The Normalization of Silencing: The Interplay between Nurses' Experience of Working Conditions and Gender Equality Ideals

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Horft framhjá þöggun: Samspil reynslu hjúkrunarfræðinga af vinnuskilyrðum og hugsjóna um jafnrétti kynja

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Abstract

Despite Iceland's reputation as one of the most gender equal countries in the world and the idea that gender equality is an intrinsic part of Iceland's national identity, the country's labor market is highly gender segregated. This is particularly the case in female-dominated sectors such as education and the caring professions. As a case in point men make up about 5% of nursing staff in Iceland, which is low compared to countries with similar levels of gender equality, such as the other Nordic countries. As a female-dominated profession, nursing has long been linked to vocation and altruism, where the commitment to help and care for others is considered one of the most fundamental attributes of the professions' identity. The feminized construct of care may be a key factor in discouraging men in Iceland from entering the nursing profession. Moreover, working conditions of nurses in Iceland have been characterized by understaffing and high rates of attrition due to work-related health problems. Considering the gender imbalance in the nursing profession, the aim of this dissertation is to explore nurses' perceptions of the interplay between their working conditions and gender equality ideals in Iceland, focusing on power relations and occupational well-being.

The dissertation is based on data collected through semi-structured interviews with 31 nurses working at the National University Hospital of Iceland, 24 women and 7 men. The interviews centered on the participants' expectations for the job and what prompted them to become nurses. Working arrangements, the impact of working conditions on their health, communication and cooperation with colleagues and supervisors and possibilities for autonomy and professional development were also topics of discussion. In the first article the theoretical approach describes the multiple and often incompatible tasks of nurses. The other two articles draw on social constructionist and poststructuralist feminist theories. Analysis of the interviews was guided by reflexive thematic analysis, and the results were presented in three articles.

The first article addresses various dimensions of power dynamics in the nurses' work, considering the demanding working conditions, interactions and cooperation with other professions and the effects of the gender imbalance. The findings reveal that the working life of the participants is characterized by deep-rooted traditions concerning gender and roles in the hospital hierarchy. As a symbol of the power imbalances and restricted autonomy which they experience, nurses' working space and professional boundaries are spatially and symbolically neglected by other professionals. The result is the nurses feel that their professionalism is undermined. To deliver necessary professional care, they make compromises at the expense of their own health. This sometimes borders on being unethical, while the nurses seek a balance between their professional conviction and expectations of the organization. In their opinion, attracting

more men nurses could enhance equality and positive atmosphere. Working on wards with a balanced gender ratio is for them a liberating experience.

The second article focuses on effects of gender-based stereotypes on career choices and work life of the participants, in which these stereotypes turn out to have substantial influence. The women describe how they glid 'naturally' into nursing while the men faced that ideas of masculinity classified them as deviant. The men also had to define for themselves the content of nursing and caring to justify their place in the profession. Stereotyping also strongly influence on-the-job experiences of woman nurses, whose work contributions and knowledge tend to be less valued than those of the men nurses due to notions that associate women with weakness and submission. The woman nurses believe that men nurses can be positive role models for them in being assertive and speak their mind when they are subjected to oppressive behavior.

The third article addresses how nurses' prior expectations for the job compare to their actual work life. The findings reveal how stereotypes about feminine submission prevail on the wards where only women nurses work. Strict rules require the nurses to stay on the ward for the entire shift, resulting in gender isolation from participating in the general space of the hospital. They experience a lack of trust and support from their superiors, and that the hospital management practices put the hospital's interests above the nurses' well-being. This experience of indifference has harmful effects for nurses, their clients and many parts of society. It is a major cause of nurses leaving work and influences their experience of discrepancy between their aspirations for the job and reality of work. Most of the female participants had found it difficult to make ends meet financially and workload had negatively affected them and their families.

The results from the articles indicate that the feminization of nursing as subservient helps explain the associated gender imbalance and disempowerment nurses experience at work. Attracting more men nurses could enhance gender equality but may prove difficult due to gendered stereotypes of nurses. It is also a task that requires extensive societal discussion on the power of stereotyping and the definition of gender equality. Considering the nurses' poor working conditions, hospital management must revise the occupational policy and qualification requirements of managers and supervisors. The situation may be different in other nurses' workplaces.

In this dissertation, my assumptions are that a profession's gender equality status must be understood/examined in the context of working conditions, health protection, professional recognition, autonomy and respect. The findings indicate that the participants experience unhealthy working conditions and a lack of support from their supervisors and the hospital management. Strong hierarchical power, sustained by stereotypical essentialist ideas, limits nurses' professional recognition. The findings also indicate that the feminization of nursing disempowers women nurses and deters men from entering the nursing profession. It can therefore be concluded that the participants do not enjoy the rights and conditions that are prerequisites for gender equality.

Keywords: Gender, nursing, hospital management, professional boundaries, masculinities

Ágrip

Þótt talið sé að á Íslandi sé kynjajafnrétti með því mesta í heimi og að hugmyndin hafi mótað síðari tíma þjóðarvitund, er vinnumarkaðurinn mjög kynskiptur. Það á sérstaklega við þar sem konur eru í meirihluta, svo sem í kennara- og umönnunarstéttum. Karlar eru um 5% hjúkrunarfræðinga, sem er lágt hlutfall samanborið við lönd sem Ísland hefur verið talið standa jafnfætis í kynjajafnrétti, svo sem hin Norðurlöndin. Sem kvennastétt hefur hjúkrun gegnum tíðina verið tengd köllun og fórnfýsi, þar sem viljinn til að hjálpa og annast aðra er talinn einn helsti þáttur í ímynd stéttarinnar. Það má vera að hugtakið umhyggja, sem hefur á sér blæ kvenlægni í merkingunni undirgefni, sé lykilþáttur í því að letja karla á Íslandi frá að hefja feril í hjúkrun. Starfsaðstæður hjúkrunarfræðinga á Íslandi einkennast af undirmönnun og fjöldi þeirra hættir störfum vegna vinnutengdra heilsufarsvandamála. Með hliðsjón af kynjahallanum í hjúkrunarstéttinni er meginmarkmið verkefnisins að kanna upplifun þátttakenda af samspili vinnuskilyrða og hugmynda um kynjajafnrétti á Íslandi, með áherslu á valdatengsl og líðan í starfi.

