let me talk to you" (12, 581).

> I think a lot of patients equate male nurses rightly or wrongly with doctors and see them in the same light. And the procedures that are performed by doctors and by male nurses are seen in the same way, as appropriate and medically necessary and professional in nature. We sort of basically ride the coattails of that profession I think sometimes. Not intentionally, I mean it's done in the patient's mind. We don't present or hold ourselves up as being physicians when we do things but I think in the perception of a female patient it's like 'Okay, well my gynecologist is a male so this nurse is a male, what's the big deal'. (11, 379)

Some of the participants believed that there was occasionally a double standard with how they were treated differently by patients because of their role as a nurse. Because males

are not expected to be in a particular role, the participants felt that they had to prove themselves with the patient before the patient would accept them in the role as nurse.

> Female nurses don't have to prove themselves. They go in, they do the job and it's expected of them. Male nurses have to prove that they have that same ability to perform the job. I had a patient recently - she came in about a month and a half ago. She'd never had a male nurse before and there was a lot of ribbing and she was a very sarcastic individual and we hit it off. I mean it took a couple days before she was comfortable with me looking after her but we had a very good relationship. It just sort of progressed from there. (13, 133)

Another form of the double standard is when patients equate the participant with physicians. That is, if the physician can do this, then it is all right if a male nurse does the same procedure.

> There is a double standard I believe. I think that men have understood for a long time that women are nurses so some of the care that is delivered to them would be from women, in terms of being catheterized, or washed or in any respect. I think that women will say, "Well you're a male nurse, that's sort of like a doctor and I've gone to my gynecologist." So a lot of them equate it as being appropriate if they connect you somehow with the medical profession. But I think there are some women that are somewhat surprised and perhaps a little bit uncomfortable with it. Especially when you're just getting to know a patient. (11, 80)

Some of the participants suggested that male nurses worry about providing personal and intimate care with female patients. One of the reasons for this may be explained by the belief that males are typically the aggressors in today's society. The following excerpts illustrate how males have been stereotyped as the aggressors in society particularly in the media.

> Maybe it's a stereotype but typically the male is the aggressor. If anything happens it's easier for the female nurse to say this is just a horny old man coming on to me, I didn't do anything. Whereas if a guy was ever accused of something, I think an institution would take the accusations much more seriously. Maybe I'm incorrect in that but that's a perspective that you get. Just from reading the news from media. If a male's accused of sexual impropriety it's taken much more seriously I think initially than if a female is. (4, 229)

> Patients that have never had a male nurse before don't know what to expect. Maybe a little bit of fear. Because, well it doesn't help them, what you've been seeing on TV. I'm pretty sure some of the older patients think, "Oh, my God I'm going to be molested or something terrible is going to happen to me". And I don't know whether or not that's unfounded because there's a lot of really sick individuals out there and TV does play a large part in the way we think. (13, 520)

The above statements suggest that there is a societal belief that male nurses may allow their aggressive tendencies to carry over into the care they provide for their female patients. Because of this, male nurses are aware of the need to be cautious when providing personal and intimate care with female patients. This need for caution may be due to society's perception as to what is appropriate or it may be due to the nurse's own perception of what may be construed as appropriate. One participant identified that it was not necessarily a public issue, but the provision of personal and intimate care should be an individual issue for the nurses themselves.

> I don't know if it's a public issue. But I think it should be an issue with every individual who's providing the care. You have to be aware of your own limitations. You have to be very aware of yourself and of course you have to be ethical. So there is an issue, but more than that, it's dealing with intimacy and so that always requires reflection on your own motivations. (14, 55)

Legal considerations influencing the provision of personal and intimate care with female patients

Male nurses believe that they need to be cautious because of the potential for being accused of impropriety. Many of the participants expressed concern that this could indeed happen to them because of the nature of the work that nurses do, particularly during the provision of personal and intimate care with female patients. Since society assigns males with the characteristic of aggressor, a number of the participants identified concerns that they had when providing personal and intimate care with female patients. Some of the concerns expressed by the participants were the inability to provide privacy while ensuring

that they themselves are protected from inappropriate accusations and the need to be wary when providing personal and intimate care with younger patients. The following excerpts present some of the concerns expressed by the participants regarding this issue.

> I think male nurses in this day and age feel a little more wary or perhaps uncomfortable from a medical legal standpoint in terms of younger female patients. I guess with some male patients in certain cases because of the news media, books, things that are out about sexual abuse and the types of things that are going on in the community and around the world in terms of intimacy and the respect of others. (2, 64)

> I think it should be a concern. I have friends who are teachers and they leave their doors open to their classrooms every time there's somebody in, opposite and even the same sex, just to protect themselves. And that's something that you cannot do as a nurse. I mean in terms of privacy issues, you can't have a person undress or unclothe in front of you and maintain a way for other people to observe what you're doing. Just doesn't work. So I think that's kind of a significant issue in terms of things. It's to protect yourself. Because you never know when accusations will happen. And it sounds bad, but I've seen very good people get screwed around by accusations that are false. Regardless of whether or not the fact that matters that this patient is a psychiatric patient. I worked in psychiatry one time. A girl told another guy that 'if you do anything I'll say that you were trying to hurt me or whatever'. And so you have to be careful of things like that. There are psychiatric patients in the general hospital that will do things to get back at you. They're borderline personalities. They don't like you. So you have to be careful to protect yourself because it's your livelihood. You have a good life ahead of you, looking forward to things and it can all be jeopardized by somebody making accusations. Regardless of whether it's true or not. I mean you do things to make sure that if there's something going on, you don't lose everything that you've worked hard to accomplish. (4, 83)

> I know it's happened within the facility that I work at, is that the odd person, the odd male I think in most cases the orderlies, but in some cases male nurses, have found themselves in situations where it's been suggested that they've done something improper during intimate care. Which is devastating for anyone. I mean the simple allegation, hospitals being small towns that they are, soon are everywhere. And so I think that you have to be very mindful of that. And I don't know that there's much you can do about that. The patient says that you have done such in an improper manner and you're the only person in there. I think that you can run into some problems. I've been fortunate that way I guess in that I haven't encountered that. (11, 881)

One of the participants expressed that not only male nurses, but also female nurses, should

be just as concerned with possible charges of impropriety. The participant also suggested possible reasons that charges of impropriety may occur.

> To me it sort of reels back to the sexuality of being in hospital and being exposed. There is hype in the news media, in terms of sexuality and people being abused or misused or what have you. There's a current thing in Nova Scotia where a female nurse is being charged with sexually assaulting a 16 year-old male patient. So, there seems to be a lot of this type of business in the media in the forefront right now. I think for people that don't have that type of direction towards patients or people or in their personal lives, I think that it makes us a little bit nervous that this could happen. Somebody could come out and say something to you. The public is free to do those types of things. My experience with patient representatives in hospitals and some of the complaints that come back to us in terms of nursing care, it can really sort of askew your perception of what the situations were when these patients were in hospital. Some of them are, they've come out of anaesthetics, they've received analgesics, they have hallucinations, or they become sleep deprived so their whole perception changes. So in a personal situation, if you're giving perineal care to somebody that can be misconstrued by the public. I think with all the business that's going on in the forefront this is a reason of concern for both male and female nurses at this point. (2, 87)

Male nurses (and as the above quote demonstrates, female nurses also) need to concern themselves with the possibility that in the process of providing personal and intimate care (or any kind of care for that matter) with their female patients, they may be perceived and accused of inappropriate behaviour. Another aspect of providing personal and intimate care with female patients is that the male nurse may feel uncomfortable in providing the care strictly because of the potential for accusations to occur. One participant described a situation he ran in to when taking a course.

> When I was taking the nurse clinician program, part of our rotation was to go on a consulting visit with consulting physicians and basically be like the intern or the resident that that was on for that service. I spent a week with endocrine and on my very first day there was a young female patient that had multitude of non-specific complaints. She had problems with her breasts lactating, hemorrhoids and all this sort of business. Because of the intense training we had with the medical students we knew to take a systematic approach and we're supposed to go in there and practice all of our head-to-toe physical assessment skills. So I examined her fully but I felt extremely uncomfortable. It got to a point where I felt that this could

> present some problems or trouble for me, if this female patient suddenly decided I was undressing her too far or whatever. But it turned out that everything was fine and that it was my own perception. She was basically there to have a physical exam and have her complaints met with. But I felt very uncomfortable at that time because I was in a room alone with a female patient and I felt that I should have had somebody else there with me while I was examining the patient. (2, 181)

Because of the above concerns many participants bring a chaperone into the room with them when performing certain aspects of care.

> The ones I'm usually careful with are anybody who has had a past psychiatric history or something like that. I'm very leery of them. I always make sure somebody else goes into the room with me. If they have a psychiatric history, if they have a drug abuse history or something like that and they're unstable I always get this uneasy feeling that you're prone to accusations or something. That's the only fear I've ever had. I've dealt with patients like that and I've always covered myself by going in with another female just to be on the safe side, to protect myself legally. I guess you don't really have to, but it's just something from my own personality that because of their background and the nature of the person, they set me sort of uneasy, I don't trust them. And you don't know what they're going to pull next. So it's always, I try to cover myself. Like you walk in there and you don't know if the gun is loaded or not. So it's better to be safe than sorry. (12, 241)

> There have been a few procedures that I have been required to do as a nurse and just from my own safety, not the patient's, I've had a female staff member come in while I've done the procedure. When I first started out there was a vaginal suppository we had to do. And just to cover myself there was another female nurse that came in, just to keep it above board and that there was nothing funny that went on. I came in, I performed the duty that I was assigned to do which was insert the medication and that was it. And I did that more to cover myself than for the patient. I guess it was good for the patient too I mean, she saw that there was someone else in the room, but I was thinking more for myself, that I didn't want any things happening. Well I wouldn't want anyone to think that I'm abusing the patients sexually or anything along that line. I think there is situations where we do have to worry about that. I would rather cover myself legally and not have to worry about the headache afterwards. I should've done this. This way I cover myself going into it. Someone there of the same gender, she knows that everything was above the board, then I'm covered. (13, 180)

> There've been times when the attitude of the girl or the woman made it feel to me that this was not a thing I should be doing without having another female in the room. And I've always got another female to sort of be there when I performed it or have her help me perform the procedure. There are times when the people's attitude

> seemed to be that 'I'm not sure that you should be doing this to me'. And I have run across people who have histories of suing people and I've taken a lot care with those types. I can't mention any names but there are people in this city that do come to my particular hospital who have a long history of suing anybody that looks at them the wrong way. It shouldn't be necessary that I have to feel that way. I mean I'm there to do what's needed. It's just that some people just don't seem to understand that. (15, 182)

One of the concerns also expressed was not so much the need to have a chaperone but rather the logistic ability to have a chaperone present when needed. One participant suggested that physicians have chaperones present when required but nurses do not have that ability due to resources.

> The only problem is doctors usually with their one on one care often have the advantage of being able to ask for an assistant. And they come in for a few minutes and have the time and the resources to ask an assistant to come in and be with them when they're providing intimate care. Whereas nurses don't have that resource. (4, 215)

Another participant suggested the idea of individualizing the need for a chaperone but commented on the need for caution as to who should be allowed to decide if a chaperone is needed.

> Well I guess one aspect would be is it physically possible to have a chaperone in there carte blanche every time you're in there with a female patient. I think probably what needs to be done is to be individualized on specific patients based on your assessment. That's not to say that there aren't people or male nurses in the health care field that are sexually deviant and derive pleasure or are doing things that they shouldn't be doing. So if left up to them to decide whether there was a chaperone or not then they could basically call it any way they want type of thing. So for my own self, not being sexually deviant of course, I would be comfortable making that sort of judgement call at the time. But what to do in a general practice I don't know. Is it manpower feasible in terms of can you provide somebody that would do that in addition to their job. Or who's going to do it? (2, 633)

A previously quoted participant expressed that he was aware of male nurses who had been accused of improper behaviour. Even though he was aware of this happening he himself did not believe that it was important for him to be concerned about this possibility.

> I don't worry about that at all. I just I don't. And maybe I should worry about it more. But if you had to have someone of the female persuasion in the room every time you did anything of an intimate care, I mean you might as well hire twice the staff or at least have a staff member follow me around all day long. If you think that for some reason someone could create some problems for you, then you may want to pull someone else in there. I just don't know if you can foresee every single one of those situations. All you can do is conduct yourself in a manner that can't be misconstrued as anything other than care. And that's why I suggest that it's best to explain very clearly what you're going to do and 'If you are uncomfortable with this, tell me now, or at any point, and I will remove myself from the situation.' I think on the odd occasion it does happen that people do misconstrue what you're doing. That hasn't happened to me personally. But there's certainly a lot of potential for that. And so I think in that respect you have to be very, very clear as far as what you're doing. And that should avoid any of that. But yes you know the possibility exists that somebody could decide because they're in an emotional state or psychologically this is how they draw attention to themselves. Or if someone is just outright evil I guess, that they could take advantage of the situation for their own profit or gain. I just haven't encountered that. But I have heard of situations where people have found themselves in situations like that. And I think for the people, it was devastating. I don't think you can avoid that situation in all circumstances. It's like the men who find themselves in a situation where someone's called rape or teachers have been accused of doing improper things within the classroom setting. Things that have later proved to be untrue or the person who's charged them have done it in a vindictive manner. I guess nurses and physicians are opened up to that sort of threat as well. I guess anyone who works in a close and intimate line of work can find themselves in that situation. I don't worry about it though. Maybe I should worry about it more. (11, 911)

Some of the participants indicated that additional societal factors that influenced the provision of personal and intimate care with female patients had to do with the culture and upbringing of the patients and or the nurses.

Culture and Upbringing of the Patients and or Nurses Influence the Provision of Personal and Intimate Care With Female Patients

Society is a melting pot of cultures, and methods of raising children vary. These factors play a role in the development of the patient and the nurse and ultimately affect their perception of how "things should be". This value or belief carries over into all aspects of

life, for the nurse - their professional role, and for the patient - their role as a patient. Culture can influence the provision of personal and intimate care by a male nurse as evidenced by the following excerpt.

> Nursing has been traditionally dominated by females. And men, because there was no choice have just gone along with it and they may not say as much as a female would. For whatever reason. I have had a couple of instances where I've seen that males, especially when it's cultural differences, that they have asked a male to do certain things or the doctor to do certain things with the care that needed to be done. But I don't see it quite as often as I think it would be the other way around with males to females. (10, 80)

The participants were asked what characteristics of the patient could make it more or less difficult to provide personal and intimate care. One of the participants responded:

> What can make it difficult I think would be the cultural differences that you might encounter. In Winnipeg it's such a melting pot that we do see from A to Z. So that can come into play sometimes. I worked with a lot of aboriginal people in Ontario through an interpreter. The words that I picked up in the language that we would try to communicate was one of the things that might be a little difficult. (6, 166)

The above participant identified not only culture as being a factor that influences how care is provided but also the fact that language itself can be a barrier and can influence how care is provided. If one includes cultural differences and the inability to appropriately express oneself (nurse to patient or patient to nurse) then it is no wonder that the provision of personal and intimate care can be affected. It is not just foreign languages that can create difficulties. Another participant expressed how it is important to be able to communicate on the same level as the patient. That is, sometimes the way one is brought up dictates how he or she communicates.

> Language is a big one. Language. I find not so much with the women. A lot with the men that you sort of have to listen to them very carefully when they're speaking to you to how do you put it, I guess like it's a radar sense to pick up what type of person they are. And there's some you can talk to on an intellectual level and there's some that you just use good old street language and you know that's what they like.

> If you walk in with this professional attitude and everything's respectable, some people take offence to that. They like to be treated like a friend off the street and they don't like being treated like they're sick, some people. They'll take their treatments but in the meantime it's like 'Don't treat me like I'm an invalid or something'. (12, 198)

As the above participant explained, it is not only with female patients that language plays a factor in the provision of personal and intimate care.

The participants also expressed that the patient's own upbringing can influence how they perceive the care that is being provided to them. As one participant expressed:

> Not every patient is going to think the same. Everyone has different upbringing, different views on sexuality, different views on intimacy and care. And where that changes you know. If one patient thinks that doing rectal swabs is too intimate for them or that a male would be doing this that they don't want to expose themselves in that way. I mean where does that come from? It's something that they've been brought up with or learned at some point that they're uncomfortable with that happening, for whatever reason. Where someone else, again, will have a different upbringing and think nothing of it. But to say why they think that, I don't know. You just have to deal with each case individually. And that's kind of what I like to do is try and deal on an individual basis. And in three years of nursing I've had actually very few patients that have refused care, very few, I think maybe two or three. (10, 238)

Another participant expressed that it does not have to be the patient's upbringing but rather the nurse's upbringing that can influence the provision of personal and intimate care with a patient. In the following excerpt the participant's comment was in response to the question of whether or not there should be a concern with male nurses providing personal and intimate care with female patients.

> There could be concerns depending on your background if you've abused people in the past or whatever. You just have to look out that way. Other wise I don't think there's a more of a concern for males than females. I was going to say, unless someone's brought up really conservatively as a male and brought up in a certain way that they would have a very hard time with females. But I realized I came from that background and it wasn't a problem to adjust. Having to do with a naked woman and taking care of her and that sort of thing. I guess someone who grew up in a conservative background, you know it kind of shocked me at first but

> it was no problem, I adjusted very quickly. So I don't really have any inhibitions about it. Unless the person is a very aggressive person who would really scare off some women that sort of thing you know. Then I'd have concerns I guess depending on their personality and their character. Really, that's the issue as far as I'm concerned. (7, 64)

Another participant expressed his answer this way.

> I really don't think it should be. It should place a bearing. I mean once you have a person in there doing the job and doing what's necessary to complete the job to a safe level, there shouldn't be an issue - I don't think. I guess that's my own upbringing. As long as a person's capable of performing the job safely and adequately then there shouldn't be a problem with race or gender. I mean, what what's the difference between me and you? There shouldn't be because you should be able to handle the job just as well as I can. (13, 81)

Another participant discussed how a religious upbringing could influence the nurse-patient interaction.

> I've worked with a couple of nurses whose religion is very staunch and so anything that's overtly sexual or suggestive or if the patient's a bit rough around the edges, they may be somewhat uncomfortable with the care. So sometimes a strict religious upbringing or a very moral background will make them a bit uncomfortable with situations they find themselves in. But I don't know a lot of male nurses that have encountered that sort of experience. (11, 312)

Interestingly, the stereotypical societal concept that males are the aggressors, particularly in relation to sexuality appears to be utilized by the male nurses' own colleagues. That is, female nurses have a tendency to ask their male colleagues to address issues that they themselves do not wish to address, as evidenced by the following excerpt:

> There's been a patient, actually this week, making sexual comments to the nurses. Just sort of general comments. And one of the nurses came to me and said that I should go talk to him about his behaviour. Which I didn't, because really, she had the problem with the patient. If she had the problem she should take it up with him instead of talking to me for me to go talk to him. Sexual comments were made to her or in her presence so I felt it better that she deal with it than myself. (2, 661)

Society influences how a person reacts to any given situation. When one considers the complexity of societal influences surrounding the provision personal and intimate care

by male nurses with female patients it is a wonder that further concerns or issues do not develop. The appropriate education of nurses, although influenced by societal norms and expectations, is important if one is to overcome the potential concerns or issues identified thus far in the analysis. Nursing education is the last segment to be addressed.