Verkefnið byggir á hálfstöðluðum viðtölum við 31 hjúkrunarfræðing sem starfa á Landspítala - Háskólasjúkrahúsi, 24 konur og 7 karla. Viðtölin snerust um væntingar þátttakenda til starfsins og hvað hafi haft áhrif á þá ákvörðun að verða hjúkrunarfræðingur. Vinnufyrirkomulag, áhrif vinnuskilyrða á líðan og heilsu, samskipti og samstarf við samstarfsmenn og yfirmenn, svo og möguleikar á sjálfræði og faglegri þróun voru einnig umræðuefni. Í fyrstu greininni varpar fræðilega nálgunin ljósi á fjölmörg og oft ósamrýmanleg verkefni hjúkrunarfræðinga. Í hinum greinunum er stuðst við sjónarhorn félagslegrar mótunarhyggju og póststrúktúralískar femínískar kenningar. Viðtölin voru þemagreind og niðurstöðurnar settar fram í þremur greinum.

Fyrsta greinin fjallar um ýmsar hliðar valdasamspils í starfi þátttakenda, með hliðsjón af krefjandi vinnuskilyrðum, samskiptum og samstarfi við aðrar stéttir og áhrifum kynjahalla. Niðurstöðurnar sýna að starf þátttakenda einkennist af rótgrónum hefðum um kyngervi, þ.e. félagslega mótað kyn, og hlutverk í stigveldi sjúkrahússins. Sem tákn um það valdaójafnvægi og skerðingu á sjálfræði sem þátttakendur upplifa er að rýmislegt og táknrænt vinnurými þeirra og fagleg mörk eru lítt sýnileg öðru fagfólki, sem þátttakendum finnst vera vanmat á fagmennsku þeirra. Til að finna jafnvægi milli faglegrar sannfæringar sinnar og væntinga stofnunarinnar gera þeir málamiðlanir á kostnað eigin heilsu sem geta verið á mörkum hins siðlega. Þátttakendur telja fjölgun karlkyns hjúkrunarfræðinga geta stuðlað að auknu jafnrétti og jákvæðu andrúmslofti, sem er reynsla þeirra af deildum með tiltölulega jafnt kynjahlutfall.

Í annarri greininni er fjallað um hvernig staðalmyndir um karlmennsku og kvenleika móta starf hjúkrunarfræðinga. Sögur þátttakenda sýna áhrif staðalmynda um kyn á starfsval þeirra og daglegt starf. Val kvenna er talið eðlilegt, en karlar glíma við ýmsar hindranir vegna þess hve fáir þeir eru og sem frávik frá hefðum. Þessar staðalmyndir hafa áhrif á starfið, samskipti og aðgang að úrræðum, en vinnuframlag og þekking

kvenkyns hjúkrunarfræðinga er minna metin af öðrum fagstéttum en þekking karla. Karlarnir lýstu því hvernig þeir, eftir vandlega íhugun, yfirstigu hindranir rótgróinna hugmynda og viðmiða og fóru í hjúkrun, en hafa jafnframt þurft að skilgreina sjálfir inntak hjúkrunar til að réttlæta stöðu sína í stéttinni og tilheyra henni. Kvenkyns hjúkrunarfræðingar hafa minna táknrænt rými og áræðni en þeir karlkyns til að koma kvörtunum og skoðunum á framfæri þegar þær mæta yfirgangi, og telja karlana geta verið jákvæða fyrirmynd þar.

Þriðja greinin fjallar um að hvernig væntingar sem hjúkrunarfræðingar höfðu til starfsins í upphafi ferils samræmast veruleika í starfi. Niðurstöður sýna að ímynd hjúkrunar, tengd undirgefni, er ríkjandi á deildum þar sem eingöngu kvenkyns hjúkrunarfræðingar starfa. Þar gilda strangar reglur um viðveru og þess krafist að þær yfirgefi ekki deild yfir vaktina. Þetta leiðir til kynbundinnar einangrunar þar sem hjúkrunarfræðingarnir fara á mis við þátttöku í almennu rými sjúkrahússins. Þeir upplifa skort á trausti og stuðningi í samskiptum við yfirmenn og að stjórnunarhættir sjúkrahússins miðist við hagsmuni sjúkrahússins á kostnað velferðar þeirra. Skeytingarleysi yfirmanna hefur skaðleg áhrif á hjúkrunarfræðinga, sjúklinga þeirra, aðstandendur og víða í samfélaginu. Það er jafnframt ein helsta orsök þess að hjúkrunarfræðingar hætta störfum og ýtir undir upplifun þeirra af misræmi milli væntinga til starfsins og raunveruleikans. Flestir kvenkyns þátttakendur höfðu glímt við bágan fjárhag og vinnuálagið hafði haft ýmis slæm áhrif á þær og fjölskyldur þeirra.

Niðurstöður benda til þess að (kven)ímyndir hjúkrunar tengdar undirgefni eigi þátt í að útskýra kynjahallann í stéttinni og hindri valdeflingu hjúkrunarfræðinga. Að laða að fleiri karlkyns hjúkrunarfræðinga gæti valdeflt stéttina en valdaleysi og erfiðar vinnuaðstæður fæla ef til vill burt þá karla sem hafa áhuga á starfinu. Þessi staða krefst samfélagslegrar umræðu um áhrif staðalmynda og skilgreiningar á jafnrétti kynjanna. Þar sem stór kvennastétt hjúkrunarfræðinga starfar við óásættanlegar og hættulegar aðstæður þarf stjórn sjúkrahússins að endurskoða starfsmannastefnu, og hæfniskröfur yfirmanna hjúkrunarfræðinga og annarra stjórnenda. Hugsanlega er staðan önnur á öðrum vinnustöðum hjúkrunarfræðinga.

Í þessari ritgerð eru forsendur mínar þær að jafnrétti kynja í fagstétt verði að skilja og skoða í samhengi vinnuskilyrða, heilsuverndar og faglegrar viðurkenningar og virðingar. Með hliðsjón af markmiði verkefnisins, sem lýst er hér að ofan, benda niðurstöður til þess að starfsaðstæður þátttakenda séu heilsuspillandi og þá skorti stuðning frá yfirmönnum og sjúkrahússtjórn. Eðlishyggja og staðalímyndir um undirgefni viðhalda stigveldinu, valdaleysi hjúkrunarfræðinga og kynjaslagsíðunni. Það á sinn þátt í að letja karla frá því að hefja nám og störf við hjúkrun. Því má álykta að þátttakendur njóti ekki þeirra réttinda og skilyrða sem eru forsendur kynjajafnréttis.

Leitarorð: Kyngervi, hjúkrun, stjórnun sjúkrahúsa, fagleg mörk, karlmennska

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Preface

Prior to my nursing studies at the University of Iceland, I had worked at hospitals since I was 18. While living abroad, I took several courses in sociology and worked in health care. After returning home, I started my career in nursing, which in many ways was rewarding and meaningful. I then had an on-the-job accident at the hospital while preventing a patient from falling. At that time, I resumed studying sociology at the University of Iceland. I then quit my permanent job, but I have since worked as a substitute nurse, for example filling in for nurses on sick leave. This role has given me freedom, distance and diverse experience, because I am not confined to one department. Over the years, especially in the wake of my injury, I have become increasingly aware of and critical of the working conditions at the hospital.

During my undergraduate studies in sociology, I took a course on ergonomics in 2017, where one of the projects was to apply a measurement tool from The Administration of Occupational Safety and Health to examine work-related risks of employees at a workplace. The measuring instrument, Workplace Risk Assessment, contained items such as work-related accidents, stress and rest, and was designed to measure objective rather than subjective factors. The participants, all women, comprised the nurses in one ward at the National University Hospital of Iceland. The results revealed that they all had suffered several accidents while at work, with musculoskeletal injuries that affected their well-being and working ability. Often these incidents went unreported to supervisors and hospital management. In discussions following the assessment, the nurses talked about how they had blamed themselves for the incidents. They assumed they could have done something differently, or that the job entails these risks, and injuries are therefore unavoidable. They shared that the incidents/accidents most often occurred in conditions where there was understaffing, a lack of aiding equipment or a sudden change or deterioration in the health of patients. During these discussions, I realized that I had also suffered a work-related accident, a revelation that was both shocking and liberating.

Years before the incident, I had been a shop steward for two wards, which included finding solutions for nurses whose rights had been violated. They sought assistance for issues related, for instance, to wage inequality among the nurses on the wards, which arose due to wage secrecy rules, lateral violence, and repeated violations of rules on rest between shifts. Due to power relations in the hospital, there was little success. Through these experiences, I came to realize how disempowered the nurses were, and that their well-being was routinely neglected by the occupational health and safety policy of the hospital and management. The work-life reality of these nurses did not fit

the idealized image of women in Iceland as independent and empowered. There were discrepancies that needed a clearer explanation. This motivated me to pursue a doctorate after my MA studies.

In the working process of this dissertation, I have sought to be aware of how the balance between the participant's experience and the researcher's is delicate. When exploring a field one is familiar with and interviewing individuals with similar working backgrounds, this is important, it concerns trust and professional work practices in the research process. In the chapter of data and methods I will discuss these aspects in more detail.

1 Introduction

1.1 The Objective and Scientific Value of the Study

The overall aim of this dissertation is to explore the interplay between nurses' experiences of working conditions and gender equality ideals in Iceland. Considering the gender imbalance in the nursing profession, the focus is on power relations and occupational well-being. This research is pressing and important; the findings may shed light on why despite Iceland's reputation as one of the most gender equal countries in the world and the idea that gender equality is an intrinsic part of Iceland's national identity, men make up about 5% of nursing staff. Through the participants' stories the interviewing method can reveal underlying power structures, which affect nurses' work life. The importance of the dissertation also lies in that existing literature indicates that there is a glaring discrepancy between the level of education and responsibilities of nurses on the one hand and working conditions that are often detrimental to health on the other. Research suggests that in Iceland as well as worldwide, nurses' working conditions are stressful, resulting in health hazards, burnout, and high turnover rates (Brynjólfsdóttir, 2018; Donnelly, 2014; Happell et al., 2013; Johnson, 2011; Lu et al., 2019; Marc et al., 2019; Simard & Parent-Lamarche, 2021). Work-related events, such as musculoskeletal injuries, are seldom reported and the culture of healthcare organizations often lacks a channel for support and complaints from nurses (Mullen, 2015; Vendittelli et al., 2016). It has been asserted that the hero discourse, glorification of nurses and their work, has been used by health systems as a regulating tool to ignore workload and understaffing (Kubsch et al., 2021; Mohammed et al., 2021; Stokes-Parish et al., 2020; Teresa-Morales et al., 2022).