Factors Influencing Nursing Education as it Relates to the Provision of Personal and Intimate Care by Male Nurses

I Don't Remember Hearing About This!

Throughout this analysis many issues and factors have been identified that affected the participants in the provision of personal and intimate care with female patients. Many of these factors or issues arose while the participants were still in nursing school (and continued to play a role throughout the participants' career). It could be suggested that since these factors or issues arose in nursing school, the issues should also have been dealt with in nursing school. However, the majority of the participants could not remember being given information in their basic nursing education on how to approach the psychological and emotional issues of providing personal and intimate care with female patients (or for that matter male patients also). It should be noted however, that all of the participants believed they had been provided with sufficient information regarding the technical aspects of performing personal and intimate care, to be able to perform the care safely and appropriately. As one participant explained:

> I think the information that would have helped was provided for the most part. I can actually remember the lab setting where we went in to do baths, and the gals were wearing bikinis. The female nursing students, and, I'm sorry, bathing suits not necessarily bikinis. And the males were wearing shorts and I think somehow I got shafted there, I had a male giving me a bath. All those good looking young gals (laughs). But there were the principles that they taught us, pretty much the things that needed to be done. You know, consider the temperature of the water, keep the

> patient covered. Don't expose the patient. And I remember in clinic or I was already nursing, there was a fellow in one class, really nice guy, really trying. Well I was in my second year he was in his first year. Trying really hard to get through. And he left a blind patient, (laughing) with the side rails down, totally naked on the bed, a male. I think that's sort of breaking all the rules. (Laughs) He'd forgot a towel or something. Left, opened up the door came running out into the hallway. He was funny. But that's kind of an extreme case. So I think that the training was good and it built on the clinical experiences I'd already had. I think I was working with nurses that were pretty in tuned in how to provide that sort of care well. And I had good role models as an orderly. (5, 656)

However, the participants (including the previously quoted participant) also identified some shortcomings of their basic nursing education as it related to personal and intimate care. The participants believed that a minimal amount of time was spent on the psychological and emotional aspects of providing personal and intimate care. This psychological aspect was not just how the patients may have felt, but also how the participants themselves felt when learning how to provide personal and intimate care with patients. The following excerpts provide some idea as to what the participants felt was missing from their basic nursing education.

> I think maybe just more discussion around patient response in the psychosocial elements. I mean we had very good preparation for the actual physical care. You know, providing perineal care and so on was described in good detail. There were demonstrations and so forth. So I had confidence in the psychomotor skill. But I think discussion with a female teacher about the impact of a male nurse walking in and providing that care and how to address it, I think that would have been very useful. And I don't recall any of that kind of discussion. My attitude was probably in response to the attitude that was given to me as - I'm a nurse and that's your role and you do that. (1, 292)

> Well there wasn't, I don't recall much talk about the psychological impact. I think I can recall in nursing school the instructor made a comment associated with our learning the clinical part of bathing patients. And telling the females in the class that if a male became roused to leave the room. Or, to even avoid that, to wash with firm pressure and not light touch and those sorts of things. Which probably makes sense, knowing physiology, light touch you know is going to be arousing. So I can remember that being covered to the females but I can't remember a specific discussion to males. You know, 'What to do if you became roused.' I don't

remember if it was specifically addressed. It might have. But I may not recall it. (5, 687)

I think again the comment about perception is that you may feel you're going in and doing everything as per policy, and everything was just going totally perfectly fine but not actually knowing how the person was feeling about it. I think that there wasn't as much emphasis put in how the person actually saw what was being done. Or asking them, 'Are you okay? Do you understand what's going on? Do you have any comments?' Or, 'Is there any questions you want to ask?' It was more like, Let's follow, get the position, get the patient in this position, get this, get that, get this, get this, get this, wipe this, do that -- pull the covers up, leave. Then document and chart. But there wasn't a lot of focus on at the end of the day did the person feel that they were abused through this situation? Because nobody spoke to them through it or nobody explained what was going on, or asked them how they felt. And that's the only one major negative impact that I can think of, that well, wasn't from student days, was having a patient call back to say that she felt the care that she had received was questionable. Even though it was totally perfunctory and this bit about just because nobody had spoken with her during it, to explain what they were doing and she didn't, had no idea what was happening or why. But just felt that she had been mistreated. (8, 640)

I think that we just needed somebody. Everybody sort of struggled through it. Same way we struggle through going to a ward. Is that we just learn by observing other people. How they handle things. But there's nothing formal. And there has to be something formal provided for how you deal with intimate and personal care. We skirted it in the communications things. When they did the aggressive and the assertive and you know all those things. And I thought that they could have been doing a much better job in dealing with questions of intimacy. Because what happens is that we deal with the things that are easy to deal with. But we're not forced to look at the real meat. There's nothing there to prepare you for it. And then if you don't do well, then unless you have somebody to talk to, it would be the difference of whether, 'Do I continue? Is this the right thing for me to do or not?' It's got to be I don't know what you'd call it, but patient relationships. I don't know. That seems to me as something like that. (14, 670)

The same participant went on further to say that:

I think it just touches a very deep place within us. A very deep place. That's all I can say. Is that most in nursing is dealing with the technical portions of it and by far the more difficult things we're going to have to deal with are the psychological and emotional. So yes that's the area in which you are most vulnerable. Well there are a number of areas. I mean like there's also the male who rejects you too. That's the other side. (14, 718)

Although it was mentioned in detail previously, only one participant identified the

need to include a medical-legal perspective when learning how to provide personal and intimate care. When asked what information would have benefited him in his nursing education his response was:

> Probably some medical legal aspects. What to do if you are in this type of situation. Or somebody says you did something that is found to be inappropriate. I think probably some more formal classroom type of things or labs to say, 'Look here, this is how you wash the female patient. Or this is how you do whatever or some other aspect of that type of care.' I think probably yea, it seemed to be the one area that was maybe a bit lacking at the time. (2, 453)

Even in nursing school, the concept of implied sexuality played a factor in the provision of personal and intimate care with female patients. Because of this some of the participants commented how there was not enough focus on how to deal with the sexuality of providing personal and intimate care. As one participant stated: "As nurses we're taught to take a holistic approach towards the patient. The one area that seems to be lacking is the sexual area. Nobody feels comfortable to bring up that type of topic or talk about it" (2, 117). Later in the interview this same participant expanded on this apparent lack of information experienced by nursing students.

> I think it all sort of boils back to sexuality. That's the one aspect in nursing and even in medicine that is not well addressed. People seem to have a fear or aversion or are secretive about these types of matters and when it does come up I think people are a bit shocked and really don't know how to handle it. And each person, there's no sort of one set way of dealing with things. Which is a little bit different than how you're taught to deal with certain things. If somebody's blood pressure is low, well then you do this. And if somebody's depressed you need to do this. When this type of care comes up its sort of a little bit of a nebulous type of area. And I think educators should provide a little more education in that regard. (2, 479)

The participants were asked if including information on how to approach the provision of personal and intimate care would be beneficial in a nursing curriculum. The majority of the participants believed that it would be beneficial. The following excerpt

illustrates one participants' belief about how sexuality should be better addressed.

> Yes, I think it would be quite beneficial. I think that from my experience human sexuality was perhaps a three or four day block issue within nursing school. But it didn't really, I mean it was more to try to make you feel comfortable with sexuality as opposed to trying to figure out what the dynamics of female-male interaction. And especially in the context of health care, but also building from like you know a background of North American society and what the expectations are. (8, 743)

The previously quoted participant identified that there was not enough time spent on the issue of sexuality and the provision of personal and intimate care. However, other participants also identified the importance of including general information of this nature in a basic nursing curriculum.

> Yes I think it's so much a part of care, at least in a hospital setting, I'm sure in the community as well, that I think it would be helpful if there was an opportunity to discuss certain particular situations that might occur. Or even make people think about their own feelings about providing that care. You know just like I'm having an opportunity to think about it now where normally you don't. At least you don't analyze things. It's enough of part of nursing life that it justifies being analyzed you know, discussed, talked about. They talk about a lot of other issues that you may never come across. This is one that very much is a part of nursing. (5, 725)

> Oh definitely, I think. Just to give them a better sense, a better feel. I believe any knowledge is good for anything. The more you know about something the better its going to be. It provides you rationale. Opportunity to ask questions. Further anything that you might doubt sort of thing. (9, 507)

> Yea I think it would. I mean it would give you a little bit more ground work to deal with. But again, I'm a big believer in experience. So you're always going to need that. I mean, I was taught that way. And we went through nursing school, there was theory but then there was practicum too, and it was a lot hands on. And you learned as you went on through your two years. What to do, what worked, what didn't work. (13, 581)

The participant above introduced another aspect of what is required or appropriate in a nursing education program. The majority of the participants agreed with the premise that it would be beneficial to include information on how to provide personal and intimate care with female patients. However, some of the participants suggested that it would be

difficult to do so because there is "no set way" of providing the care. One participant suggested that there was nothing specific that could be taught, but rather it was the nurses themselves that determined how the situation would be handled.

> Nothing specific, I mean just to be realistic. You might feel uncomfortable with providing care. I mean you just have to be realistic about it. There's no set method on, 'Okay, how are you going to make these people comfortable?' I mean from nursing I've learned a lot of times, textbook material goes out the window when you're providing care. Because you provide care to, if you're in the profession long enough, thousands of different people. And I mean each and every one them is individual. There's no set way of providing care for everybody. You deal with it one patient at a time. Sure you can use strategies whatever they may be, but you use what works. But it's got to be professional. You use what you can. Whether it be comforting through talking to them. Whether it be sedating them. Whether it be giving them analgesia. You do what you can while maintaining professionalism and being ethical. I mean within the boundaries of a nurse. You do what you can to help them feel comfortable. But to use specific strategies, I think that a lot of it comes naturally. If you're just not a social person and not built to provide care you might not be able to make these people feel comfortable - just naturally. I mean you could teach somebody all the strategies that you learn in textbooks on how to make people feel comfortable. But if you're not a people person or for lack of better words teach until you're blue in the face but this person just might not be able to do it. (3, 836)

Other participants also agreed that although it would have been beneficial to include some additional information in their basic nursing education regarding "how" to provide personal and intimate care, that, it would be difficult to do so as there is "no one way of doing it". Some of the participants also believed that one just has to go through the experience of performing personal and intimate care often enough until there comes a point in time that the uncertainty or discomfort that is felt is no longer a concern. One of the participants expressed it this way:

> I think anyone that goes into nursing finds their own way of doing things. There is no set way of developing rapport with patients. There's no set way of dealing with intimate care. I think you find your own way and develop your own philosophy and your own approach. I think life experience has basically helped. But you can't always insert life experience into someone when they first start nursing. I think though that there is some merit in a nursing program per se to talk about intimate

> care. Not to just sort of shrug and say this is life and you know struggle your own way through it. I think there are ways of suggesting and explaining what you're doing. Explaining why you're there. And maybe there is in nursing programs. Maybe there was at the time. I just don't remember that being part and parcel of what you're taught. And that really, these are ways that you can find yourself getting through the experience a lot easier. So I think that there is some merit in giving people strategies and I think specifically male nurses. Male nurses should be taken aside by a male instructor and he should say, 'Okay guys here's this study that suggests that these are issues for male nurses. So as a group, because we're still a minority within the nursing community, these are issues that we have to be aware of. And here are some strategies that have worked for some male nurses.' I mean that might have been helpful. I think for the students, the male nurses that I graduated with, we all had to find our own way. There was no set experience. I think the program was set up that we weren't to be coddled or to be given special treatment. I think in that one area though it might have been helpful, now that I think about it. And I think, like I say, we all found our own way to get through it and to deal with it but something might have been helpful. Something to consider. (11, 575)

Another participant agreed with the premise that there is no set way of teaching how to approach the provision of personal and intimate care. However, this participant was not so certain that providing information in a basic nursing education curriculum would actually help. When the participant was asked whether it would be beneficial to include information on personal and intimate care in a nursing program this was his comment:

> I don't know. It would depend on how this thing is developed. Because feeling uncomfortable giving intimate or personal care, that's just something you have to deal with. Whether it be a male or female patient. I mean I felt uncomfortable for whatever reason providing intimate personal care to male patients. I would have to say that I felt equally comfortable or uncomfortable providing care to both sexes of patients. For specifically just female patients I don't know. I just think it's something that - like a lot of things, can't be taught out of a textbook. I mean you get a baseline of how to go about these things but eventually it's something that you deal with. And you develop your own system. You develop your own ways. It's not really something that's learnt out of a book. But again you got to be taught something just to get a baseline. But I think it's something that comes out of the person themselves and the nurse themselves. It's something you develop over the years. Which is something that can't be taught. So as far as putting it into a curriculum, I personally don't know how effective it would be. Would it make people better nurses or not, I don't know. Has it ever been done before, and made people better nurses? I can't really answer that. I mean, to say yes or no, I wouldn't be able to answer that. (3, 927)

So Should We Be Doing Something?

The participants identified that for the most part, their nursing educational programs prepared them for the technical component of providing personal and intimate care. There was however a concern expressed by the participants as to the lack of information provided regarding the psychological and emotional components associated with the provision of personal and intimate care, both from the patients' perspective as well as from the student's perspective. The implied sexuality surrounding the provision of personal and intimate care appears to be where some of the concern lies among the participants. It should be noted however that one participant suggested that too much emphasis is placed on sexuality and in so doing, that is what makes the provision of personal and intimate care more difficult for male nurses.

> Myself if I were included making a decision on that I really wouldn't make a big issue on it. My way of looking at it is I think there is far too big of an issue being made about it. I mean, there's too much stigma on this sexual thing like male-female. We're not male-female. We are registered nurses. We've been trained for that. Hopefully very well. We take our job and our responsibility seriously and that's it. I don't think it should be an issue. It's not something that I would say 'We better put together this six month course to teach these people'. Because you can't teach it. If you teach them to be a nurse, and if you teach them to have respect for their patients, that's it. Respect your patients. And if you learnt what's taught to you, I mean that's all you need. You're concentrating on being a nurse. Not being a male nurse or being a female nurse. You're a registered nurse. We're both called the same thing. Whether you're male or female, you're a registered nurse. (12, 624)

This same participant goes on to say that:

> If you make an issue out of it, then right away everybody's going to be on their guard like, 'Oh geez, I better watch it you know. Like this must be a big issue if they're putting in like out of a five year program to become a BN and they got to put six months aside to teach me how to be a male nurse'. Like then you've attached that stigma. So that you're always going to put the guys on the leery you know. And then your patients aren't going to get the care because they're always going to sit there and be leery about the female patients. They're going to be, 'Well geez, I don't know if I want to do that you know, because I might get in trouble. They might yell I sexually

fondled them or something'. (12, 649)

Even if the implied sexuality surrounding personal and intimate care was not a concern for any of the participants, there is still the question of "how" do you approach the provision of personal and intimate care while considering the psychological and emotional aspects related to it. Two additional excerpts help illustrate the concern that may be experienced by male nursing students when learning how to cope with providing personal and intimate care with female patients.

> I think there's probably an issue. I don't remember it being addressed in nursing school in a formal way. But it's something that all men in nursing have to figure out. How to get around. I think it's expected that women will give intimate care to men as nurses and it's just part of the job and men, it's kind of something that you have to approach. And there's not, well at least when I was in nursing there wasn't a lot of talk about how it was going to be done. It was just assumed that you were going to give intimate physical care at some point and you had to figure out how to do it. (8, 47)

> You have to come to terms with it. If you start trying to delegate or hand over or avoid all areas of intimate care, then I don't think you're going to be able to function effectively as a nurse. You need to recognize that it's normal to be uncomfortable. I mean I think you need to attach some normalcy to the feelings that you experience, especially when you're first getting into the area. And maybe even for myself now. If I'm doing intimate care, maybe there is a certain amount of discomfort I have with doing it still. Except that maybe I'm just incorporating it into, 'Well this is normally how I feel when I start this procedure. And so now it's normal and it's not going to paralyse me or prevent me from doing care'. I think that you need to explain to male nurses, students, that first of all it's normal to be uncomfortable. This is probably something that you don't do a lot of. You don't do on a daily basis. It will become more comfortable as long as you keep focussed on why you're there. As long as you're sensitive to what the patient's needs for intimacy are, as in, you know, please cover up portions of it that don't need to be uncovered. Please be gentle and take your time. Take as much time but as little time as you need. That you should be okay. That you'll get better at it. And then if you feel like there's any chance that the patient needs support have someone there. And try and get to know them as a person. And always engage the person throughout the procedure. And explain everything fully. Then you should be okay. There shouldn't be anything that's misconstrued in terms of what you're doing. So that'd be my advice. (11, 934)

Some of the participants suggested that it was not just a concern or issue with male nurses or male nursing students, but rather, it was a concern experienced by any nurse or nursing student regardless of gender. As one participant commented: "Even for women it's a big problem. I think there should be a few weeks spent on it" (8, 775). One of the participants who previously taught in a nursing diploma program commented that:

> Well, having been a teacher I addressed those issues with my male students. I addressed the issue with female students who were providing personal care. Let me put it another way. I addressed the issues associated with providing personal care to patients with my nursing students because once again, we can't make the assumption that female students have any less issue or difficulty with it. (1, 323)

Another participant suggested that providing information in a nursing curriculum regarding how to approach the provision of personal and intimate care would be helpful not only to male and female nursing students, but also to other health care disciplines.

> I think it would be beneficial for male or female students. I don't think it should be restricted to one way or the other. And you might through research find out that there's slightly different issues. And I don't know if the issues would be that much different from physician to nurse to unit assistant. Which to me is kind of a larger issue – 'How you approach a human being when providing personal care?' I think it would be a valuable component. (4, 721)

Although it was not unanimous, it appears that the majority of the participants agreed that there was some room for improvement in the information provided in the basic nursing education programs regarding how to approach the provision of personal and intimate care by male nurses with female patients. There was also a suggestion to include this kind of information for both genders as the belief was that the concerns and issues surrounding the provision of personal and intimate care was more of a human issue rather than a gender issue.

So What Do We Include – And How Do We Teach It?

The participants were asked what information (that is, what knowledge, skills or aspects relating to attitude) they would include in a basic nursing curriculum that would be beneficial for the provision of personal and intimate care. As previously mentioned many of the participants suggested the inclusion of psychological and emotional aspects relating to the provision of personal and intimate care would be beneficial. However, other than that, the participants did not have many suggestions as to what actual information to include. Only two of the participants actually had a suggestion as to what to include in the curriculum. One participant suggested including the all-encompassing strategies of professionalism, privacy protection and rapport building.