In the hospital environment where conditions of clients change rapidly and where understaffing is persistent, nurses' professional ethics towards their clients is a top priority. Situations can require that responsibility for the well-being and safety of clients outweigh those of nurses. Work-related health issues and injuries are therefore often overlooked, assessed subjectively, and thereby downplayed. As an ongoing problem in the nursing profession, only a fraction of work-related events such as musculoskeletal injuries are reported (Vendittelli et al., 2016). Subjective assessments are situational and depend on the priorities of the work, responsibility of nurses and on personal judgment. Incidents are often interpreted as a normal by-product of work, as the consequences are not measured objectively by medical research when musculoskeletal injury is suspected. Subjective assessment may reinforce outdated ideas of femininization and altruism in nursing, which play a crucial role in nurses' lack of

autonomy and disempowered position in the hospital hierarchy (Kubsch et al., 2021; Prosen, 2022), contradicting professionalism (Girvin et al., 2016; Slettmyr et al., 2017).

The primary assumption undergirding this dissertation is that a profession's gender equality status must be understood/examined in the context of working conditions, health protection, and overall professional recognition, autonomy and respect. As I will later discuss in greater detail, I utilize poststructural feminism to shed light on power structures in institutions and to emphasize the social construction of gender, in order to critically analyze and expose the gender-based stereotypes that contribute to the marginalization and oppression of nurses. The importance also lies in the fact that many nurses have not been willing to participate with feminists, (as I will discuss in section 3.1.2), maybe due to said feminists' notions often portraying nurses as submissive, which nurses may have understood as if the caring aspect of their profession was being devalued.

Despite the relevance of nurses' circumstances to feminist analysis, many nurses have been reluctant to work with feminists. It is partly because feminists have kept up the image of nurses as submissive and of their place in the hierarchy as a manifestation of oppression. Seeing feminists' position in a man's world of theory and power can be at odds with nurses' self-identities as women, meaning theory is incompatible with care (Green, 2012). It masks the ability to think critically through a feminist lens, and therefore nurses accept their status as subjects in health service, not agents.

Although most nurses are women, gender biases in the profession impact men as well. In the working environment, gender discrimination—for instance, regarding sexuality or intelligence—contributes to lower job satisfaction among men nurses compared to their female peers and leads to feelings of marginalization (Kim & Lee, 2019; Sasa, 2019). Having a man nurse role-model they can identify with can challenge stereotyping (Teresa-Morales et al., 2022; Terry et al., 2020). It is essential to take steps to challenge gendered stigmatization against the nursing profession that categorizes people according to stereotypes, and to promote the idea that people of all genders and backgrounds can be carers (Elliott, 2016; Sasa, 2019; Stewart et al., 2021; Younas et al., 2022). I have found no Icelandic research on nurses' working situations from a gendered angle.

1.1.1 The Icelandic Context

Iceland's high ranking in gender equality measurements in the global context is primarily explained by successful women's rights movements and solidarity campaigns against discrimination (e.g. sexual harassment and abuse) and in favor of genders sharing power and decision-making. Still, a significant adjusted gender pay gap exists in Iceland (World Economic Forum, 2025), which has stimulated more nuanced discussions about assessing the value of various professions populated primarily by

women, such as nursing and education. In Iceland those professions have high educational requirements, and nursing has been taught at the university level since 1973, with a Bachelor of Science degree earned after 4 years or a Master of Science degree after 6 years (The University of Iceland, 2025). Despite Iceland's international reputation, as a paradise of gender equality (Erlingsdóttir, 2021) some professions are mostly occupied by women; as a case in point in 2023 men made up only about 4% of nurses (The Icelandic Nurses' Association, 2023). Their share had increased by two percentage points between 2021 and 2023 (from 2%). According to Guðbjörg Pálsdóttir, president of The Icelandic Nurses' Association, this increase is to some extent due to foreign men nurses who have moved to Iceland. New numbers for 2024 show an overall increase to 5% (personal communication, March 20, 2025).

In 2021, The Icelandic Nurses' Association conducted a survey on public views of men nurses. The findings were encouraging, revealing that people in Iceland generally have a positive attitude towards men nurses. Moreover, 92% of respondents did not think that the gender of a nurse matters when they receive nursing services. The respondents believe that the same positive personal qualities characterize male and women nurses (Daníelsdóttir et al., 2021).

While the lack of men nurses further exacerbates Iceland's serious nursing staff shortage, the nursing work force is missing men's participation. The gender composition of Iceland's nursing profession is far from reflecting the society's gender ratio. The country's attempts to attract men to the profession—such as an experimental project run since 2018 where male students were exempted from paying school fees—have been largely unsuccessful (Icelandic Ministry of Health, 2020). A two-year effort launched in the fall of 2001 aimed to get more men into nursing. It included, e.g., an advertising campaign and presentations in upper secondary schools. The year after the campaign, many more men enrolled in nursing programs than ever before. However, that number did not carry over to the second year, possibly because the men nursing students experienced uncomfortable attention from students and teachers due to their gender, or did not get through clausus (Kristinsson, 2005).

Promoting nursing through masculine images such as in the acute fields, such as in emergency settings and intensive care departments, as has been done in Iceland, has proved ineffective. Nursing images were then pictured in a gendered manner, maybe discouraging those not looking for that.

To help challenging stereotyping of nurses and nursing orderlies and to arouse boys' interest in nursing, the project *Nursing Boys* was implemented in 2021 and 2022 for boys in 9th grade at some lower secondary schools in Reykjavik and Akureyri. This was a collaborative project between the Gender Equality Committee of the National University Hospital of Iceland and the nursing faculties of the University of Iceland and the University of Akureyri. Workshops for boys were set up and an effort was made to

actively involve the boys with some nursing interventions, for example through role playing. Time will tell whether the project will have a positive impact (Ingadóttir, 2023).

For men, the feminized construct of caring is a significant barrier to choosing a career in nursing; the roles and norms within nursing education and science contradict traditional masculine roles (Baker et al., 2023; Salamonson et al., 2023; Teresa-Morales et al., 2022; Younas et al., 2022; Zeb et al., 2020). The question of why men in Iceland do not study nursing has been frequently asked, and many possible explanations are available—for example, cultural and historical ideas of gendered qualities may cause men to feel that they are undermining (Nordic) masculinity by entering the caring profession. The primary explanation is probably that nursing simply doesn't cross men's minds as an option, because the profession is broadly assumed to be an exclusively female occupation (Gíslason, 2005). In Iceland there are perhaps more entrenched ideas about gender roles than has been assumed in the equality debate, and which potentially hinder equality. This will be explained in section 1.1.3 on the Nordic paradox. The small size of Icelandic society is also worth considering, which may mean that those who follow unconventional paths are more prominent than in larger societies. Men who might want to enter nursing also have few role models and perhaps the fear of being labeled gay is a hindrance.

1.1.2 The Nordic paradox

In countries that rank highly on gender equality indexes, for instance Iceland and Norway, transferring societal values to individual-level values and practices may meet obstacles, leading to the so-called Nordic gender equality paradox (Minelgaite et al., 2020). Gender imbalance acting as self-sustaining in female-dominated professions such as care work and teaching is considered an indicator of this paradox (Lähteenmäki-Smith et al., 2023), and is partly maintained by gender stereotypes (Ellemers, 2018; Rippon, 2019; Sánchez-Rodríguez et al., 2023; Stewart et al., 2021).

In the Nordic countries, various policy initiatives have been aimed at correcting the gender imbalance in nursing, such as implementing gender quotas in nursing schools to attract men nurses. In Norway, these policies appear promising: in 2021, about 10% of Norway's nurses were men, and their number increased to about 11,8% in 2023 (Statistics Norway, 2025). The aim of such actions is also to secure a sufficient future workforce and to provide a diverse nursing staff that reflects the multiple backgrounds and needs of patients (Nordfjell & Nielsen, 2019).

1.1.3 Research questions

This dissertation tackles the contradiction between the position of Iceland on the international scale of gender equality and the working conditions of nurses, in terms of health, gender diversity and equality, professional respect and autonomy. Consequently, the research questions are the following:

- How do the participants perceive their working experience considering Iceland's reputation for gender equality? This question covers how nurses' work, skills and education are evaluated by other professions and the management within the health system. The focus is on opportunities for occupational health and safety, autonomy, professional respect, managerial support, and professional growth.

- To what extent do nurses experience stereotypical and essential ideas of gender differences and qualities from colleagues, from other professions or clients (patients and their relatives), friends and family, and/or wider society? How do those ideas and related expectations affect nurses' choice of profession, work-related well-being and power relations at work?

The scientific value of this dissertation lies in its feminist, poststructuralist approach to understanding nurses' experiences of gender imbalance and stereotyping in nursing. As the approach views gender difference as a social creation, nurses' situation in the hospital hierarchy is viewed in relation to the social construction of gender. To my knowledge, this dissertation is the first work of scholarship to apply a poststructuralist lens to research on the nursing profession in Iceland. Such a lens opens the door to identifying underlying power structures and essentialist ideas and to correcting gendered assumptions about nursing. These findings can hopefully benefit those interested in entering the nursing profession, attract young men to nursing education and/or help to equalizing the gender imbalance in nursing. The literature and the findings in the dissertation can generate discussion among nursing students and give them insight into theories of power structures and gender diversity in the nursing profession. Finally, the stories of the participants in this dissertation may provide important data that can be used to improve working conditions and hospital managemental culture.

The next chapter defines and contextualizes the dissertation's key concepts.

1.2 Terminology

1.2.1 Gender

In the 1970s, feminist social scientists began to use the term 'gender' to distinguish analytically between biological and social forms of sex and what had been called sex roles (Haig, 2004). The definition of the term gender is not absolute but varies between disciplines. From a sociological perspective, the definition is that gender is a socially constructed set of actions that are not necessarily tied to one's biological sex. This is illustrated e.g. by the notion of 'doing gender' by West & Zimmerman (1987), and Judith Butler's (1988) notion of 'performative gender'. Gender relations intersect with all other social factors, and gender is one of society's key guides for making sense

of self and others and for organizing social behavior (Martin & Slepian, 2021; Ridgeway, 2011). According to some scholars, people feel they must hold each other accountable to cultural norms and socially defined behaviors of gender performance for mutual predictability and to determine the position and identity of people in a social group (West & Zimmerman, 1987).

A poststructuralist feminist perspective emphasizes the social construction of gender. In this view, gender is formed and maintained by institutions through interactions with others in society and plays a central role in establishing and maintaining power relations (Prasad, 2018). Poststructural feminist theories challenge gender categories as dual and fixed, arguing instead that they are fluid and belong to multiple categories (Cheek, 2000; Cornwall, 2007).

Here, I draw on the poststructural feminist works of Judith Butler (1988, 1990, 2008), whose notion of gender performativity challenges the heteronormative ideas of gender and binary oppositions of men and women and their alleged inborn distinctions. According to Butler, gender must be understood as a fluid and socially constructed phenomenon: all bodies are gendered from the beginning of their social existence and cultural inscription. The ontological stance is that there is no 'reality' or 'gender' before human perception and discourse; reality is produced through a process of regularized, constrained and repetitive constitutive acts. The repetitiveness of gendered acts is performative if it produces a series of effects. The acts follow society's scripted expectations and norms and serve a social policy of gender regulation and control; they legitimize and sustain suppressive situations, as the subject has a limited number of 'costumes' from which to make a constrained choice of gender style (Butler, 1988, p. 528).