> Well you'd have to stress the professional aspect. You have to stress that you're there as a professional to do a set procedure. Get them to understand that it's the professional attitude that the person sees more than the gender. I'm pretty sure that's what it is myself. That's my opinion anyway. The more professional you are, the easier it will be for both of you. So I guess it's going to fall into professionalism as a basis. And like patient's privacy has to be protected and to bring on the feeling of security with you. The rapport, well, not everybody can do that type of thing. I've established a set, my own personal rapport type thing which I get on very quickly with but a lot of people may not be able to do that right away or even ever. Really that's about all. (15, 486)

The other participant suggested a psychology course that would help the male student understand that women may react differently than men to different situations.

> I'm not sure what kind of information the school of nursing could have given me to help me through that. It wasn't much in the way of male-female type of instruction type thing. How to deal with females type thing. I was older when I went through nursing, so I've had a bit more experience than the younger people did I guess. They could offer a psychological course I guess or a couple of classes for the men, 'You're dealing with females and they tend to react differently to this and that'. As a young man most of the time women confuse you completely, I know they do now. Even after thirty years I get confused at times. So I suppose there could be some kind of psychology course or even a couple of classes just to sort of help you get to the point where you have to deal with women in a different way than you do men. It's really

hard to say. Been so long since I was a student nurse. (15, 423)

The participants were also asked what methods of disseminating these strategies, skills or attitudinal aspects they would utilize if they were going to include this information into a nursing curriculum. The analysis identifies four groups of categories or strategies that the participants believed could be utilized to help in providing the necessary information regarding the provision of personal and intimate care. These categories are: 1) Providing the experiences, 2) Pairing off of students, 3) Inviting guest speakers, and, 4) Nursing instructors' role. Each category will be discussed separately.

Providing the Experiences

All nursing interventions require the opportunity to practice what have been taught to allow for the assimilation of the particular behaviour into the repertoire of the student. The provision of personal and intimate care is no exception. Because of the psychological and emotional components associated with the provision of personal and intimate care, both from the patient's and nurses' perspective, the need to have opportunities to "practice" this intervention is very important for the comfort of the patient and nurse. As one of the participants stated: "If I'm comfortable I do a much better job at nursing. If I'm very uncomfortable in dealing with these psychological issues it's a lot tougher for me to be myself and to give good care" (7, 468). This same participant discussed how he used to focus on a particular task such as catheterization and that by focussing on it without talking to the patient, it made the situation more uncomfortable for the patient. When asked what is different now he commented that experience has improved his competency and communication skills:

Ok, you gain experience so that the task itself becomes easy to you. And so you

> don't have to think about what you are doing. Or you do but you just know how to do it. It's just like that (snaps fingers) and it comes. The other part is I gained confidence in talking to people. I used to not be good at talking to patients. It terrified me. I didn't have. Whenever I was at a party whatever, I found it difficult communicating with people. But that's something that I've learnt over time is to you meet someone and I can just start a conversation with them and go on. And that's something I definitely learned through nursing. Through experience. (7, 643)

Another participant also commented on the need for students to have the opportunity to perform the technical components of the skills they are being taught. This will allow them to overcome the "newness" of the situation and to develop their own coping mechanisms. It is important to note however, that the participant identified that the performance of personal and intimate care is much more complex than the performance of other skills or interventions that also have to be performed.

> For me I found a lot of that to be an issue of just doing things regularly. It's kind of like the first time you do an IM your hand shakes. And you do it 20 times and it's like, 'Okay it's nothing new.' You've gotten past it. You know it will hurt the person but you can't dwell on it. You have to do it. And it's very similar it's kind of not as concrete a situation as a simple IM. The situation's more complex I think than that. But at the same time I think the basic principle is there. It's a matter of repetitive doing it. Finding out your own strengths and weaknesses for coping towards things. I mean everybody deals with things differently. (4, 676)

Other participants also identified the importance of having the opportunity to gain experience with the skill of providing personal and intimate care. When one of the participants was asked what would have helped him in his basic nursing education his response once again identified the need for opportunities to "practice" the necessary skills in a nursing program.

> I guess experience. But you don't get the experience until you actually get in there doing it. So yea it would have been great to have some more experience behind me, but you don't, that doesn't happen. There's always a first time. And you build from there. (13, 558)

Another participant identified that he was well prepared for the technical aspect of

providing personal and intimate care. When asked what was discussed to make him feel that the necessary information was well taught his response was:

> Basically the way you washed a person. I mean rather than grabbing just some old wet sloppy cloth and walking in there and scrubbing away like you're washing a dirty car or something. I mean there is a proper technique the way to wash a person and it looks professional and gets the job done and it's done with dignity. Not just scrub scrub scrub and away you go. That's a hard one to answer though. I don't think there is anything that can be taught. A lot I found with nursing is, you can be told a lot of stuff. You can read a thousand books, but there's nothing like just getting in there and doing it. And there's no way you can prepare a person for that. You have to go. You have to do it. Working on that first female or that first male patient, it's a fear that you have to overcome. You get in there. You do your job you've been trained for and gradually everything works out, it becomes easier. (12, 541)

The above comment once again reinforces the idea that basic nursing education provides the student with the appropriate technical skills to perform personal and intimate care, but there is more than just the physical "hands on" aspect of personal and intimate care. The participant believed that some parts of the procedure cannot be just "taught" but rather experience is what ultimately makes the procedure easier.

Another participant also identified how experience makes the performance of personal and intimate care easier. When the participant was asked what he would tell a male nursing student if the student approached him asking how to deal with providing personal and intimate care with a female patient his response was as follows.

> And I think that's an important thing, and that's something that you don't just get overnight. That's something that that comes with experience. You know that's something you have to build on. And yes the first time you do things generally, you're nervous. I mean, because it's something new. I think we, as humans, like to be in comfort zones. We like to have repetition or things that are the same. But once you've done things a couple times, and especially in nursing, you do things over and over and over and over again. It doesn't take long to master skills and to do certain things. At least I found it that way. And I think that would be an important thing to get. Tell this person, 'Look you probably will be nervous doing this the first time, but try to relax and try to build a rapport with this person'. And explaining things and giving them options you know. Saying, "Look, you can tell this person, 'Look,

> I'm a little bit nervous about this.'" And I hope that they can say that they're nervous, that's okay. Tell them the truth. The truth is always the best thing to do. (10, 807)

Pairing of Students

Some of the participants felt that during the basic nursing education program, the pairing of students into male and female partners would be beneficial in the development of the student's ability to perform personal and intimate care with a member of the opposite gender. It would obviously be important to ensure that the students paired with each other had a comfortable relationship prior to the initiation of this strategy. However, it was believed that partnering students of the opposite gender would provide an opportunity for the development of empathy as well as learning how to "deal with" the differences. One of the participants suggested that if one is able to perform certain procedures on somebody that they knew, then it would be easier to do the same procedures on patients. The idea was that if you are professional with someone that you know, then it is that much more likely that you will be professional with a patient.

> If you're able to do it to a classmate of the opposite gender, and be able to go in there and be professional about it, I think that's one of the ways to start showing people what it's like to provide personal care. Because in some ways you can almost sympathize with the person a little bit better because you know them. And they're people that you know in class. And if you can be professional with them, you might be able to transfer that over. That was something that I remember. Quite specifically now that I think back. And that's the one thing that stuck out in my mind. (4, 741)

Another participant identified the reality of not being able to pair students into male and female partners. He did however express that if it were possible that would be the ideal. However, because that possibility does not exist at present, he then provided some alternatives to be considered.

> I know it's kind of difficult but if you had a fifty-fifty ratio in your class. I mean

> pairing them up male-female would be ideal. I know we did bed baths on each other in nursing school. That's one place you have to start. But the reality is you're not going to get a fifty-fifty class. It's always a minority for the male so I guess maybe an open forum of talking in class. Like having discussion between them - the two groups, sort of splitting them up and having a little role playing going on about what would guys say and what the women would say and back and forth. That might help. They give you just a little bit of an idea of what to expect when you're going in. What kind of questions they might be saying. I know, especially with students, it's hard to come out with some of graphic questions. And whether they want to say it out loud in front of a class or not. But some of them are going to be asked. (13, 596)

One participant suggested that it might be beneficial to segregate the participants and have an opportunity for questions and concerns to be aired in a setting where the students may feel more comfortable being separate. The participant however, goes on to say that it may also be beneficial to have both groups together to hear the concerns expressed by each group. The participant ultimately suggests that trying both methods may be the most appropriate alternative.

> It might be beneficial to actually segregate out the male-nurse portion of the program to talk about that. Not in a way that makes the needs different. But I think for men and women, the approach, there may be different issues. I'm not sure actually if the issues would be different or not. I think that if the men were all together in one room I think you would get a more a more candid forthright, 'Yea I'm uncomfortable with this'. I think that you would have a group of men that might be able to identify with the discomfort of each other's feelings. I think if you tried to do it in a setting where both sexes are being taught or having discussions about it, it might be uncomfortable. I think you'd have to trial both ways. If you had men and women in the room talking about it I think that it'd be beneficial for female nurses to understand that yes, there are some areas where their co-workers may feel like they're being compromised. If they're sensitive to it then maybe they can help you in that respect. Or at least be supportive if you find you're having to deal with intimate care. I think you have to trial it both ways. Or, have a combination of both. Certainly the experience that men have and the approach to women may be of a significantly different nature that you may want to separate the men out for that portion and then, and then maybe come together at the end of the session and talk about what the issues are. Maybe just talk among yourselves and then list them out so both parties know exactly that they're uncomfortable or that this can be an issue. I think it's, I think it's probably beneficial to combine the two. (11, 970)

Guest Speakers

Some of the participants suggested that inviting guest speakers may be the best method of educating student nurses regarding the psychological or emotional aspects surrounding the provision of personal and intimate care. As one of the participants explained:

> I mean it's something that I think can be included in a lecture. But I think the personal approach of having somebody come in and talk about their experience is always more beneficial than just somebody mentioning it in a lecture. (10, 902)

The participants believed that inviting experienced nurses to discuss how they "deal" with situations that they run into would be helpful. As one of the participants explained:

> I think having experienced nurses coming in and talking to the class to me was always the most fascinating. Those are the things I remember the most. When you hear personal stories. Those are the things you remember because you can relate to them. I always, and everybody in the class really enjoyed when we had guests coming in and talking about personal stories that they had. Whether it was somebody working up north or whatever. I really enjoyed listening. You seem much more attentive when it's a personal issue and somebody can relate that to you in a good way. (10, 891)

The participants also believed that inviting patients who have experienced care by a nurse of the opposite gender might also help enlighten the students as to how the patients feel when the procedure of personal and intimate care is being performed. One participant identified a number of guest speakers that he thought would be beneficial in helping students understand the psychological and emotional aspects surrounding the provision of personal and intimate care.

> I think I would get a number of resources. I would try and get a female patient's point of view who's willing to talk about her experience. I think the experience touches the emotion between people. I think that would be helpful. I think bringing in an experienced male nurse who's done those things would be another way of

> doing it. I think somebody who deals with sexuality so that people could feel more at ease with the sexuality that's involved with it. I mean because a lot of it is the whole shame thing. I mean either you have shame or else you exploit it. I mean like it's you're ashamed of it or you run with it. Those are three I could think of right away. I think that it's bringing in resource people from different points of view. (14, 729)

Nursing Instructor's Role

The participants also identified the importance of having role models throughout their education. One of the participants identified how he watched one of his friends perform personal and intimate care with a female patient, and how that was important for him as a student to be able to witness the interaction.

> I had a good friend of mine that I was working with in my class at that time and working with him got through it. It was you know got in there and I watched him and after that it was no problem. (12, 349)

Although the above participant identified his friend as a role model who helped him understand how to provide personal and intimate care, it was most often the student's nursing instructor that provided the necessary role modeling. The nursing instructor was considered pivotal for the student to learn "how" to perform personal and intimate care with a patient. When asked how the participants coped with the situation the first time they had to perform personal and intimate care with a female patient one of the participants said: "I think just through discussion with the instructor" (8, 306). Another participant remembered how the instructor had to come and help him the first time he performed personal and intimate care.

> Half way through the instructor came in and I think she finished up because (laughing) it took me so long. And that was really bad. I really got nervous after that wondering if I could do it or not. (7, 485)

The above quote identifies a concern that some male nursing students have when

performing personal and intimate care for the first time with a female patient. The participants believed that it is important for the nursing instructor to be available to the student to provide support and understanding that this may not be the easiest skill for the student to be performing. One of the participants expressed how he remembered the instructor being there and guiding him through the procedure and incorporating the whole concept of nursing into the procedure.

> I think it was awkwardness. Not knowing exactly what or how you should be doing it if you've never given personal hygiene to an elderly female. I remember having instructors there helping who were and I think that was the biggest thing is the people who are experienced and had given care to many people and could guide you through that kind of situation. And then talk to you after about how do you go about uncovering people's bodies and wash them, do that kind of thing plus. So it was that whole technique of how do you do assessments at the same time you're giving physical care without getting so totally caught up with, 'My God I'm washing somebody's bare bum!' So that it became part of your work life rather than part of a big experience kind of blanked out the rest of what was going on. So I remember trying to model yourself after teachers. Instructors who knew how to give physical care as part of total care. Rather than this was just going to be a wash and a bath and then we're going to move on to our list of questions or assessment later. (8, 278)

One participant identified the importance of having a male nursing instructor as a role model. He identified how important it is for the student to be able to identify with the instructor while emphasizing the importance of rapport building with the patients.

> I remember one professor talked to us just about his own experience in nursing. It was very helpful to me as a male talking to the whole class but I felt like you can have that bonding because he's a male, you're a male. You can kind of relate to his experiences and how he relayed it about his personal experience with palliative care patients. And you know, to me that was very important to hear how the rapport building and to get to know this person and you have a bond that develops between you. You know it's not necessarily gender based anymore it's just on a human level, where you're able to care for this person. It changes. When that rapport is built. It really does. I think that's very important. When the caring is there I think a lot of those gender issues can disappear. As a student that was very important, that you have a male talk to males about these types of issues. And again rapport building and things like that because you have to learn how to do those things. It's not always, 'Everybody's different'. Not everybody is as caring as the next person. Or they have

> different approaches. But these are things that can be learned over time. And having that as a student was very beneficial. (10, 755)

The quote above identifies perhaps the most important component of all of the possible ideas that one would incorporate into a nursing education program, and that is the importance of learning how to care. As the participant stated, it is the development of the rapport and caring for the patient that causes any concern with gender to become a non-issue.

This chapter analyzed the data resulting from interviews with fifteen participants. The analysis identified four factors that impact on the provision of personal and intimate care by a male nurse with a female patient. The analysis identified: 1) factors influencing the comfort of female patients when receiving personal and intimate care with male nurses; 2) factors influencing the provision of personal and intimate care with male nurses; 3) factors dealing with societal considerations and expectations relating to the provision of personal and intimate care; and finally, 4) factors influencing nursing education as it relates to the provision of personal and intimate care by male nurses.

CHAPTER V

DISCUSSION OF FINDINGS

Introduction

In this chapter I discuss the findings of this study. The chapter includes a brief synopsis of the first four chapters followed by a discussion of how well King's theory "fit" as the conceptual framework for this thesis. I will answer the research questions posed at the beginning of this study and include other important findings of significance. I will also provide a section on reflection and reflexivity discussing how this study and the process necessary to complete the study have affected me as a beginning researcher and as a person. And finally, future implications for nursing research, education and practice are identified.

Statement of the Problem

Nursing is one of the few professions in the world where the crossing of societal barriers and social boundaries are expected, accepted and condoned as a necessity to ensure the health and wellbeing of the people under the nurse's care. As discussed by Lawler (1993), this acceptance includes the breaking of taboos and crossing boundaries and barriers in providing care that persons would normally carry out themselves. The idea of nurses having to cross societal boundaries of what is deemed socially acceptable degrees of exposing the body and touch is also discussed by Gallop (1993); Pennington, Gafner, Schilit, & Bechtel (1993); Peternelj-Taylor (1998); Smith, Taylor, Keys, & Gornto (1997) and Seed (1995). Few professions necessitate the performance of procedures and duties that would normally be considered an invasion of the personal privacy, boundary or space of an individual. Personal privacy can have psychological, emotional, spiritual, cultural or

intimately physical components (Barron, 1990; Carlson, 1991; Estabrooks & Morse, 1992; Glen & Jownally, 1995; King, 1981; Scott, 1993; Seed, 1995).

In addition to the normal societal taboos of crossing societal boundaries and barriers as they relate to the body, there are also legal considerations when one discusses the provision of personal and intimate care by members of the opposite gender. Documented cases of male nurses being refused the option of working in some areas strictly because of their gender have been identified (Burtt, 1998; Coombes, 1998; Hawke, 1998; Trandel-Korenchuk and Trandel-Korenchuk, 1981). It is therefore important for the male nurse to be able to use appropriate strategies and interventions to ensure that the patients under their care do not experience emotional or psychological discomfort as a result of the provision of personal and intimate care. By ensuring the patients under their care are comfortable with the care being provided the male nurse can minimize potential emotional, psychological or physical discomfort. In addition by ensuring the patient's comfort with the care being provided the male nurse can minimize the possibility of being accused of impropriety during the provision of personal and intimate care.

Nurses have predominantly been women since the time of Florence Nightingale. Because of this, North American society (in particular) has come to accept and expect that a nurse is female. This idea has been identified by a number of authors positing the same premise (Dowler, Jordan-Simpson and Adams, 1992; Hesselbart, 1977; Struthers, 1995; Villeneuve, 1994). Along with this expectation comes the understanding that nurses (women) perform certain procedures and interventions considered personal and intimate. Canadian society as a whole understands and accepts this necessity, and, although the probability exists that not all patients are comfortable having a female take care of their

personal and intimate needs, this was something that became normalized.

However, men also become nurses. Interestingly enough, men were nursing and caring for people long before Florence Nightingale became the "symbol" of nursing. Unfortunately, around the same time that Florence Nightingale began "legitimizing" nursing as a profession, men's participation in nursing began to decrease (Lodge, Mallett, Blake, Fryatt, 1997; Poliafico, 1998; Simpkin, 1998). This decreased representation ultimately resulted in society becoming less accustomed to the idea that men can be nurses, resulting in a sex-role stereotyping particularly in North American culture. Men who become nurses are not always as readily accepted as a caregiver capable of providing the care necessary to ensure the patient's health and wellbeing (Seed, 1995). This is particularly true when the care is to be provided to a female patient and the care is of a personal and intimate nature.

As stated earlier, there have been documented court cases of male nurses being refused the opportunity to work in certain areas of a hospital (for example in labor and delivery) strictly because the nurse was a male. Employers in these court cases indicated that because of the personal and intimate nature of the care provided, it was unlikely that female patients would feel comfortable with the care being provided by a male nurse. The employers indicated that they were also concerned for the employee because of the potential for false accusations being laid regarding inappropriate behavior by the male nurses (Burtt, 1998; Coombes, 1998; Hawke, 1998; Trandel-Korenchuk and Trandel-Korenchuk, 1981).

Nurses are required to touch patients in ways that are unacceptable in any other context. The simple fact that a male nurse is a man is not reason enough to assume that

the male nurse will in some way act unprofessionally when providing the necessary care to any patient. It appears that the underlying concern regarding the provision of personal and intimate care with female patients is the implied notion that male nurses are unable to separate the patient's need for care and the implied sexuality of the personal and intimate care situation. It would be inappropriate to come to this conclusion without scientific research and evidence to justify this stance.

One of the most important aspects of nursing is the ability of the nurse to ensure the patients under their care are comfortable – physically, emotionally and psychologically. In this study, patient comfort was the most commonly identified goal of all participants, which is congruent with the literature identifying comfort as a tenet of nursing practice (Cameron, 1993; Hamilton, 1989; Kolcaba and Kolcaba, 1991; Morse, 1983). However, a female patient may not feel comfortable with a male nurse providing her with personal and intimate care. This led me to the purpose of this study.

Purpose of the Study

The purpose of the study was to identify what strategies, behaviors or interventions are used by male nurses when providing personal and intimate care with female patients to ensure their patients do not feel emotionally and psychologically uncomfortable. Other research questions to be answered were:

1. From the male nurse's perspective, is there an actual or potential perceived concern by patients or society with the concept of male nurses providing personal and intimate care with female patients?
2. Are there circumstances or situations in which the performance of personal and intimate care by a male nurse with a female patient is acceptable, and, at

other times not acceptable for the patient?

3. When a male nurse provides personal and intimate care with a female patient, what verbal and non-verbal behaviors indicate to the nurse that the patient is experiencing psychological or emotional discomfort with the situation?

The above research questions, as well as additional findings of the study will be discussed later in this chapter.

Research Design

Because of the nature of the information sought a qualitative approach to the study was appropriate. I decided that the most appropriate type of qualitative approach would be to use the technique of person-centered interviewing based on the method described by Levy and Hollan (1998). I also incorporated aspects of descriptive micro-ethnography as the method of inquiry. This would enable me to attain an insider's perspective, or the emic, on the reality of the participant's understandings of their situations without having to actually observe the participants while they performed the procedures considered personal and intimate (Fetterman, 1989; Polit & Hungler, 1995).

The study incorporated a convenience non-probability sample consisting of 15 male registered nurses working in a tertiary care and secondary care hospital. The participants were registered with the Manitoba Association of Registered Nurses. Because the participants were all registered nurses they not only had the legal authority to perform all aspects of nursing care, but also, their employers used the participants to the fullest of their educational and legal capabilities.

The University of Manitoba Faculty of Nursing Ethics Review Committee provided ethical approval for this study. Approval was also attained through the Access Committee at

the Health Sciences Centre (Appendix G). All ethical standards including confidentiality, the right to refuse or withdraw from the study, the signing of a written consent form (Appendix H), and all other ethical considerations were incorporated into the study.

Discussion of the Findings

All of the data were based on the participant's perception of the situations and how they remembered them. From a moral-ethical perspective it would have been inappropriate to have a male researcher observing a nursing intervention of a personal and intimate nature with a female patient, while trying to ascertain the effectiveness of the interventions utilized by the male nurse to make the patient feel comfortable during this time. Thus data were based on the participants' memory as to how the events unfolded and their "reading" of the female patients' responses.

During the course of this study I became increasingly aware of the complexities involved during the provision of personal and intimate care by male nurses with female patients. The focus of the study was to discover what male nurses did to help alleviate any emotional or psychological discomfort their female patients might have experienced when these nurses provided personal and intimate care to them. Factors that influence the nurse-patient relationship, as well as factors that male nurses take into consideration when providing personal and intimate care with female patients, are pertinent to the overall comfort of not only the patient, but the male nurse as well. Participants identified the patient's comfort as being the most important aspect when providing direct care.

Conceptual Framework

King (1981) proposed a conceptual framework for nursing focussing on the

dynamics of the nurse-patient interaction (Appendix A). This framework for nursing supposed that nursing focuses on the care of human beings interacting with the environment. King (1981) identifies interrelated personal, interpersonal and social systems each containing concepts that ultimately affects the nurse-patient relationship. King (1981) believes that the participants in the relationship establish goals, and that the interactions between the participants enable the goals to be met (Appendix I). How well these interactions play out determines the attainment of the goals.

In this research study, the overall goals of the patients and participants were the same as in any nurse-patient relationship, that is, the attainment of the patient's best level of health possible. However, there was also an underlying and generally unstated goal between the participants and the patients. This goal included personal and intimate care, completed with the least amount of emotional and psychological discomfort experienced by the patient (and the nurse for that matter).

The Personal System

The personal system as identified by King (1981) includes the concepts of perception, the concept of self, growth and development, body image, the concept of space, and time. Throughout the study all of these concepts were readily tied into the findings. The patients' perception and nurses' perception of situations were identified as important aspects in how comfortable they (patients and nurses) felt with the care provided. The concept of self as described by King (1981) is based on the beliefs and values of individuals. King (1981) states that "when inconsistencies in beliefs tend to appear, the self tries to avoid them or clarify them. Each new experience tends to influence change in self" (p. 27). Participants identified how the beliefs and values of the

patients (and the nurses) played a role in the overall interactions between the nurse and patient. For example, one participant grew up in a religious and conservative household. Because of his upbringing he initially found it difficult to provide personal and intimate care with female patients. Growth and development played a factor in the provision of care by the participants. All of the participants identified that caring for a younger female was much more difficult than an older female. Normal stages of growth and development identify that adolescent and teenage girls are more conscious of their changing bodies and are much more likely to be uncomfortable having personal and intimate care performed for them by anyone, but especially if the nurse was a male.

The concept of body image played an important factor in how the patient felt about having care provided to them by a male nurse. When the patients did not feel good about themselves or in some way felt self-conscious about their bodies or their situation, male nurses had to approach the situation with more care and concern as to how to accomplish the necessary personal and intimate care. One participant described how obese patients often apologize for their obesity and appeared more embarrassed when having personal and intimate care provided. King (1981) also identified that it was in this category that sociocultural factors also played a role in how the patient would react or respond to having a male nurse provide them with personal and intimate care.

King identified that a person's personal space or boundary is subjective and therefore depends on the patient's perception whether or not that personal space is being violated. She also identified that personal space is dependant on the persons' culture and that personal space is a learned behavior (King, 1981). Participants identified the need to infringe or intrude on the personal space of the clients. It was by knowing how to

accomplish this aspect without making the patient feel uncomfortable that enabled the participants to complete the necessary personal and intimate care.

Time was the final category in the personal system. King (1981) described time as relational and that the sense of time depends on the person's perception and uniqueness. Participants identified the need to be efficient and competent so that they would not have to spend inordinate time performing interventions or procedures of a personal and intimate nature with their female patients. The participants believed that taking the least amount of time necessary would help minimize the possible emotional or psychological discomfort being experienced by their female patients.

The Interpersonal System

The interpersonal system was the next system identified by King in the theory of goal attainment. This system included the categories of interaction, communication, transactions, role and stress. The participants in the study stressed the importance of interacting and communicating with their patients. All of the participants identified communication, as the most important aspect in the repertoire of interventions they used to complete the necessary care required by their patients. It was here, however, that I have the most difficulty with King's theory and the concepts within the theory. A limitation or perhaps weakness that I found in the theory was the differentiation and clarity among the concepts of interaction, communication and transactions. I believe that although King explains the differences among these concepts, it is more difficult to separate and differentiate them in the application of the theory in a research situation. When one communicates with anyone, he or she is having an interaction, and, when one interacts with someone to come to an agreement on a certain goal, then the interaction becomes a

transaction. Because of this, I believe it is difficult to separate these concepts from one another in a research or for that matter, everyday situation. I submit that the three categories are all part of the communication process. They may be different forms or methods of communicating or alternately, different components that are used as required, depending on the goal of the communication occurring between the participants of the interaction.

King (1981) also identifies the concept of role as being important in the interpersonal system. This concept also played a factor in the interactions of the male participants and their female patients. The fact that the participants were able to identify themselves as the nurse or as the caregiver, and the fact that the patients were placed in the patient's role, provided the participants with the authority, responsibility, and justification to perform interventions of a personal and intimate nature. It also provided the patients with a justification as to why it was acceptable for this male (nurse) to be performing some personal and intimate procedure or intervention with them. Taking on a role enabled the patients to accept what was being done, when in any other situation or context they would not normally have let this person have access to those particular areas of their body unless they were intimately involved with that person.

King (1981) also identifies stress as a major concept in the interpersonal system. King (1981) discussed how stress could have an impact on the nurse-patient relationship and ultimately on the overall goals of the interaction. Stress can be manifested in many ways and one of them is by the real or substantial discomfort that may be felt by a female patient when a male nurse provided her with personal and intimate care. The participants identified that they always assessed for discomfort (stress) when performing personal and

intimate care with all patients, but particularly female patients. In addition, the male nurses also assessed their own stress level when having to perform personal and intimate care with a female patient. By knowing how comfortable they were with the situation the male nurse could then utilize the appropriate strategy and therefore provide the most appropriate intervention. If they were concerned about the need to provide care with the female patient because of concerns about having their interventions misinterpreted as something other than appropriate, it was then that the male nurse may ask for a colleague to chaperone, to change assignments with a female colleague or to approach the situation differently, perhaps more professionally or more matter-of-factly.

The Social System

The final system identified by King (1981) as being a major concept in the theory of goal attainment is the social system. This system contains such concepts as organization, authority, power, status, and decision making. However, social systems also include family, cultural and socioeconomic groups, religious systems, educational systems, work systems and peer groups (King, 1981). Once again a limitation of King's theory is trying to separate these concepts from one another. Alternately, it is almost a form of "pigeon holing" someone by trying to categorize them into a group with the belief that because they are from that group they are going to act, react, behave or identify with the group's beliefs, values, customs and thinking. Culture and the other concepts, shape the interactions and relationships between nurses and patients. However, it is the synergy between the nurse's culture and the patient's culture; the nurse's gender and the patient's gender that help determine how the relationships will progress. People are complex, and the male nurse must factor in all of these concepts when he assesses his patient.

Ultimately, it is the male nurse's assessment of the patient in the "here and now" rather than the social system he or she belongs to that determines the type of intervention he will use to make his patient feel comfortable during the provision of personal and intimate care.

King discusses how organizations provide authority, power, and status to enabling an individual to accomplish something he or she is required to complete. As a nurse, the professional organization stipulates and sets standards as to what behaviors and interventions a nurse is legally able to perform. The organization where the nurse works also stipulates the behaviors and interventions a nurse is allowed to perform. The patient's and nurse's peer groups, work groups, family, culture and religious system provide beliefs and values that may determine, by the perception of the nurse and patient, how the person may act in any given situation. That is, how they are going to perform their role. All of these concepts are part of a person's role, which is a concept in the interpersonal system. Although the role a person takes on is determined by the situation, the role can only be acknowledged if the person in that role meets the criteria or characteristics required of the role. These requirements or criteria may be provided by organizations, the education of the person, or come from the individual him or her-self. Because of this overlap of concepts and their characteristics I again found it difficult to separate and crisply distinguish the difference among them.

I would use King again because her conceptual framework of nurse-patient interactions helped me in separating out and identifying where in the three systems, that is, the personal, interpersonal and social systems, the data fit. Some of the data seemed to fit in all three categories, once again strengthening the notion of the complexity of caring

for patients of the opposite gender.

I would use King's theory of goal attainment again because it incorporates all aspects of the nurse-patient relationship. King (1981) looks at the biological, psychological, social, cultural, spiritual and developmental aspects of the individuals involved in the nurse-patient relationship or interaction. The comprehensiveness of King's theory is it's strength, but at the same time the theory's comprehensiveness is also one of it's downfalls. That is, the theory's comprehensiveness at times makes it unwieldy when trying to "fit" aspects into the various components of the theory. The male nurse however, has to consider all of these aspects when caring for an individual. A male nurse has to take these aspects and others into consideration when performing personal and intimate care with a female patient.

Problem Statement, Research Questions and Other Important Findings

In this section I address the problem statement, answer the research questions and provide other pertinent findings of the study. As previously stated in the literature review, there is a paucity of literature specifically related to the focus of this study. There is no readily comparable literature that can be compared and contrasted to the findings of this study. Rather, there are a few well structured studies based on similar or related concepts to this study, as well as declarative articles, publications based on questionnaires and surveys, and studies where the validity of the findings are questionable at best. Whenever there is relevant literature I compare the findings of this study to other studies.

The problem statement for this thesis was: What are the strategies, behaviors and interventions used by male nurses in the provision of personal and intimate care with a female patient that enables the patient to feel psychologically and emotionally

comfortable?

The findings of the study indicated that the participants utilized a number of different strategies, behaviors and interventions when providing personal and intimate care with female patients. The strategy utilized depended on factors specific to the participant as well as specific to the patient. These were classified into four main sections: communication, cognitive, emotive and behavioral. A fifth section, workplace setting or situational factors, was identified as an aspect that had to be taken into account in the overall provision of personal and intimate care by a male nurse with a female patient.

The strategies also had a focus on either the participant or the patient. That is, the study demonstrated that it was not only important for the patient to feel emotionally or psychologically comfortable while receiving personal and intimate care, but it was also important for the nurse to feel emotionally and psychologically comfortable while performing the personal and intimate care. Specific strategies used by the participants were not enacted to alleviate discomfort on the part of the patient, but rather to alleviate their (nurses') discomfort. Table 2 below provides a schematic overview of the categories and accompanying strategies as identified by the participants.

Table 2 Overview of Categories and Accompanying Strategies

Category	Strategy
Communication	• Rapport building and explanation giving • Seeking permission • Use of humor
Cognitive	• Detachment • Distraction
Emotional	• Respect • Empathy and caring
Behavioral	• Providing privacy • Trading patient assignments • Providing a female alternative • Having a chaperone present

Communication Strategies

The findings indicated that the most important strategy used by participants was communication. Communication included rapport building and explanation giving, seeking permission and the use of humor. Participants noted the need to build a rapport with their patients before performing personal and intimate care. They stressed the need to have their patients' feel comfortable with them as their nurse before delving into personal and intimate care. Tagg's (1981) study of male nurses working on an obstetrical unit observed that patients believed they would not be embarrassed if a male nurse helped with breast feeding as long as they were given time to establish a relationship. Although not focusing on male nurses, Lawler's (1993) research supports the importance of communication in that the nurse must communicate effectively before invading the patient's privacy.

As in all aspects of nursing, the importance of communication with the patient is extremely important (Potter & Perry, 1997). Communication provides a means for the

nurse-patient relationship to develop. Communication also enables the nurse and the patient to develop and agree upon the goals to be attained in the particular interaction (King, 1981). The participants noted that it was of utmost importance to provide an explanation for all interventions with their patients. From the participant's perspective, providing explanations and reasons minimized emotional or psychological discomfort experienced by patients. Explanations enabled patients to become part of the care process and provided them with information to make informed decisions and therefore an informed consent to the particular procedure. The participants believed that this strategy helped foster the nurse-patient relationship by identifying to the patient that she was part of the team making decisions about her care. The need to provide explanations is also voiced in Potter & Perry (1997).

Another communication strategy used by the participants was to seek permission from patients before performing interventions, whether personal and intimate or otherwise. The participants believed that by seeking permission from the patient they were able to accomplish two goals. The first goal was the completion of the necessary care; the second goal was to develop the nurse-patient relationship.

The last communication strategy used by male nurses when providing personal and intimate care with female patients was humor. The use of humor, when involved in providing personal and intimate care, was also identified by Seed (1995) as a strategy used by neophyte and more mature student nurses. Participants used humor to "take the edge off" a situation. Humor was used as a means to make the patient more comfortable. It also provided a means to step over certain societal boundaries. Participants also used humor to help them feel more comfortable with the care situations. Humor assisted

participants to perform personal and intimate procedures with their female patients by making the situation less serious and more acceptable. It is somewhat more difficult to be emotionally or psychologically uncomfortable when one is laughing and finding a situation humorous. Humor can be a powerful tool in the repertoire of the nurse in dissipating fears, uncertainties or uncomfortable situations experienced by their patients or themselves (Potter & Perry, 1997). It is important to note that humor must be used with caution. If humor is used at the wrong time, or in the wrong context, or more importantly, if it is perceived inappropriate in the mind of the patient, then humor can have a negative consequence. It appears that the participants have, through experience, developed an understanding of when humor can be used effectively and when it is better to use some other strategy.

Cognitive Strategies

One cognitive strategy used by participants was detachment. Participants voiced the need to occasionally detach, "block out" or "depersonalize" a situation to ensure they remained comfortable with the provision of personal and intimate care. This strategy also provided comfort to female patients. This strategy was also useful in situations that were emotionally or psychologically difficult. This strategy was more frequently used when the participant identified with the patient or in some way felt that it was important to separate the reality of what he was doing from the person (patient) with whom he was performing the intervention. The need to detach made the nurse more comfortable, although by doing so there was a secondary effect of also making the patient more comfortable. The participant identified something within himself that required him to distance himself from the situation by whatever means possible while still administering

the care required. This strategy was used when the participant did not want his personal feelings to interfere with the situation. The female participants in Lawler's study (1993), had difficulty providing personal and intimate care with male patients. They too needed to develop strategies to deal with providing personal and intimate care with opposite gender patients. Seed (1995) identified that female nursing students often had to remember to look at the men as patients rather than men when providing care. This indicates that the need to detach from the situation is also done by female nursing students.

The most frequently identified use of detachment occurred when the participant cared for a patient to whom they were in some way attracted. Although attraction does not necessarily include sexuality, some of the care provided by nurses has an implied sexuality that cannot be taken lightly, and the participants understood this. (The concept of sexuality and how it relates to the provision of personal and intimate care will be discussed later.) To ensure safe, appropriate, professional care was provided to their patients the participants utilized detachment to be able to accomplish the necessary care without making their patients or themselves emotionally or psychologically uncomfortable. One participant described how by using the strategy of detachment he would be able to provide personal and intimate care for his mother.

The second cognitive strategy used by participants was distraction. They indicated that distraction enabled the nurse to take the patient's mind off the situation immediately at hand. That is, by distracting the patient from what was actually occurring, the patient did not become uncomfortable with the performance of the personal and intimate intervention. A participant described how he had to almost climb into the tub with a burn

victim to be able to perform the necessary intervention of debridement. By talking with the patient about anything other than the procedure being performed the participant distracted the patient and essentially normalized the situation. By talking about everyday events, the procedure took on the same connotation, that is, that it also was an everyday event. If the patient saw and understood that this particular intervention was an everyday commonplace occurrence (accomplished by the nurse not having to focus on the intervention, but rather focussing on anything but the intervention), then the likelihood of the patient feeling emotionally or psychologically uncomfortable would be minimized. Another obvious advantage to using distraction, particularly in the example provided above, is for pain relief. Potter and Perry (1997) discuss how distraction can be used as an adjunctive therapy for pain. I could not find literature that specifically identified distraction as an intervention in the provision of personal and intimate care.