As gender identity is established through behavior, different genders can be constructed via different behaviors, and gender may be conceptualized not as something one 'is', but something one 'does.' Performance is not a singular 'act' or event, but rather a ritualized production. Repetitive acts can evolve over time and are rarely static, although individuals can come to think of their behaving as a sign of natural qualities (Butler, 2008). The notion of gender performativity helps to explain how unequal gender regimes persist, as individuals adhere to existing norms and ideas of roles. As for the feminized construct of nursing, through repetitive learned acts, nurses perform and 'do' gender to fit the accepted norms associated with 'doing' nursing.

1.2.2 Gender binary

Gender binary describes the system in which a society slots its members into one of two sets of gender roles and gender identities, which assign attributes based on their biological sex (chromosomal and genitalia) (Lorber & Moore, 2007). Gender binary also refers to the classification of gender into two distinct forms—

masculine and feminine—whether by social system, cultural belief, or both simultaneously (Card, 1994; Garber, 1997; Rosenblum, 1999). Most cultures use a gender binary by highlighting two genders, men and women (Maddux & Winstead, 2019; Sigelman & Rider, 2017).

For this dissertation, the term 'gender binary' is important in relation to the feminized and gendered nature of nursing, the gender imbalance in the profession and power relations of nurses in their workplace. As mentioned in section 1.2.1, poststructuralist feminism emphasizes the social construction of gender and its effects on power relations (Prasad, 2018, p. 187; Judith Butler, 1988, 1990, 2008). Similarly, Lorber (1993) has argued that failing to question the practice of dividing people into these two groups confirms the fact that the gender dichotomy is arbitrary and leads to false expectations of both men and women, as they often find more significant within-group differences than between-group. Abed et al. (2019), Lorber (1993) and Wickham et al. (2023) have argued for replacing binary categories of femininity and masculinity with more fluid constructs of gender. For the nursing profession, it would be beneficial for the gender imbalance and an important step towards equality and reflect society, as diversity and innovation in the profession suffer and are limited by traditional binary gender roles and norms which are imposed and reinforced within nursing education and science.

1.2.3 Gender essentialism

Gender essentialism is a form of essentialism which attributes distinct, intrinsic, biological and/or psychological traits to men and women (Hepburn, 2003; Heyman & Giles, 2006). Examples of gender essentialist thinking include, for instance, the claim that women are naturally more nurturing or emotional than men. Many feminist theorists have rejected gender essentialism as it tends to oversimplify the complexity of human identity and diversity, reinforcing and perpetuating stereotypes and prejudices (Stone, 2004). Moreover, it disregards the strong influence of social, cultural, or environmental factors (Devitt, 2008).

This dissertation focuses on how nurses' work has been branded as low-skilled women's work, and aims to deconstruct linguistic expressions and idiomatic phrases, such as nurses being trained handmaidens to doctors. Some of the discourses and stereotypes appear in the essentialist emphasis on the caring and protective factor, based on the assumption that gender roles, culture and behavior are determined by individuals' nature and biological functions. These dominant perceptions continue to impact professional identity and relationships (Smith, 2019; Wolfenden, 2011) and stand in stark contrast to the profession's academic- and skills requirements. As previously discussed, gendered assumptions about nursing have also contributed to the low representation of men in the profession as well as poor retention and recruitment of males in the profession (Girvin et al., 2016).

1.2.4 Stereotyping

Stereotypes have been defined as fixed and often unfair or untrue beliefs, cognitive structures and behavioral expectations about a type of person and/or social group. Stereotypes often justify and legitimize power relations and roles and are developed through socialization (Hinton, 2019). Ideologies that perpetuate the gender inequality can be explained, in part, by gender stereotypes, regardless of the gender composition of the group in question (Casad & Wexler, 2017; Ellemers, 2018; Rippon, 2019; Sánchez-Rodríguez et al., 2023; Stewart et al., 2021). Role stereotyping of gender occurs when individuals are ascribed overgeneralized characteristics based solely on their gender (United Nations, 2014).

The nursing profession is rife with gender stereotypes, most notably that nursing is a feminine profession connoting powerlessness and submission (van der Cingel & Brouwer, 2021). Gender biases are partly maintained by gender stereotypes (Ellemers, 2018; Rippon, 2019; Sánchez-Rodríguez et al., 2023; Stewart et al., 2021), such as images linking femininity, nursing ability, and nurturing.

In section 3.2, on stereotyping and gender, I will describe in detail various aspects of stereotyping.

1.2.5 Hegemonic masculinity

In this dissertation, I use the term hegemonic masculinity in reference to men nurses' position in the hospital hierarchy, as a minority in an undervalued, female-dominated profession. Hegemonic masculinity is defined as a pattern of practice which legitimizes men's dominant position in society and justifies the subordination of other marginalized ways of being a man and is considered superior to femininity (Connell, 2005). It represents the most culturally honored form of masculinity (Connell & Messerschmidt, 2005). When men subvert hegemonic masculinity by entering a female field such as nursing—a process some scholars call 'crossing over'—they put their masculine image in jeopardy (Baker et al., 2023; Connell, 2005:78; Harding, 2007). Discourses of hierarchical power and how privilege is constructed are also challenged in masculinity studies. Anderson & McCormack (2017) argue in their approach to 'inclusive masculinity' that when men increasingly challenge traditional ways of being, it should reduce stigma for those men wanting to enter traditional female jobs. Following Elliott's (2016) concept of caring masculinities this means redefining gender roles.

1.2.6 Hospital hierarchy

Regardless of nurses' high educational level and professional expertise, their working conditions are characterized by strong hierarchical organizational structure; these environments are generally stressful and unhealthy, with high turnover rates, and lack managerial support (Lu et al., 2019; Marc et al., 2019; Simard & Parent-Lamarche,

2021). Moreover, nurses often lack professional autonomy because their skills and capacities are not recognized by medical and institutional hierarchies. The discourse of the care-cure or doctor-nurse dichotomy exists between nursing and medicine, as for many other female-dominated health occupations, and has historically justified nursing's subordination in the hospital hierarchy (Allen, 2015; Batliwala, 2019; Treiber & Jones, 2015).