Emotional Strategies

The third category of strategies used by participants was entitled emotional. That is, the participants ensured that they showed their patients respect and, empathy and caring. The participants believed that the development of the nurse-patient relationship required the participant to demonstrate respect for his patients. Respect helped build trust. Respect for the patient included providing the patient with some control over the health care experience. Whenever possible, that control included being able to decide who would provide personal and intimate care. Participants voiced that providing the patient with a choice enabled her to trust the nurse and therefore, felt more comfortable when accepting personal and intimate care from him.

The participants also described the necessity to demonstrate an empathic and

caring attitude towards their patients. By being empathetic and caring the nurse was able to understand how the patient may be feeling when being provided with personal and intimate care by a male nurse. Bottorff (1991) identified the importance of feeling with the patient and sharing the discomfort that the patient is feeling. Promoting comfort is a way to demonstrate a caring attitude. All of the participants identified the promotion of comfort as the main goal in caring for their patients. The literature also identifies comfort promotion as a major goal in nursing. Armitage (1983), Cameron (1993), Hamilton (1989), and Morse (1983) all identify the importance of addressing broad aspects of comfort (including emotional and psychological) when caring for patients. Emotional and psychological needs have to be met to ensure the patient feels comfortable (Kolcaba and Kolcaba, 1991).

Behavioral Strategies

The fourth strategic category used by the participants was behavioral. That is, the participants ensured their patients were provided with privacy during personal and intimate care, regardless of whether the care was physical, emotional or psychological. Participants identified how they would ensure that the curtains were drawn or that they covered their patients whenever personal and intimate care was being performed. Lawler (1993) discusses the importance that nursing places on privacy. She discusses how no one knows the work that nurses do because of the need for nurses to maintain privacy, and they often do that by working behind curtains. Maintaining privacy demonstrates to the patient that the nurse is aware of the potential for discomfort that the patient might experience because of a particular situation or encounter, and is willing to take measures to minimize the discomfort. Attending to privacy helps build the trust necessary for an

effective nurse-patient relationship.

Another behavioral strategy was trading patient assignments or providing a female alternative to female patients. Participants occasionally traded assignments with a female nurse because of the patients' discomfort with a male nurse performing personal and intimate procedures. It was not necessarily the fact the participants were male, but it may have been the situation the patient was in that made it more appropriate for a female to be in attendance during the provision of the personal and intimate care. One participant described how he traded assignments when a young female came in to emergency after being sexually assaulted. The participant knew that the assault itself was traumatic enough for the patient, without further compounding the situation by having a male nurse perform the personal and intimate interventions required as a result of the assault. By providing a female alternative the participants promoted a sense of trust and this strengthened the nurse-patient relationship.

Use of female chaperones was at times also incorporated. Lodge, Mallett, Blake, & Fryatt (1997) and McKenna (1991) identified that in the 1970's all male midwives had to have a chaperone present when providing intimate care with a patient. The concern at that time was the potential for improper advances being performed by the male midwife as well as preventing unsubstantiated allegations of assault. Now, almost 30 years later, the participants have expressed those same concerns. A number of the participants identified the concern of being accused of sexual impropriety when caring for female patients. One participant identified that, when working in a psychiatric unit, a female patient on the unit threatened to accuse a male nurse with sexual abuse if the nurse did not give the patient some medication that she was requesting. The participant identified

that whenever he provided care for this patient he would have a female colleague come in to chaperone, thus ensuring that false accusations of impropriety could not occur.

Workplace Setting and Situational Factors

The last category was workplace setting and situational factors. While not a particular strategy or intervention, these factors influenced how participants performed of personal and intimate care. The participants identified that with more acutely ill patients there was less concern as to who provided personal and intimate care. Patients in intensive care or those who are acutely ill or debilitated do not express concerns if their nurse happens to be male.

When a patient is acutely ill there is a greater emphasis on meeting the person's basic needs. As the patient improves, their basic needs no longer require the same emphasis, allowing the focus to shift to other needs. One of those "other" needs is for the patient to feel comfortable with their nurse. It is only when the patient is well enough to become aware of the normal boundaries being crossed that the gender of the nurse influences a patient's comfort level. This aspect was also identified by Johnston (1987), Lemin (1982), Lodge, Mallett, Blake, & Fryatt (1997), Mynaugh (1984), and Tagg (1981). Tagg identified that patients with male midwives had no concerns during the actual labor period (while the situation was more acute), but these same patients had more concerns if the male midwife had to care for them in the home or during the post-natal period. Mynaugh (1984) reported similar findings. In Lemin's 1982 study, patients had no concerns with a male nurse caring for them in the hospital, but they experienced concerns if they had to be cared for by a male nurse in the home (the idea being that they were more ill in the hospital than at home). Johnston (1987) concluded that there was less

concern with intimate contact in the emergency room because of high patient acuity. Although the above studies are somewhat dated, similar findings were reported by Lodge, Mallett, Blake, & Fryatt (1997) when they interviewed female gynecological patients and identified the acuity of the patient as playing a factor in the patients' embarrassment.

Other factors, in addition to patient acuity that influenced the participant in his provision of personal and intimate care were the following: the need for the intervention to be completed, the resources available to provide alternatives if possible, and, the overall busy-ness of the nurse. If the need to perform a certain procedure was emergent, the procedure would sometimes be conducted with the knowledge and understanding that this was not the ideal manner to manage the situation, but that the patient's immediate physical condition took priority over their emotional or psychological needs. Once the patient's physical needs were met, then participants addressed other needs such as psychological or emotional concerns. It must be noted that if the psychological or emotional need was the primary consideration, the participants dealt with that aspect initially, an example being the participant who had a female colleague care for a young female patient who had been sexually assaulted. In this situation the patient's emotional and psychological well being was the priority over the physical trauma that resulted from the assault.

There were situations where the participants had to perform certain procedures or interventions with their female patients when their female colleagues were unavailable to "cover" for them. For example, when a participant had to perform an intimate procedure on a patient in emergency because all of the female nurses were busy elsewhere. Sometimes a lack of resources or just the general busy-ness of work, necessitated that

interventions occurred at the expense of the patient's emotional or psychological comfort. The participants did, however, state that such occurrences happened when there was no other alternative available to them. As with much that this study has looked at, there is no literature that I have found that discusses or addresses the above factors.

Other Research Questions

The secondary purpose of the study was to answer the following research questions:

1. From the male nurse's perspective, is there an actual or potential perceived concern by patients or society with the concept of male nurses providing personal and intimate care with female patients?

The majority of the participants identified that there were times, albeit rarely, when their patients or their patient's family would express concern with them providing personal and intimate care. One of the participants reported that during his obstetrical rotation as a student, a mother of his patient expressed concern with his caring for her daughter. The concern was alleviated once the mother observed the care being provided her daughter by the participant. The participants stressed that it depended on the patient (for example, a patient who had experienced care being provided by a male nurse in the past), or the situation (for example the severity of the patient's situation) whether or not a concern was expressed. For the most part, female patients or their families did not have a concern about a male nurse providing personal and intimate care.

Someone entering the heath care system in need of intervention will most probably receive that intervention by a stranger (male or female). This concept has been accepted by society as an acceptable reason to breach the societal norm of not touching or

viewing someone's naked body unless one is in some type of relationship with the person (Curtin, 1993; Domar, 1986; Hurst and Ward; Rowan, 1993; Vella, 1991; Vousden, 1980). There is a paucity of research dealing with the acceptance or non-acceptance of male nurses versus female nurses in the provision of personal and intimate care. The only study of this kind that I was able to find was by Lodge, Mallet, Blake & Fryatt (1997). These authors researched the perceived levels of embarrassment with physical and psychological care provided by male and female nurses. Their study found that women preferred female nurses for care that could cause embarrassment. However, as with all studies there were inconsistencies among the participants in their answers to the study questions. Anapol and Wagner (1978); Arnold, Martin and Parker (1988); Kelly (1980); and Haar, Halitsky and Stricker (1975) all found that the majority of females would prefer to have a female physician rather male physician. Unfortunately these studies, as well as being dated, focussed on physicians and not nurses and with the changes that have occurred in societal norms during the last 15 to 20 years it is not known if these findings are indeed indicative of how women currently feel about the subject.

The participants in this study suggested that by demonstrating professionalism, competence, efficiency and utilizing good communication techniques, the patients they cared for had no concerns that their nurse was male. For those patients who did voice a concern, the participants identified that it was well within the patients' rights to decide who should care for them. The participants also expressed that if it made the patient feel better to have a female nurse perform certain personal and intimate procedures or interventions, then that was what was important – the comfort of the patient, not who would provide the care.

2. Are there circumstances or situations in which the performance of personal and intimate care by a male nurse with a female patient is acceptable, and, at other times not acceptable for the patient?

The participants did identify situations or circumstances where it was more acceptable or appropriate if female nurses performed certain personal and intimate interventions or procedures with female patients. Young adolescent females, females concerned about body image, or females in situations that involved major emotional or psychological insult (for example physical or sexual assault) were identified as the most likely patients to be concerned with the provision of intimate care by a male nurse. I could only locate one piece of research that specifically addressed this aspect of personal and intimate care provision. This one study discussed the patients' concern with body image post delivery as the reason for feeling uncomfortable with having a male nurse provide personal and intimate care (Morin, Patterson, Kurtz, & Brzowski, 1999). The participants of my study also identified that they themselves might have some discomfort performing personal and intimate care with patients in the situations listed above.

As discussed earlier, participants acknowledged that they have to be comfortable performing a particular procedure in the first place in order to make their patient feel comfortable. Feelings of modesty, embarrassment, shyness and not knowing how to "break" social norms of male-female relationships are aspects that male nurses have to overcome in order to feel comfortable when providing personal and intimate care with patients. George and Quattrone (1989), Lawler (1993), Merrill, Laux and Thornby (1990) and Seed (1995) all identified that people have these feelings regardless of whether they are a nurse, doctor or member of another heath care discipline. The participants identified

that it was necessary for them to overcome these feelings to be sufficiently comfortable to provide such care.

3. When a male nurse provides personal and intimate care with a female patient, what verbal and non-verbal behaviors indicate to the nurse that the patient is experiencing psychological or emotional discomfort with the situation?

The participants identified a number of patient-related behaviors that they recognized as indicative of emotional or psychological discomfort. These behaviors were identified as consequences of not attending to the patient's comfort. In other words, the participants believed that if they did not pay attention to the patient's emotional and psychological comfort during the performance of personal and intimate care, then the patient would express behaviors or cues, indicating discomfort with the situation.

The behaviors were categorized into four areas: facial cues, emotional or psychological cues, withdrawing cues and protective motion cues. (For a listing of the behaviors see Table 1 on page 153). Once again the paucity of research on the topic of comfort and how it relates to personal and intimate care precludes me from identifying any literature on this aspect. What has been identified though is that comfort is central to nursing (Potter and Perry, 1997). Therefore whenever a patient experiences discomfort it is of utmost importance that the nurse do whatever is required to ensure that their patient's discomfort is dealt with. What has been identified through my research is the fact that the participants expressed an ongoing assessment of their patient's emotional and psychological comfort (or discomfort) throughout the time when personal and intimate care was being performed. This ongoing assessment allowed for quick alterations in the manner in which care was accomplished. Ongoing assessment also enabled participants to

reevaluate the strategy or intervention they were currently using to ensure that it was still effective during the course of personal and intimate care.

The three research questions identified at the beginning of the study encompassed important knowledge domains that I wanted answered. However, because the study was qualitative in design other pertinent information was identified during data analysis.

Other Findings of Significance

During data analysis, a number of additional findings were identified. The four most pertinent findings, however, can be categorized as 1) trust, 2) professionalism, 3) sexuality, and 4) the complexity of assessment. Each of these findings are discussed separately.

Trust

Participants identified that trust was necessary for the nurse-patient relationship to develop appropriately. By gaining the patient's trust, the participants were able to accomplish the necessary nursing interventions required by the patient. These interventions were not only those of a personal and intimate nature, but rather, any intervention. Trust is required in order to develop a therapeutic nurse-patient relationship (Potter and Perry, 1997). Interestingly, King (1981) does not mention the importance of trust in her theory of nursing. The need to develop trust will enable the patient and nurse to overcome concerns and uncertainties that each might have of the other. Without trust the interpersonal interactions expressed by King as being so important will not occur. Patients have to trust their nurse for all aspects of their care. If a patient does not trust his or her nurse then they may feel uncomfortable when the nurse has to perform personal and intimate care with them.

Professionalism

Professionalism was identified by all of the participants as the major means to accomplish necessary nursing interventions. By acting professionally, participants were able to cross over those unwritten but general societal boundaries and taboos that are in place outside of the patient role and the nurse role. Professionalism denotes knowledge, skill and attitude (Chapman, 1977; Curran, 1985; Gilcrest, 1987; Kerr and MacPhail, 1991). The participants believed that by acting professionally (which included being competent in their performance of their duties), they were able to keep their patients emotionally and psychologically comfortable during the provision of personal and intimate care. By being professional, participants also developed a comfortable nurse-patient relationship, which they identified as important. Galbraith (1991) also identified the fact that men in nursing value relationships with their patients.

Participants believed that by being caring, competent and knowledgeable they were able to demonstrate professionalism and this demonstrated comportment provided patients with comfort in knowing that they were in competent hands. Tagg (1981) and Sweet (1974) identified the need to be qualified to perform required tasks and duties as important. The participants believed that if patients perceived their nurse to be professional, they did not object or demonstrate any discomfort with having a male nurse provide personal and intimate care.

Interestingly, although the participants never actually mentioned their professional organizations, the standards and the Code of Ethics established by the Canadian Nurses Association (CNA) and the Manitoba Association of Registered Nurses (MARN), are what these participants used in their everyday practice. As students, and later on, as

professionals, these participants understood the importance of maintaining ethical and professional standards when providing care with their patients.

Sexuality

People are sexual beings and because of this they bring their sexuality with them to whatever health care experience they encounter (Bernhard & Dan, 1986; Lawler, 1993; Savage, 1989; Watson, 1991). Regardless of what one would like to think, there is a sexual connotation associated with the provision of personal and intimate care. Society has identified that male and female genitalia and female breasts have a significant sexual component. Therefore anything associated with the manipulation, touching, or viewing of these physical parts has a sexual component that has to be dealt with by the patient and the male nurse. Even something as seemingly innocuous as a back rub may have a component of sexuality to it. One participant discussed a situation during the provision of a backrub, where he felt some loss of control because of the perceived intimacy of the backrub. Sanford, Hawley and McGee (1992) identified that backrubs and massages have sexual connotations and that male nurses providing these interventions may be perceived as a man first and foremost, rather than as a nurse.

Males in nursing have to deal not only with patient perceptions, but also their own perceptions as well as society's perceptions as to the appropriateness of them performing personal and intimate care with female patients. Two-thirds of the participants identified the importance of understanding and acknowledging the occasional sexual feelings that they experienced while caring for their patients. The importance of identifying, acknowledging and accepting the fact that sexual feelings and attraction can and do occur, not just with the nurse, but also with the patient, has been discussed by Gallop, 1993;

Holyoake, 1998; Pennington, Gafner, Schilit, & Bechtel, 1993; Peternelj-Taylor, 1998; and Smith, Taylor, Keys, & Gornto, 1997. The participants were emphatic, however, that by being professional and maintaining the necessary professional comportment, they were able to ensure that the patients received the care required.

The implied sexuality of the situation also caused the participants to identify legal concerns potentially associated with the provision of personal and intimate care. The concern of being accused of impropriety while caring for a female patient had the participants in some situations requesting a chaperone to be present during the performance of certain personal and intimate interventions such as during catheterizations or providing personal hygiene with some patients. In other situations, participants simply changed assignments with female colleagues to ensure that this potential problem did not surface. Potential legalities or concern regarding the potential for legal implications related to the provision of personal and intimate care has been identified by Bennett (1984), Boughn (1994), Brown (1986), Brown (1987), George and Quattrone (1989), Gill (1995), Greenlaw (1982), Hall (1993), Hawke (1998), Kaur (1993), Squires (1995), Trandel-Korenchuk & Trandel-Korenchuk (1981) and Welch (1996).

An aspect not discussed in any depth, but rather mentioned a few times by the participants, was the perception by the patients or their families that the participant may be homosexual. This aspect was not discussed during the interviews other than the occasional times that the participants mentioned it. If the patients or their family members held this perception, none of the participants suggested that that this in any way determined their acceptance or non-acceptance in the performance of personal and intimate care for the patient. It would however be interesting to identify if indeed the

sexuality of the nurse (male or female) plays a factor in the emotional and psychological comfort level of the patient.

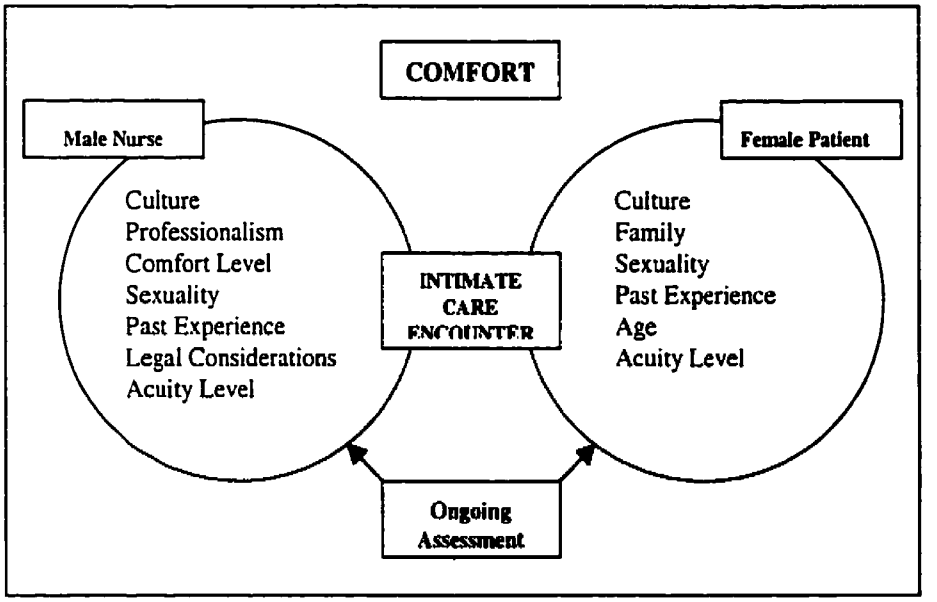
The final significant finding deals with the complexity of the assessment of the patient.

Complexity of the Assessment of the Patient

Throughout the performance of any nursing intervention, personal and intimate or otherwise, participants continually assessed their patients to ensure that they were comfortable with what was happening. This was not just assessing physical comfort, but also emotional and psychological comfort that comes with the belief that one is safe and secure; that one is going to be provided the best care possible in the least intrusive manner available. The participants' goal was to provide the kind of comfort that one feels when they trust the person providing the care.

The ongoing assessment was complex. The visual representation of this ongoing assessment is represented in Figure 2 on the page following. Factors affecting the female patient are interpreted from the male nurse's perspective and may not be the same factors that would be identified if the female patient were specifically questioned.

Figure 2 Complexity of Providing Personal and Intimate Care



Participants expressed that everything they do is ultimately based on the desire to ensure patient comfort. However, to be able to accomplish this the participants had to assess for and take into account many factors. These factors dealt not only with the female patient but also the participant themselves.

Factors that the participants took into consideration when providing care for their female patients included the patient's: 1) culture (this included their upbringing and their religion); 2) family (which had some component of their culture as well as their beliefs and values included); 3) past experiences (This included their life experience as well as their hospital experiences and their experiences with male nurses. It was here that the patient's sexuality also came into play); 4) age (this was considered from a developmental as well as experiential level); and, 5) acuity level.

Factors that participants brought to the health care arena also played a role in determining how they assessed patients. The male nurse brings to the nurse-patient

relationship his culture (including his religion, beliefs and values), professionalism, comfort level with the care needing to be provided (this includes the nurse's sexuality), past experiences (both in life and as a nurse), perceived need for legal considerations, and his knowledge regarding the acuity level of the patient.

As King (1981) suggests, the nurse-patient relationship is based on the desire to accomplish agreed upon goals. In this study, the goal was the provision of personal and intimate care by a male nurse with a female patient without the patient feeling uncomfortable (physically, emotionally, or psychologically). Although the goal was not necessarily stated that way when the participants interacted with their female patients, the underlying assumption was that neither the nurse nor the patient wanted to feel uncomfortable with the care being provided.

Once the above two components (nurse and patient factors) were assessed, the participant would decide what strategy or intervention he would use during the intimate care encounter. Participants utilized an ongoing assessment of these factors and others, depending on the situation and individualized to the patient, and at times, the moment. This ongoing assessment enabled the participant to determine whether or not the intervention chosen would enable him to complete the necessary personal and intimate care, while ensuring that his patient did not experience discomfort because of the care she received.

Because this assessment was ongoing, the strategy or intervention used would change from one patient to the next or from one moment to the next with the same patient. The most intriguing aspect of this assessment was the ability of the participants to determine a strategy or intervention that would allow them to cross the normal societal

boundaries of what is and is not acceptable as far as touching, viewing, poking, prodding or in some way manipulating the body of someone of the opposite gender is concerned. They were able to accomplish this because of the context of the situation they and the patient were in, that is, in a nurse-patient relationship. It was their respective roles, that is, the patient's role as a patient and the nurse's role as a nurse that allowed the nurse to accomplish the necessary nursing intervention. Interestingly the participants were able to perform this assessment and come to this determination sometimes in a matter of moments. It appears that male nurses have to assess many factors before even beginning the provision of care.

Reflexivity and Reflection

Through my years as a nursing instructor I on occasion had the opportunity to be asked the questions "How do you do it?" or, "What do I do?" or, "How do I do it?". These questions came from male nursing students who were uncertain as to how to approach a patient of the opposite gender and provide personal and intimate care for that patient. Through time I came to realize that I really had not given the idea much thought. I just "did it". There was no secret solution. There was no one way to get it done. There was no strategy or intervention used. I just acted myself. I just did what I had to do. I just performed the procedure because it was expected of me and it had to be done. It was my job. I was a nurse and my patient required nursing care. I was there to be a nurse. I had to perform certain procedures that required me to view, poke, prod, manipulate and touch certain parts of women's (and men's) bodies that I would not normally be allowed to do by law or by societal convention in any other scenario. And I had to do this without my patient feeling physically, emotionally or psychologically uncomfortable with the care

provided.

Until I asked those questions I never thought about what I did. I never thought about how uncomfortable and uncertain I may have been when I first started nursing, or for that matter throughout my career, and had to perform personal and intimate care. What was always important was how the patient felt and whether or not the patient was comfortable. It never occurred to me that it took much thought or consideration to do what I did, let alone how I did it. It was just done.

And that is where the seed for this study was planted. I began to wonder if indeed male nurses do have a repertoire of strategies and interventions that they use when they provide personal and intimate care with female patients. I began to wonder if those strategies and interventions could be identified. I wondered if they could be taught to students to help them deal with the feelings of uncertainty and lack of confidence when faced with having to perform procedures and interventions of a personal and intimate nature with their patients. And so I chose this concept as my study.

This study has provided me with a clearer understanding of what it takes to be a male nurse. Nursing is a demanding profession. It requires a level of professionalism that is not appreciated by the public, government, other members of the health care disciplines, patients, and unfortunately sometimes by nurses themselves. Nursing requires commitment, determination, strength, intelligence, caring, and, the ability to interact with people when they are at their worst. Nursing requires an ability to communicate not only socially but also therapeutically. What I have learned through this journey of discovery is something that I always knew. Male nurses, have all these qualities. Male nurses care about their patients. They care about how they feel. They care that what they do for their

patient makes an impact on the lives of their patients. They care that the patient is comfortable. They care, and the act of caring is complex and sophisticated. Caring does not just happen. It is an attitude that develops over time. And it is an attitude that male nurses have in abundance.

But what I have also learned is that sadly, male nurses have to overcome obstacles to providing care that they should not even have to think about. The fact that there are still members of society that believe that male nurses are not appropriate care givers in certain situations specifically and only because they are male, is a sorry commentary on society's beliefs and values surrounding male-female interactions. That male nurses have to be concerned with legal implications simply for doing their job is inappropriate. That male nurses have to consider so many factors before even trying to provide certain aspects of care is unfortunate. But male nurses do all of these things and accept all of these barriers and still provide the care that their patients require, because they do care.

And this is how I have changed during this process of inquiry. I have changed because I have come to realize that I do not "just do it", but rather, I methodically choose what strategy and intervention I will use when performing personal and intimate care with my patients. I have learned that there are many techniques that I have done in the past, and that there are many techniques that I can try in the future.

I have also changed because I have come to realize that in order for a man to be in nursing he has to overcome certain obstacles that his female counterparts do not have to consider. For example, female nurses generally do not have to wonder if the patient will or will not accept them. They also do not have to consciously think about the fact that they may be inappropriately charged with impropriety whenever they care for a patient of

the opposite gender. And probably most importantly, the female nurse will never be questioned as to their ability to care based solely on their gender. These examples and others are considerations that male nurses do indeed have to take into account when they care for female patients. I do however acknowledge that this in no way infers that this is the case for each and every male nurse or for that matter for every male nurse whenever he cares for a female patient. However, there is an increased likelihood that these questions will be asked by a male nurse during his career, whereas, there is a decreased likelihood of these same questions being a concern to a female nurse during the course of her career. The fact that a male nurse overcomes these obstacles without difficulty because he cares enough about his patients to do so is inspirational. I have changed because I find myself honored to work along side of so many professional, dedicated, committed and caring men.

I have also learned that research is the lifeblood of nursing. It is what nursing is based on. I have learned through this process that for every answer there is to a question there is a new question to be answered. I have learned that the quest for knowledge does not always come from within but can also come from without. And finally, I have learned that as an educator, I have not always provided my students with the necessary knowledge and skills to properly understand the complexities of caring for female patients (or for that matter any patient), particularly when the care is of a personal and intimate nature. And this leads me into the next section, that being, future implications and recommendations.

Future Implications and Recommendations

Nursing Practice

The findings of this study can have an impact on nursing practice, not just for male nurses but for female nurses as well. Female nurses could, in all probability probably do, use the same strategies and interventions used by male nurses in the performance of personal and intimate care. The consequences of not attending to the patients' comfort are important considerations for any nurse when caring for patients. Patients have to feel comfortable in the knowledge that they will be provided the best care possible with the least amount of physical, emotional and psychological discomfort. Nurses could be made aware of the possible strategies and interventions that have been identified here and could then employ them in their own area of work.

Nursing Administration

Administrators everywhere have to come to terms with the fact that male nurses are not different from female nurses. They are nurses. They have the same educational preparation and they expect the same considerations as their female counterparts. Nurses, whether male or female, are professionals who have a job to do and for the most part, do it to the best of their abilities. Gender should not and cannot play a factor in the overall picture of patient care. However, as a professional, a nurse would have the knowledge, understanding, caring and empathy to know when to withdraw from a care situation if it was going to cause discomfort of any kind for the patient, even if the reason for the discomfort was the nurse's gender.

Obviously, patients have the right to choose who will and who will not care for them. And they should have that right. However, administrators should not be the ones to

decide whether or not a male nurse or a female nurse is appropriate to work in one area and not another. That decision should be based on the nurses' ability and not the nurse's gender.

Male (and female) nurses need to feel confident in the fact that their administration will back them up if a situation arises that could lead to legal implications. The concepts of patient's rights, risk management, and quality improvement are important in an organization. However, the male nurse needs to feel confident that the beliefs, values, and policies of the facility or organization provide him with the authority, power and rights to perform whatever care is necessary for the patients under his care. If a nurse does something that is unethical, immoral or illegal relating to patient care, then that nurse should suffer whatever consequences befall him or her. If however, the nurse has only performed his or her job, then the nurse should be assured that the facility or organization would be behind him or her.

Nursing Education

It is in this area that the majority of future work needs to be focussed. Participants identified shortcomings in their basic nursing education relating to the provision of personal and intimate care. The participants all agreed that their education prepared them in how to "do" the procedures. They all felt prepared to perform the actual hands of a procedure, but many of the participants expressed that they were never told how to address the emotional and psychological aspects of the procedures being performed. The participants felt that it would be beneficial if nursing curricula included information on how to manage the complexities of encountering someone's body, especially someone of the opposite gender. The participants noted that this kind of information would be

beneficial to male as well as female nursing students. As discussed earlier, men and women both have concerns as to how to breach the normal societal boundaries required of some nursing interventions and procedures, specifically personal and intimate care.

Lawler (1993) commented on these same aspects. That is, nursing education emphasizes the procedures, but students learn to control their emotions and embarrassment by themselves. She also reported that nurses are not educated in the practicalities of breaking societal norms and boundaries related to male-female interactions and relationships. What has not been addressed is how students learn to identify the verbal and non-verbal behaviors that indicate their patients are uncomfortable with the care being provided. What is also not addressed in a formal way is what strategies or interventions the students can utilize when they are required to perform personal and intimate care with a patient of the opposite gender.

This is perhaps the most important recommendation of this study. Nursing educators and nursing curricula need to address the issue of how students become comfortable with not only the provision of personal and intimate care, but how they become comfortable within themselves when they have to provide this type of care. Students should be provided with role models, and opportunities for discussion of how they feel about the provision of personal and intimate care. They should have opportunities to openly discuss the feelings that they have when providing personal and intimate care. They also have to be provided with strategies and interventions that they can use to make their patients and themselves comfortable during the provision of personal and intimate care.

Future Research

The scarcity of research on male nurses caring for female patients in general, and more specifically, relating to the provision of personal and intimate care, is indicative that this is an area that needs to be researched. Research needs to be conducted relating to the provision of personal and intimate care in general. Additional research needs to be conducted relating to the provision of personal and intimate care by female nurses and by male nurses.

In addition, further research following the same lines of this research study would be beneficial. It would be interesting to research the issue of whether or not the male nurses indeed did accurately assess the perceptions of their patients and how they were feeling during the provision of personal and intimate care. This could be accomplished by interviewing female patients who have been cared for by male nurses to identify what if any concerns they may have had with the care they received from the male nurse.

Another research study that should be conducted would be to determine if there are similarities or differences in the care provided by male nurses with female patients versus male nurses with male patients. As more men enter the field of nursing further research will be necessary to ensure that concerns and issues related to the provision of care by male nurses are properly addressed.

REFERENCES

Adamson, T. E., & Watts, P. A. (June, 1976). Patients' perceptions of maternity nurse practitioners. American Journal of Public Health, 66, 585-586.

Allanach, E. J., & Golden, B. M. (1988). Patients' expectations and values clarification: A service audit. Nursing Administration Quarterly, 12(3), 17-22.

Allekian, C. I. (1973). Intrusions of territory and personal space: An anxiety-inducing factor for hospitalized persons - An exploratory study. Nursing Research, 22, 236-241.

Anapol, D., & Wagner, N. N. (July - August, 1978). Patient provider preferences and the pelvic examination. Nurse Practitioner, 13.

Anderson, P. B. & Aymami, R. (1993). Reports of female initiation of sexual contact: Male and female differences. Archives of Sexual Behavior, 22, 335-343.

Armitage, P. (March 30, 1983). Strategies for dealing with discomfort. Nursing Mirror, 23-25.

Arnold, R. M., Martin, S. C., & Parker, R. M. (December, 1988). Taking care of patients- Does it matter whether the physician is a woman? [Women and Medicine Special issue]. Western Journal of Medicine, 149, 729-733.

Artinian, B. A. (1988). Qualitative modes of inquiry. Western Journal of Nursing Research, 10(2), 138-149.

Barnett, K. (1972). A theoretical construct of the concepts of touch as they relate to nursing. Nursing Research, 21(2), 102-110.

Barron, A. (1990). The right to personal space. Nursing Times, 86(27), 28-32.

Benda, E. (1981). When the postpartum nursing student is male: A challenge to maternity instructors. Journal of Nursing Education, 20(4), 5-8.

Bennett, H. M. (March/April 1984). Sex discrimination. Critical Care Nurse, 4, 120.

Benoliel, J. Q. (1984). Advancing nursing science: Qualitative approaches. Western Journal of Nursing Research, 6(3), 1-8.

Bernhard, L. A., & Dan, A. J. (March, 1986). Redefining sexuality from women's own experiences. Nursing Clinics of North America, 21, 125-136.

Blundell, S. (June, 1990). Men in maternity nursing. The Canadian Nurse, 18-19.

Bohlen Primrose, R. (January, 1984). Taking the tension out of pelvic exams. American Journal of Nursing, 72-74.

Bonifazi, J. (September, 1999). It's a woman's world: The hazards of being a male nursing assistant. Contemporary Long Term Care, 21.

Boughn, S. (1994). Why do men choose nursing? Nursing & Health Care, 15, 406-411.

Bottorff, J. (1991). The lived experience of being comforted by a nurse. Phenomenology & Pedagogy, 9, 237-252.

Brink, P. J., & Wood, M. J. (Eds.). (1989). Advanced Desing in Nursing Research, Newbury Park: Sage Publications.

Brown, M. D. (Summer, 1986). Viewpoint: Female-only intrapartum nurses: policy and the law. Health Care Management Review, 11(3), 93-95.

Brown, M. D. (July, 1986). "Why won't they let us help deliver babies?". RN, 61-62.

Brown, M. D. (May, 1987). Male nurses: Do they belong in obstetrics? Journal of Nursing Administration, 17(5), 3.

Brown, P. & Yantis, J. (1996). Personal space intrusion and PTSD. Journal of Psychosocial Nursing, 34(7), 23-28.

Brown Doress, P., & Nelson Wegman, P. (1992). Working toward mutuality: Our relationships with men. In The New Our Bodies Ourselves: A Book by and for Women. The Boston Women's Health Book Collective. Toronto: Simon & Schuster. Bush, P. J. (1976). The male nurse: A challenge to traditional role identities. Nursing Forum, 15, 390 - 405.

Burnard, P. (1991). A method of analyzing interview transcripts in qualitative research. Nurse education today, 11, 461-466.

Burtt, K. (September, 1998). Male nurses still face bias. American Journal of Nursing, 98(9), 64-65.

Cameron, B. L. (1993). The nature of comfort to hospitalized medical surgical patients. Journal of Advanced Nursing, 18, 424-436.

Carlson, K. (1991). Boundaries: Personal limits. Journal of Post Anesthesia Nursing, 6, 225-226.

Chapman, C. M. (1977). Concepts of professionalism. Journal of Advanced Nursing, 2, 51-55.

Christman, L. P. (1988). Men in nursing. In Wesley, H. H., & Fitzpatrick, J. J. (Eds.). Annual Review of Nursing Research, 6, 193-205. New York: Springer Publishing.

Cole, A. (1993). Men and misconduct. Nursing Times, 89(46), 18.

Condon, E. H. (January/February, 1992). Nursing and the caring metaphor: Gender and political influences on an ethics of care. Nursing Outlook, 40(1), 14-19.

Coombes, R. (March 4, 1998). Jobs for the girls. Nursing Times, 94(9), 14-15.

Cooper, M. (August 26, 1987). A suitable job for a man? Nursing Times, 83(34), 49-50.

Cummings, S. H. (1995). Attila the hun versus Attila the hen: Gender socialization of the American nurse. Nursing Administration Quarterly, 19(2), 19-29.

Curran, C. R. (September, 1985). Shaping an image of competence and caring. Nursing and Health, 371-373.

Curtin. L. L. (June, 1993). Patient privacy in a public institution. Nursing Management, 24(6), 26-27.

Cyr, J. P. (July, 1992). Males in nursing. Nursing Management, 23(7), 54-55.

Davis-Martin, S. (April, 1984). Research on males in nursing. Journal of Nursing Education, 23, 162-164.

De Augustinis, J., Isani, R. S., & Kumler, F. R. (1963). Ward study: The meaning of touch in interpersonal communication. In Burd, S. F. & Marshall, M. A. (Eds.). pp. 271-306. Some Clinical Approaches to Psychiatric Nursing. The Macmillan Company: New York.

Decker, W. H. (1986). Occupation and impressions: Stereotypes of males and females in three professions. Social Behaviour and Personality, 14(1), 69-75.

Dillon McDonald, D. & Bridge, R. G. (1991). Gender stereotyping and nursing care. Research in Nursing & Health, 14, 373-378.

Domar, A. D. (Winter, 1985/1986). Psychological aspects of the pelvic exam: Individual needs and physician involvement. Women and Health, 10(4), 75-90.

Donkor, A. (1993). The gender trap. Nursing Times, 89(7), 43.

Dowler, J. M., Jordan-Simpson, D. A. & Adams, O. (1992). Gender inequalities in care-giving in Canada. Health Reports: Statistics Canada, 4(2), 125-136.

Drew, N. (Summer, 1986). Exclusion and confirmation: A phenomenology of patients' experiences with caregivers. Image: Journal of Nursing Scholarship, 18(2), 39-43.

Durant, R. H., Seymore, C., Jay, M. S., Freeman, D., Sharp, C. & Linder, C. W. (1987). Pediatric residents' assessment of adolescents' experiences during pelvic examination. Journal of Adolescent Health Care, 8, 407-412.

Edgeland, J. W. & Brown, J. S. (1988). Sex role stereotyping and role strain of male registered nurses. Research in Nursing & Health, 11, 257-267.

Edgeland, J. W. & Brown, J. S. (December, 1989). Men in nursing: Their fields of employment, preferred fields of practice, and role strain. HSR: Health Services Research, 24, 693-707.

Ekstrom, D. N. (1999). Gender and perceived nurse caring in nurse-patient dyads. Journal of Advanced Nursing, 29(6), 1393-1401.

Eliason, M. J. (Summer, 1993). Cultural diversity in nursing care: The lesbian, gay, or bisexual client. Journal of Transcultural Nursing, 5(1), 14-20.

Eliason, M. J. & Randall, C. E. (1991). Lesbian phobia in nursing students. Western Journal of Nursing Research, 13, 363-374.

Estabrooks, C. A. & Morse, J. M. (1992). Toward a theory of touch: The touching process and acquiring a touching style. Journal of Advanced Nursing, 17, 448-456.