In section 3.3, in the literature review chapter, I will discuss the nursing profession's situation in the hospital hierarchy in greater detail.

1.2.7 Oppressed group behavior

Notions of social oppression are for instance that when a single group in society wrongfully takes advantage of, and exercises power over, another group, using dominance and subordination (Glasberg & Shannon, 2010), and that it is maintained by a variety of different mechanisms including social norms, stereotypes and institutional rules (Taylor, 2016). Sidanius & Pratto (1999) suggest that four predominant social hierarchies, or race, class, gender and sexuality, contribute to social oppression. It has also been defined by the types of harm suffered and classified into distinct types: the rule of a tyrant over the ruled, the domination of one social group over another, the harm of social norms and conventions, and economic oppression (Cudd, 2006, p. 87).

The cycle of negative oppressed group behavior was described over two decades ago in literature on oppression and nursing. The cycle arises from the powerlessness of nursing in the health care system and has been shown to have a serious negative impact on nurses and their workplace. Roberts et al. (2009) have explained how nurses as an oppressed group in the medical hierarchy with low degree of autonomy, decreased nurse self-advocacy, low self-esteem and inability and fear of confronting the authority, take out their frustration on their colleagues, identified by Fanon (1963) as lateral or horizontal violence.

The concept of oppressed group behavior may clarify why nurses often act out their frustrations on one another. Silencing is also commonly cited as an oppressed group behavior and is in accordance with the belief that 'good nurses' do not challenge the status quo and, to avoid conflict, silence themselves (Roberts et al., 2009). Behavioral studies by Hawkins et al. (2022), Karatuna et al. (2020) and Mammen et al. (2023) show that acting out or silencing are byproducts of the idealization and glorification of the caring concept and of nurses as heroes, where workload and staffing shortages go ignored by healthcare systems and where occupational policies are insufficient.

The high-stress work environments in nursing and high level of personal involvement help to explain why nurses and other healthcare workers are particularly prone to workplace violence (WPV)—defined as any act or threat of physical violence,

harassment, intimidation, or other threatening behavior that occurs at the work site, including exclusion and sexual harassment from colleagues and/or clients, that causes poor general health (Li et al., 2020; Mammen et al., 2023; Stahl-Gugger & Hämmig, 2022; World Health Organization, 2023). Despite these challenges, the nursing profession has for decades been recognized as the most trusted profession in for instance the U.S., highlighting its vital role (Smith, 2024).

1.2.8 Professionalism

The concept of professionalism usually consists of a list of characteristics such as 'possession of a distinct body of knowledge; esoteric skills; occupational control over qualification; a code of ethics; a corporate body or association; social prestige' (Hugman, 1998, p. 180). According to Icelandic ethical guidelines for nurses and their professional responsibility, nurses maintain their knowledge and skills and are professionally, ethically and legally responsible for their work (The Icelandic Nurses' Association, 2015).

A profession can climb higher on the ladder of professionalism with more relevant characteristics and consistently achieve high standards. As professions are socially constructed phenomena, their meaning and social positioning is associated with historical, temporal, cultural and ideological influence. This understanding can be a challenge for the caring professions because of the dichotomy between them and the medically dominated constructs (Fairhurst, 1981; Freidson, 2001; Rivett, 1997). Indeed, professional advancement and assertiveness are traditionally linked with and characterized as masculine traits. The nursing profession has struggled to differentiate its field from the medical profession and in the public imaginary, being both a woman nurse and a professional may seem incompatible (Apesoa-Varano, 2007; Burton, 2020; Girvin et al., 2016; Zhang & Liu, 2016).

2 Theoretical approaches

In this chapter, I will explain the theories that inform my dissertation and how and why they form the theoretical framework. The perspectives of social constructionism and poststructuralism both assume that that reality is socially constructed and multiple. Meaning and truth are not discovered but are rather constructed through individuals' interactions with the world, and they reach an agreement on the reality of certain social interactions and contexts (Crotty, 1998; MacNaughton, 2005). Further, theories and methods in research are interrelated. These perspectives suit this project's focus on the interplay between nurses' working conditions and gender equality ideals, which are in this context (seen as) socially constructed.

Meanwhile, feminism and feminist research explore how systems of power produce inequities in society and social systems, with the ultimate goal of empowering women (Hawkey & Ussher, 2022). Poststructural feminism is a branch of feminism inspired by poststructuralist thought that emphasizes the social construction of gender and seeks to understand existing power relations and underlying discourses (Prasad, 2018, p. 187). Lastly, I will explain some approaches which are relevant to the status of the nursing profession in the hospital hierarchy.

2.1 Social Constructionism

In their theory of social constructionism, Peter L. Berger & Thomas Luckmann (1967) posit that a collective understanding of the world is mutually produced and confirmed by individuals in an ongoing process: 'as man externalizes himself, he constructs the world into which he externalizes himself' (p. 122). Various aspects of social reality, such as concepts, beliefs, norms, and values, are formed through continuous interactions and negotiations among society's members, rather than empirical observation of physical reality.

This view holds that most human life functions stem from social and interpersonal influences (Gergen, 1985). The key assumption is that '...the world we live in and our place in it are not simply and evidently 'there' for participants. Rather, participants actively construct the world of everyday life and its constituent elements' (Gubrium & Holstein, 2008, p. 3). Social constructs like gender, race and class are often so ingrained that essentialists mistake them for being natural, which explains why essentialist beliefs are often positively associated with stereotyping and prejudice (Haslam et al., 2000, 2002; Yzerbyt et al., 1997).