Fennema, K., Meyer, D. L., & Natalie, O. (1990). Sex of physician: Patient's preferences and stereotypes. The Journal of Family Practice, 30, 441-446.

Fetterman, D. (1989). The first step: An overview. In Ethnography step by step, Newbury Park: Sage, pp. 11-25.

Fetterman, D. (1989). Walking in rhythm: Anthropological concepts. In Ethnography step by step, Newbury Park: Sage, pp. 26-40.

Fetterman, D. (1989). A wilderness guide: Methods and techniques. In Ethnography step by step, Newbury Park: Sage, pp. 41-72.

Fetterman, D. (1989). Finding your way through the forest: Analysis. In Ethnography step by step, Newbury Park: Sage, pp. 88-103.

Field, P. A. (1983). An ethnography: four public health nurses' perspectives of nursing. Journal of Advanced Nursing 8, 3-12.

Fisher, L. M. & Hunt Joseph, D. (1989). A scale to measure attitudes about nonprocedural touch. The Canadian Journal of Nursing Research, 21(2), 5-14.

Fontana, A., & Frey, J. (1994). Interviewing: The art of science. In Handbook of qualitative research. N. Denzin and Y. Lincoln (Eds.), Thousand Oaks, California:Sage Publications, pp. 361-376.

Freeman, A. (March 15, 1993). The physician-patient relationship and the ethic of care. Canadian Medical Association Journal, 148, 1037-1043.

Foote, R. H. (1980). Double standards? Double standards? American Journal of Nursing, 80, 1610.

Galanti, G-A. (1991). Caring for patients from different cultures. Philadelphia: University of Pennsylvania Press.

Galbraith, M. (April, 1991). Attracting men to nursing: What will they find important in their career?. Journal of Nursing Education, 30, 182-186.

Gallop, R. (February, 1993). Sexual contact between nurses and patients. The Canadian Nurse, 28-31.

Garvin, B. J. (1976). Values of male nursing students. Nursing research, 25, 352-357.

George, J. E. & Quattrone, M. S. (January/February, 1989). Law and the emergency nurse: Opposite sex stand-in nurses. Journal of Emergency Nursing, 15(1), 53-54.

Gilchrist, J. M. (November, 1987). Unionism and professionalism in nursing. The Canadian Nurse, 31-33.

Gilloran, A. (1995). Gender differences in care delivery and supervisory relationship: The case of psychogeriatric nursing. Journal of Advanced Nursing, 21, 652-658.

Glen, S. & Jownally, S. (1995). Privacy: A key nursing concept. British Journal of Nursing, 4(2), 69-72.

Gourse Berg, R. (1979). Vasectomy patients' acceptance of female physicians. The Journal of Family Practice, 9, 1107-1108.

Greenberg, E. & Levine, B. (1971). Role strain in men nurses: A preliminary investigation. Nursing Forum, 10, 416-430.

Greenlaw, J. (July, 1982). A sexist judgement threatens all of nursing. RN, 69-70.

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

Guba, E., & Lincoln, Y. (1989). Judging the quality of fourth generation evaluation. In, Fourth generation evaluation, E. Guba and Y. Lincoln (Eds.). Newbury Park: Sage, 228-251.

Haar, E., Halitsky, V. & Stricker, G. (September, 1975). Factors related to the preference for a female gynecologist. Medical Care, 13, 782-790.

Hamilton, J. (1989). Comfort and the hospitalized chronically ill. Journal of Gerontological Nursing, 15(4), 28-33.

Hawke, C. (October, 1998). Nursing a fine line: Patient privacy and sex discrimination. Nursing Management, 29(10), 56, 58-61.

Haywood, M. (1994). Male order. Nursing Times, 90(20), 52.

Heikes, E. J. (1991). When men are the minority: The case of men in nursing. The Sociological Quarterly, 32, 389-401.

Hesselbart, S. (February, 1977). Women doctors win and male nurses lose: A study of sex role and occupational stereotypes. Sociology of Work and Occupations, 4(1), 49-62.

Hollinger, L. M. & Buschmann, M. B. T. (1993). Factors influencing the perception of touch by elderly nursing home residents and their heath caregivers. International Journal of Nursing Studies, 30, 445-461.

Holyoake, D. D. (December 9, 1998). Disentangling caring from love in a nurse-patient relationship. Nursing Times, 94(49), 56-58.

Horman, D. J., Campbell, J. D. & DeGregory, J. L. (September, 1987). Gender and the attribution of the nurse practitioner and physician status. Medical Care, 25, 847-855.

Huerter, R. (1979). Female sexuality. In D. K. Kjervik & I. M. Martinson (Eds.), Women in stress: A nursing perspective, (pp.96-115). New York: Appleton-Century-Crofts.

Huggins, E. A. & Scalzi, C. C. (July, 1988). Limitations and alternatives: Ethical practice theory in nursing. Advances in Nursing Science, 10(4), 43-47.

Hughes, L. (1980). The public image of the nurse. Advances in Nursing Science, 55-72.

Hunt, M. (February 13, 1991). Who flies highest?. Nursing Times, 87(7), 29-31.

Hurst, K. & Ward, L. (July 10, 1991). Modesty in ICUs. Nursing Times, 87(28), 40-41.

Johnston, J. (March/April, 1987). Men in emergency nursing. Journal of Emergency Nursing, 13(2), 88-90.

Jourard, S. M. & Rubin, J. E. (1968). Self-disclosure and touching: A study of two modes of interpersonal encounter and their inter-relation. Journal of Humanistic Psychology, 8, 39-48.

Kalisch, B. J., Kalisch, P. A., & Clinton, J. (January, 1981). Nursing Outlook, 49-54.

Kaur, S. & Clasper, C. (1993). Male delivery. Nursing Times, 89(6), 62-63.

Kelly, J. M. (1980). Sex preference in patient selection of a family physician. The Journal of Family Practice, 11, 427-430.

Ketter, J. (1994). Sex discrimination targets men in some hospitals. The American Nurse, 26(4), 1 and 24.

Kerr, J. R., & MacPhail, J. (1991). Canadian nursing: Issues and perspectives, (2nd. ed.). Toronto: Mosby Year Book.

King, I. M. (1981). A theory for nursing: Systems, concepts, process. John Wiley & Sons: New York.

Knaack, P. (1984). Phenomenological research. Western Journal of Nursing Research,6(1), 107-114.

Kolcaba, K. Y. & Kolcaba, R. J. (1991). An analysis of the concept of comfort. Journal of Advanced Nursing, 16, 1301-1310.

Laroche, E. & Livneh, H. (1983). Regressional analysis of attitudes toward male nurses. The Journal of Psychology, 113, 67-71.

Lawler, J. (1993). Behind the screens: Nursing somology, and the problem of the body. Don Mills, Ontario: Benjamin/Cummings.

Lemin, B. (November 24, 1982). Men in a woman's world. Nursing Mirror, 32-34.

Levy, R. I. & Hollan, D. W. (1998). Person-centered interviewing and observation. In Handbook of Methods in Cultural Anthropology. (Bernard, H. R., ed.). AltaMira Press, A Division of Sage Publications Inc., Walnut Creek, London, New Delhi, 333-364.

Lodge, N., Mallett, J., Blake, P., & Fryatt, I. (1997). A study to ascertain gynaecological patients' perceived levels of embarrassment with physical and psychological care given by female and male nurses. Journal of Advanced Nursing, 25, 893-907.

Mackey, M. C. & Lock, S. E. (November/December, 1989). Women's expectations of the labor and delivery nurse. Journal of Obstetric, Gynecologic and Neonatal Nursing, 505-512.

Major, B. (1981). Gender patterns in touching behavior. In Mayo, C. & Henley, N. M. (Eds.). pp. 15-37. Gender and Nonverbal Behavior. Springer-Verlag: New York.

Mahony, C. (March 24, 1999). Men behaving badly. Nursing Times, 24(12), 28-29.

Mannino, S. F. (Summer, 1963). The professional man nurse: Why he chose nursing, and other characteristics of men in nursing. Nursing Research, 12, 185-188.

Marcelin, C. F. (1992). Men in OB/GYN nursing: A student's enlightenment or nightmare? NSNA/Imprint, 39(3), 33-34.

Marland Hitchcock, J. & Skodol Wilson, H. (May/June, 1992). Personal risking: Lesbian self-disclosure of sexual orientation to professional health care providers. Nursing Research, 41, 178-183.

Mason, P. (February 13, 1991). Jobs for the boys. Nursing Times, 87(7), 26 & 28.

Mathieson, E. (February 13, 1991). A question of gender. Nursing Times, 87(7), 31-32.

May, C. (1990). Research on nurse-patient relationships: Problems of theory, problems of practice. Journal of Advanced Nursing, 15, 307-315.

May, C. (1991). Affective neutrality and involvement in nurse-patient relationships: Perceptions of appropriate behaviour among nurses in acute medical and surgical wards. Journal of Advanced Nursing, 16, 552-558.

May, C. (1993). Subjectivity and culpability in the constitution of nurse-patient relationships. International Journal of Nursing Studies, 30, 181-192.

McCann, K. (April 17, 1991). Elderly patients' perceptions of touch. Nursing Times, 87(16), 53.

McKenna, H. P. (1991). The developments and trends in relation to men practicing midwifery: A review of the literature. Journal of Advanced Nursing, 16, 480-489.

McKie, L. (1993). Women's views of the cervical smear test: Implications for nursing practice - women who have not had a smear test. Journal of Advanced Nursing, 18, 972-979.

McKie, L. (1993). Women's views of the cervical smear test: Implications for nursing practice - women who have had a smear test. Journal of Advanced Nursing, 18, 1228-1234.

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

Merrill, J. M., Laux, L. F. & Thornby, J. I. (June, 1990). Why doctors have difficulty with sex histories. Southern Medical Journal, 83, 613-617.

Messner, R. L. (August, 1993). What patients really want from their nurses. American Journal of Nursing, 38-41.

Millin, J. (August 12, 1981). My trip into a woman's world. Nursing Mirror, 153(7), 25-26.

Morin, K. H., Patterson, B. J., Kurtz, B., & Brzowski, B. (First Quarter, 1999). Mother's responses to care given by male nursing students during and after birth. Image: Journal of Nursing Scholarship, 31(1), 83-87.

Morrin, N. (May 27, 1992). Unequal partners. Nursing Times, 88(22), 58-60.

Morse, J. M. (Spring, 1983). An ethnoscientific analysis of comfort: A preliminary investigation. Nursing Papers, 15(1), 6-19.

Mynaugh, P. A. (November/December, 1984). Male maternity nurses: The patient's perspective. Maternal Child Nursing, 9, 373-378.

Okrainec, G. (May, 1993). Gender stereotyping. Alberta Association of Registered Nurses, 49(5), 11.

Paterson, B. L., Crawford, M., Saydak, M., Venkatesh, P., Tschikota, S., & Aronowitz, T. (1995). How male nursing students learn to care. Journal of Advanced Nursing, 22, 600-609.

Pennington, S., Gafner, G., Schilit, R., & Bechtel, B. (June, 1993). Addressing ethical boundaries among nurses. Nursing Management, 24(6), 36-39.

Peternelj-Taylor, C. (1998). Forbidden love: Sexual exploitation in the forensic milieu. Journal of Psychosocial Nursing, 36(6), 17-23.

Perkins, J. L., Bennett, D. N. & Dorman, R. E. (January, 1993). Why men choose nursing. Nursing & Health Care, 14(1), 34-38.

Petravage, J. B., Reynolds, L. J., Gardner, H. J. & Reading, J. C. (1979). Attitudes of women toward the gynecologic examination. The Journal of Family Practice, 9, 1039-1045.

Poliafico, J. K. (October, 1998). Nursing's gender gap. RN, 39-42.

Polit, D. F., & Hungler, B. P. (1995). Nursing Research: Principles and Methods, (5th Ed.). Philadelphia: J. B. Lippincott.

Pomfret, I. (1994). An unsuitable job for a woman? Nursing Times, 90(22), 46 and 48.

Potter, P. A., & Perry, A. G. (1997). Canadian fundamentals of nursing. (Kerr, J. R. & Sirotnik, M., eds.). Toronto: C. B. Mosby.

Ramos, M. C. (1992). The nurse-patient relationship: Theme and variations. Journal of Advanced Nursing, 17, 496-506.

Roughan, P. A., Kaiser, F. E. , & Morley, J. E. (1991). Sexuality and the older woman. Clinics in Geriatric Medicine, 9(1), 87-106.

Rowan, K. (February, 1993). Hospital patients have a right to privacy. RN, 92.

Saltonstall, R. (1993). Healthy bodies, social bodies: Men's and women's concepts and practices of health in everyday life. Social Science and Medicine, 36(1), 7-14.

Sandelowski, M. (1986). The problem of rigor in qualitative research. Advances in nursing science, 8, 27-37.

Sanford, W., Hawley, N. P. & McGee, E. (1992). Sexuality. In The New Our Bodies Ourselves: A Book by and for Women. The Boston Women's Health Book Collective. Toronto: Simon & Schuster.

Saunders, G. (1981, May 7). Males - the sex matters a great deal [Letter to the editor]. Nursing Mirror, 9.

Savage, J. (February 1, 1989). An uninvited guest. Nursing Times, 85(5), 25-28.

Schoenmaker, A. & Radosevich, D. M. (1976). Men nursing students: How they perceive their situation. Nursing Outlook, 24, 298-303.

Scott, A. L. (1993). A beginning theory of personal space boundaries. Perspectives in Psychiatric Care, 29(2), 12-21.

Seed, A. (1995). Crossing the boundaries – experiences of neophyte nurses. Journal of Advanced Nursing, 21, 1136-1143.

Segal, B. E. (1962). Male nurses: A case study in status contradiction and prestige loss. Social Forces, 41(1), 31-38.

Seymore, C., DuRant, R. H., Jay, M. S., Freeman, D., Gomez, G., Sharp, C. & Linder, C. W. (February, 1986). Influence of position during examination, and sex of examiner on patient anxiety during pelvic examination. The Journal of Pediatrics, 108, 312-317.

Sherrod, R. A. (October, 1989). The role of the nurse educator when the obstetrical nursing student is male. Journal of Nursing Education, 28, 377-379.

Simms, L. M. (November/December, 1981). The grounded theory approach in nursing research. Nursing Research, 30, 356-359.

Simpkin, W. (December 9, 1998). Gender bashing. Nursing Times, 94(49), 32-33.

Smith, L. L., Taylor, B. B., Keys, A. T., & Gornto, S. B. (December, 1997). Nurse-patient boundaries: Crossing the line. American Journal of Nursing, 97(12), 26-32.

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

Staff. (November 17, 1993). Gender trouble. Nursing Times, 89(46), 3.

Staff. (1988, November-December). Male nurses cross barriers. Health Sciences Centre, p.3 and 6.

Staff. (April, 1995). Male nurses: Safety in numbers. Nursing, 12.

Staff. (July, 1995). Practice standards: Compromising situation? Nursing, 28.

Stillman, M. J. (October, 1978). Territoriality and personal space. American Journal of Nursing, 1670-1672.

Streubert, H. J. (1994). Male nursing students' perceptions of clinical experience. Nurse Educator, 19(5), 28-32.

Swaffield, L. (May 18, 1988). Stand by your man. Nursing Times, 84, 68.

Sweet, B. R. (1974). Patients' reactions to male midwives. Nursing Times, 1619-1620.

Tagg, P. (October 21, 1981). Male nurses in midwifery. Nursing Times, 1851-1853.

Taylor, C., Lillis, C., & LeMone, P. (1989). Fundamentals of nursing - The art and science of nursing care. Philadelphia: J. B. Lippencott.

Taylor, M. J. (1981, May 7). Males - the sex matters a great deal [Letter to the editor]. Nursing Mirror, p. 9.

Tanz Gordon, I. & Packard Green, C. (April, 1981). The impact of sex-role stereotyping on health care: A nursing education workshop. Journal of Nursing Education, 20(4), 9-16.

Trandel-Korenchuk, K. M. & Trandel-Korenchuk, D. M. (Fall, 1981). Restrictions on male nurse employment in obstetric care. Nursing Administration Quarterly, 87-90.

Tumminia, P. A. (September/October, 1981). Teaching problems and strategies with male nursing students. Nurse Educator, 9-11.

Turnipseed, L. A. (July/August, 1986). Female patients and male nursing students. Journal of Obstetric, Gynecologic and Neonatal Nursing, 345-348.

van Ooijen, E. (1995). How illness may affect patient's sexuality. Nursing Times, 91(23), 36-37.

van Ooijen, E. (1996). Learning to approach patients' sexuality as part of holistic care. Nursing Times, 92(36), 44-45.

Vella, P. V. (1991). A survey of women undergoing a pelvic examination. Australia and New Zealand Journal of Obstetrics and Gynaecology, 31, 355-357.

Vestal, C. (April/May, 1983). Men nurses who needs them?. Imprint, 30(2), 55-59.

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

Vousden, M. (July 17, 1980). An age of intimate concern. Nursing Mirror, 12.

Waddell, K. (1994). Nursing a gender. Nursing Standard, 9(30), 62. Watkin, B. (July 17, 1975). Male midwives. Nursing Mirror, 39.

Walters, V., Eyles, J., French, S., & Lenton, R. (February, 1998). Gender differences in work and family life. The Canadian Nurse, 31-35.

Watson, C. (October 24-November 6, 1991). Sexual roles in nursing care. Nursing, 4(44), 13-14.

Webb, C., & Hope, K. (1995). What kind of nurses do patients want? Journal of Clinical Nursing, 4, 101-108.

Webster's New Dictionary. (1994). Promotional Sales Books: United States.

Weiss, C. J. (1984). Gender-related perceptions of caring in the nurse-patient relationship. In Care: The essence of nursing and health. (Leininger, M., ed.). Slack, Inc., Thorofare, NJ, 161-181.

Welch, H. (1996). Nurse midwives as primary care providers for women. Clinical Nurse Specialist, 10, 121-124.

Wells, G. M. (September/October, 1977). Reducing the threat of a first pelvic exam. The American Journal of Maternal Child Nursing, 304-306.

Weyrauch, K. F., Boiko, P. E. & Alvin, B. (1990). Patient sex role and preference for a male or female physician. The Journal of Family Practice, 30, 559-562.

Whitcher, S. J. & Fisher, J. D. (1979). Multidimensional reaction to therapeutic touch in a hospital setting. Journal of Personality and Social Psychology, 37(1), 87-96.

Williams, C. L., & Heikes, E. J. (1993). The importance of researcher's gender in the in-depth interview: Evidence from two case studies of male nurses. Gender & Society, 7, 280-291.

Williams, J. L. & Newman, L. (February, 1994). The pelvic examination in primary practice: Making it easier for your patients - and for you. Consultant, 175-180.

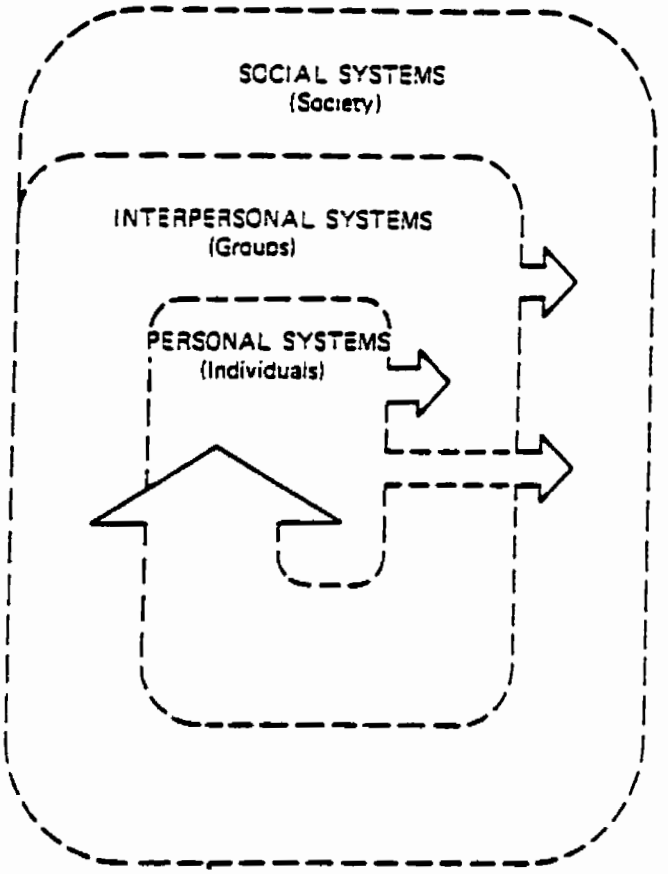
Wollstadt, L. J., Gravdal, J. & Glasser, M. (May-June, 1990). Gender and the educational experience in a primary care training setting. Family Medicine, 22, 210-214.

Woodhams, K. (September 19, 1984). Why apologise for being male?. Nursing Mirror, 159(10), 20-21.

Yonge, O., & Stewin, L. (1988). Reliability and validity: Misnomers for qualitative research. The Canadian Journal of Nursing Research, 20(2), 61-67.

Appendix A

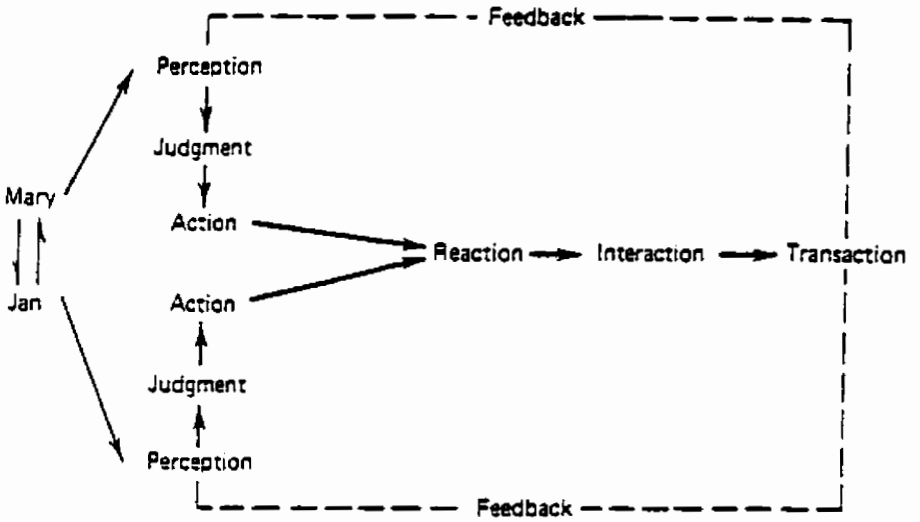
Visual Representation of King's Conceptual Framework



Taken from: King, I. M. (1981). A theory for nursing: Systems, concepts, process. John Wiley & Sons: New York.

Appendix B

A Process of Human Interaction



Taken from: King, I. M. (1981). A theory for nursing: Systems, concepts, process. John Wiley & Sons: New York.

Appendix C

Invitation and Explanation of Study for Potential Study Participants

My name is Rodney Kebicz and I am a student in the Master of Nursing Program at the University of Manitoba. For the thesis component of my program I am conducting a study entitled "The art of caring: Male nurses providing personal and intimate care with female patients". This is a dimension of nursing that is not well understood and there has been minimal research carried out in this area. To acquire a better understanding of this aspect of nursing I plan to interview male registered nurses who work in medical or surgical areas within this institution.

I would like to interview 15 to 25 male registered nurses who have during the course of their nursing careers provided personal and intimate care to female patients. I would like to gather information on the experiences, perspectives, thoughts and perceptions that male nurses have regarding the provision of personal and intimate care to female patients. I would also like to gather information about the possible strategies, behaviors or interventions utilized by these nurses when they provide personal and intimate care to female patients.

You have received this invitation to participate in this study because you are a male registered nurse who works in a medical or surgical area within the Health Sciences Center. The chairperson of the Access Committee of the Health Sciences Center has forwarded this letter to you. If you agree to participate in this study you will be interviewed at your convenience for approximately one (1) hour at a mutually agreed upon time and place. A second one (1) hour interview may be required but would only be arranged if you agreed. Participants will be asked to sign a consent form prior to the actual interview occurring.

There is absolutely no obligation on your part to participate. If you do decide to participate in the study you are free to withdraw at any time without prejudice. I would appreciate it if you could contact me within one week at 788-8334 or 339-7705 to confirm your participation in the study. If you have any questions or require any further information, please do not hesitate to contact me at the above number.

I would like to take this opportunity to thank you in advance for considering this invitation to participate.

Yours sincerely,

Rodney Kebicz R.N. B.N.

Appendix D

Follow-up Invitation and Explanation of Study for Potential Study Participants

Approximately two (2) weeks ago you received an invitation to participate in a study being conducted by Rodney Kebicz a student in the Master of Nursing Program at the University of Manitoba. The study is entitled "The art of caring: Male nurses providing personal and intimate care with female patients". If you responded to the initial invitation please disregard this letter.

I am providing this reminder letter in the event that you may have misplaced the earlier letter and may be interested in participating. All male registered nurses working in a medical or surgical area within Health Sciences Centre have been sent letters. You were invited to participate in this study because I am interested in your experiences, perspectives, thoughts and perceptions regarding the provision of personal and intimate care with female patients. Also of interest (and the major purpose of this study) is to find out what strategies, behaviors or interventions you use when providing personal and intimate care with female patients.

If you agree to participate in this study you will be interviewed at your convenience for approximately one (1) hour at a mutually agreed upon time and place. A second one (1) hour interview may be required but would only be arranged if you agreed. You will be asked to sign a consent form prior to the actual interview occurring.

I would like to reinforce that there is absolutely no obligation on your part to participate. If you do decide to participate in the study you are free to withdraw at any time with no explanation necessary.

Could you please contact me at 788-8334 or 339-7705 if you are interested in participating in the study. If you have any questions or require any further information, please do not hesitate to contact me at the above number.

I would like to take this opportunity to thank you in advance for considering participating in this study.

Yours sincerely,

Rodney Kebicz R.N. B.N.

Appendix E

Invitation and Explanation of Study for Potential Study Participants Sent by Colleagues

My name is Rodney Kebicz and I am a student in the Master of Nursing Program at the University of Manitoba. For the thesis component of my program I am conducting a study entitled "The art of caring: Male nurses providing personal and intimate care to female patients". This is a dimension of nursing that is not well understood and there has been minimal research carried out in this area. To acquire a better understanding of this aspect of nursing I plan to interview male registered nurses who work in medical or surgical areas within this institution.

I would like to interview 10 to 20 male registered nurses who have during the course of their nursing careers provided personal and intimate care to female patients. I would like to gather information on the experiences, perspectives, thoughts and perceptions that male nurses have regarding the provision of personal and intimate care to female patients. I would also like to gather information about the possible strategies, behaviors or interventions utilized by these nurses when they provide personal and intimate care to female patients.

You have received this invitation to participate in this study because you are a male registered nurse who works in a medical or surgical area within the Health Sciences Center. On my behalf, your friend/colleague has agreed to forward this letter to you. If you agree to participate in this study you will be interviewed at your convenience for approximately one (1) hour at a mutually agreed upon time and place. A second one (1) hour interview may be required but would only be arranged if you agreed. You will be asked to sign a consent form prior to the actual interview occurring.

There is absolutely no obligation on your part to participate. If you do decide to participate in the study you are free to withdraw at any time without prejudice. I would appreciate it if you could contact me within one week at 788-8334 to confirm your participation in the study. If you have any questions or require any further information, please do not hesitate to contact me at the above number.

I would like to take this opportunity to thank you in advance for considering this invitation to participate.

Yours sincerely,

Rodney Kebicz R.N. B.N.

Appendix F

Structured and Semi-Structured Interview Sheet

Hello _____. Well first of all, I would like to take this opportunity to thank you for agreeing to participate in this study. Before we begin the actual interview I have some general information and demographic questions to ask.

1. What is your highest level of educational attainment?
2. What year did you become a RN?
3. Where did you graduate from?
4. What areas of nursing have you worked in?
5. What area of nursing are you currently working in?
6. Have you worked in any other field or occupation?
7. If so, what other field?
8. What brought you into nursing?
9. What is your marital status?
10. What is your age?

I am now going to ask you some questions that will require some reflection on your part. If you do not want to answer any question or feel in any way uncomfortable with the question or the necessary response please feel free to not answer or answer as you feel comfortable.

Concern/Issue

1. What prompted you to participate in this study?
2. Do you believe there is an issue or concern with male nurses providing personal and intimate care to female patients and if so, how extensive is the concern?
3. Do you believe there is less of a concern when female nurses provide personal and intimate care to male patients and if so, why?
4. What are your thoughts about whether or not this aspect of nursing should even be a concern in the care of patients of either gender?
5. How often do you have to provide personal and or intimate care to female patients?

Feelings/Attitude

6. What would you consider or how would you define personal and intimate care?
7. What makes the performance of personal and intimate care on a female patient easier or more difficult?
8. What are your thoughts about male nurses providing personal and intimate care for female patients?
9. Have you ever been in a situation where you yourself felt uncomfortable or had second thoughts about performing personal and intimate care on a female patient?

10. What are your thoughts about male nurses working in areas specifically requiring the provision of personal and intimate care for female patients (for example labour and delivery)?
11. Can you tell me about the most positive experience you ever had when performing personal and intimate care on a female patient?
12. Can you tell me about the most negative experience you ever had when performing personal and intimate care on a female patient?
13. Try remembering back to your student days. How did you feel or what were you thinking the first time you had to perform personal and intimate care on a female patient?

Interventions

14. How did you handle the situation?
15. What would you do differently now, that you did not do then?
16. How do you deal with the issue of intrusion into the personal space or privacy of a patient of the opposite sex?
17. How do you know if your female patient is uncomfortable with the care you are providing?
18. What strategies or interventions have you used that have enabled you to perform personal and intimate care on a female patient, without the patient feeling embarrassed or uncomfortable?
19. Do you believe that you are able to alleviate the psychological and/or emotional discomfort that may be felt by your female patients when you provide personal and intimate care?

Nursing Education

20. Remembering back to your student days again, what information would have benefited you regarding the provision of personal and intimate care for female patients?
21. If a male nursing student approached you with a concern as to how to deal with the performance of personal and intimate nursing care for a female patient, what would you tell him?
22. Would the inclusion of how to approach and perform the task of providing personal and intimate care for members of the opposite sex be beneficial in a nursing education curriculum?

Finally,

23. Is there anything else that you would like to comment on that has not been dealt with in the previous questions?
24. Are there any questions that you would like to have been asked, but were not?

Well, _____, thank you for your time.

Appendix G

Ethical Approval Access Committee at HSC

June 2, 1997
Joan Jenkins RN PhD
Director Nursing Education and Research
NA 138
700 McDermot Avenue
Winnipeg, Manitoba
R3E 0T2
Dear Dr. Jenkins:

My name is Rodney Kebicz and I am a student in the Master of Nursing Program at the University of Manitoba. I have completed my course work and have submitted my thesis proposal to the Faculty of Nursing Ethics Review Committee at the University of Manitoba.

My thesis is entitled "The art of caring: Male nurses providing personal and intimate care with female patients". This research study will utilize qualitative analysis with a micro ethnographic approach. To accomplish the necessary data collection I am requesting permission to gain access to 15 to 25 male registered nurses working at the Health Sciences Centre (HSC) on a medical or surgical unit.

With voluntary participation, and after informed consent has been obtained, I will interview the male nurses for approximately one hour (with the possibility of requiring a second one hour interview), during off-duty hours. The interview will explore the strategies, behaviors and interventions employed by male nurses to minimize any psychological or emotional discomfort that may be experienced when they perform personal and intimate care with female patients.

Please find enclosed, 50 copies of a letter entitled "Invitation and Explanation of Study for Potential Study Participants". I would appreciate it if these letters could be forwarded to male registered nurses working in medical or surgical areas within the HSC. If enough participants (eg. 15 - 25) have not responded within two weeks, I would kindly request that a second letter entitled "Follow-up Invitation and Explanation of Study for Potential Study Participants" be forwarded to the same potential participants (see attached copies).

If you require further information please contact me at 788-8334 or 339-7705 or, you can contact my thesis chairperson, Dr. David Gregory RN PhD at 474-6655.

I would like to take this opportunity to thank you and the Access Committee for considering my request.

Yours sincerely,
Rodney Kebicz RN BN

Appendix H

Consent Form for Study Participants

The art of caring: Male nurses providing personal and intimate care with female patients

You are being invited to participate in a study on the strategies, behaviors and interventions utilized by male nurses when personal and intimate care (eg. perineal care, urinary catheterizations, assisting with hygiene and elimination) is provided with female patients. The study is being conducted by Rodney Kebicz R.N. B.N., a student in the Master of Nursing Program at the University of Manitoba. You are being invited to participate in this study because you are a registered nurse, you work in a medical or surgical unit of an acute care hospital and you are male. Approval for this study has been obtained from the chair of the Access Committee at the Health Sciences Centre and the Ethical Review Committee of the Faculty of Nursing, University of Manitoba.

Your participation in this study is entirely voluntary. If you agree to participate in the study your involvement will entail:

Being interviewed about the strategies, behaviors or interventions that you use when you provide personal and or intimate care with female patients. The interview will take approximately one (1) hour and will be accomplished during off-duty hours, at your convenience, at a mutually agreed upon private setting. With your permission, the interview will be audio tape recorded and later transcribed verbatim to ensure a complete and accurate representation of the interview had taken place. If you agree, a second interview may occur if additional information or clarification/confirmation of information is required. This interview would follow the same format as the initial interview.

Confidentiality

Your name, or any other identifying characteristics will not appear on any record, document or in any publication related to this study. Participants in the study will be assigned an individual code number to ensure anonymity.

No information will be shared in any way that would enable you or any of your patients to be traced and or identified. The only persons having access to the interview transcripts will be myself, the members of my thesis committee and possibly a transcriptionist who will be briefed on issues of confidentiality. The transcripts will be only be identifiable by a code number. When the tape is transcribed, any contextual and situational information will be altered or omitted to protect the identity of you and your patients.

All documents, tapes, transcripts and consent forms will be locked in a locked filing

cabinet for a minimum of seven and a maximum of ten years after which time they will be destroyed.

Voluntary Participation

As previously stated, participation in this study is strictly voluntary. You are free to withdraw from this study at any time, without question or prejudice.

Throughout the interview, any question can be refused and or the interview terminated at any time.

During the interview, you are free to request that no audio tape recording be used, or, that the tape recorder be turned off at any time.

Benefits and Risks

There are no identified direct benefits to you for taking part in this study. It is possible that reflecting on your practice may increase your awareness and sensitivity regarding the situations discussed. It is also possible that information gleaned from this research may affect your or other nurses nursing practice in the future.

The only identified risk to yourself for participating in this study is the possibility of mild psychological or emotional discomfort resulting from the sharing of personal information. If at any time you feel uncomfortable with the interview, the interview can be altered, delayed or terminated. There is also the acknowledged inconvenience of being interviewed for at least one (1) hour and possibly two (2) hours (if a second interview is agreed to and required).

Your signature on this form indicates that you have:

1. Read and understand the purpose of this study.
2. Agreed to and understand your role as a study participant.
3. Had all questions, concerns or uncertainties addressed and or answered to your satisfaction by Rodney Kebicz.
4. Voluntarily agreed to participate.

Signing this form does not preclude you from withdrawing from this study at any time, if you so desire. A copy of this form will be provided for you to keep for your records. If you wish to contact me I can be reached at 788-8334.

If you have further questions or concerns that you do not wish to direct to me, or if I am unavailable, you can contact any member of my thesis committee. My committee is comprised as follows:

Chairperson: Dr. David Gregory
Faculty of Nursing, University of Manitoba
Phone: 474-6655

Internal Member: Professor John English
Associate Professor, Brandon University
Phone: (204) 727-7457

External Member: Dr. Evelyn (Lyn) Ferguson
Faculty of Social Work, University of Manitoba
Phone: 474-6670

Date: _____ Participant's Signature:

Date: _____ Researcher's Signature:

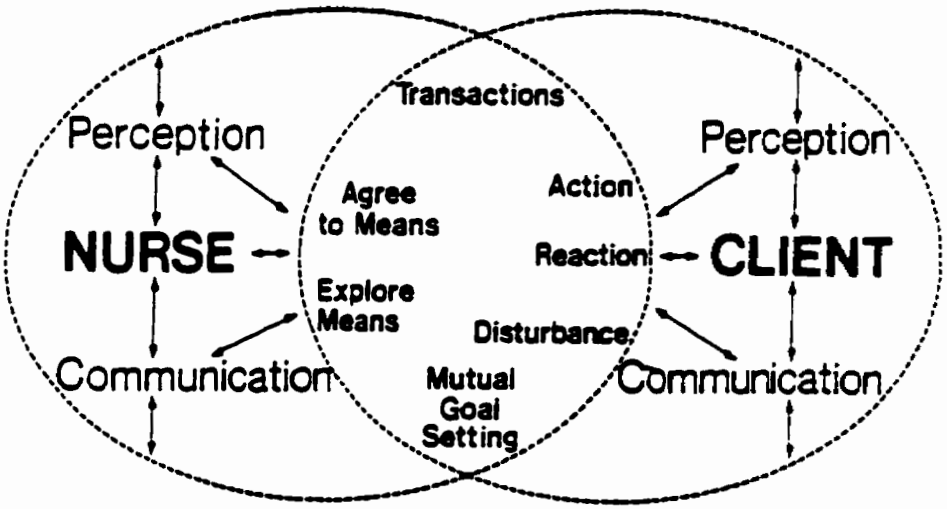
If you wish to receive a summary of the study results, please write your name and mailing address below. A copy will be forwarded to you once the study is completed.

Name:

Address:

Appendix I

Diagram of a Theory of Goal Attainment



Taken from: King. I. M. (1981). A theory for nursing: Systems, concepts, process. John Wiley & Sons: New York.