2.2 Poststructuralism

Poststructuralism is a philosophical movement rooted in the work of French philosopher Michel Foucault that emerged in France during the 1960s in response to structuralism. It questions the binary oppositions, objectivity or stability of the various interpretive structures that are posited by structuralism and considers them to be constituted by broader systems of power (Lewis et al., 1982). Poststructuralism engages in the critical theorizing of truth, reality, and the subject through an analysis of discourse, knowledge, and power (Gavey, 1989). By rejecting universal truths and binaries, which might otherwise be conveyed as neutral, objective, and apolitical, the perspective seeks to deconstruct essentializing group categories to uncover the diverse and unique experiences of individuals (Weedon, 1997). The main point of deconstruction is to unsettle and question the objectivity of what are taken to be stable concepts and conceptual oppositions, which are never neutral as one of the two terms in an opposition is usually privileged over the other (Derrida, 1970; Lewis et al., 1982). With an emphasis on plurality and tolerance to difference, poststructuralism has emancipatory and empowering potential to open different and new ways of thinking about research and social practices, such as improving the conditions of individuals and groups (Bensmaïa, 2005; Hodgson & Standish, 2009; Youdell, 2006).

2.2.1 Poststructuralism and Subjectivity

Central to poststructuralist theory and in contrast to humanist and objectivist conceptions of people as objects are the terms ‘subject’ and ‘subjectivity’. Weedon (1997) describes subjectivity as the conscious and unconscious thoughts and emotions of individuals and how they understand their relation to the world (p. 32). Weedon (1997) also suggests that poststructuralism is regarded as a paradigm for transformation and change and that subjectivity can enable us to construct meaning and reality by resisting alternative ways of knowing from our background values and engaging (finding a change) in some new activities.

2.2.1 Poststructuralism and Power

In social sciences, the concept of power relates to how individuals and groups achieve their goals against other individuals and groups. The term has been associated with the use of force and therefore it has had a negative connotation (Giddens, 2009, p. 96). Foucault argued that power was neither positive nor negative and that it was not held by the powerful over the powerless; rather it is relational, transient, and operates through knowledge production and legitimization, social norms and practices. By focusing on the concepts of power and knowledge, one can address the forms of social organization and analyze the patriarchal structure (Weedon, 1997). Power and knowledge are interconnected, as power produces knowledge and, in turn, limits what is acceptable to be known and maintains social hierarchy (Doering, 1992; Dreyfus & Rabinow, 2014). If from a poststructural perspective power is seen as relational, then

oppression is subverted or overcome in individual acts of resistance at the microlevel, transgressing social norms (Mann, 2018).

2.3 Feminism

Feminist scholars apply the perspective from poststructuralism that gender difference is a social creation, and women's subjugation is a social product formed and maintained through interactions with other individuals. Although feminism relates to a wide range of socio-political movements and ideologies, and feminists are a diverse group with different backgrounds, feminist theory strives to define and understand existing power relations and oppressive forces and how they are sustained by institutions. The main aim is to establish the political, economic, personal, and social equality of the genders (Brunell & Burkett, 2024; Hawkesworth, 2006; Mendus, 2005 [1995]; Prasad, 2018, p. 187). This is done by exploring how systems of social power produce inequities in society, in a wide range of social systems, e.g. gender, class, and race. Feminism lays the foundation for empowering women and others who are marginalized and creates new knowledge and opportunities to share their gender-based experiences (Hawkey & Ussher, 2022; Kingston, 2020). Although feminist advocacy focuses mainly on women's rights, there is a claim for inclusion of men's liberation within feminism's aims, with the argument that men are also harmed by traditional gender roles (hooks, 2000).

2.4 Patriarchy

The concept of patriarchy is central for understanding social structures from a feminist point of view. Walby (1997) argues that patriarchy is constructed through history as a social dominance system, divided into private and public spheres, restricting women and maintaining male domination. These structures are tenacious and connected to other power systems and are often invisible (Walby, 1997, p. 20). When women in the Western world entered the labor market in the late nineteenth century, their jobs were often based on their knowledge from the household and caring, and associated with gender-related characteristics. The idea of the gendered division of the spheres has been transferred to the public sphere, manifested in traditionally gender-dominated professions (Walby, 1997). From a poststructural point of view, the aim is to uncover the power relations that have, for example, maintained a gendered labor market based on essentialist ideas. Nursing is one of the female-dominated professions thought to have developed from the female sphere, having its place in patriarchal health systems.

2.5 Poststructural feminism

Poststructural feminism is a branch of feminism inspired by poststructuralist thought that combines emancipatory and transformative goals with the deconstructive and relativist approach of poststructuralism (Aranda, 2006; Weedon, 1997). The approach

emphasizes the social construction of gender and seeks to understand and expose power relations, patriarchal structures and underlying discourses that contribute to the marginalization and oppression of women, as well as how it is sustained by institutions (Arslanian-Engoren, 2002; Prasad, 2018). In this dissertation, the feminization of nursing and nurses' limited access to power and decision-making is analyzed from a poststructural feminist perspective. Using this approach, I confront the stereotypical depiction about nurses and their profession, focusing on stereotypes as social constructs made real by interaction, expectations, collective agreement, and power structures (Searle, 2010).

Numerous feminist scholars have deconstructed accepted truths about femininity as biological and essential and instead argue that gender is a social construct comprising shifting, fluid, multiple categories (Cheek, 2000; Cornwall, 2007). Examples of such deconstruction can be found in the writings of Judith Butler and Beverley Skeggs. As I explained in section 1.2.2, Butler's (1988, 1990, 2008) notion of gender as a socially constructed performative act is relevant to examining nursing as socially constructed, the power relations that then emerge and how they maintain and prolong the gender imbalance in the profession (Butler, 1990). If nursing as a female-dominated profession is seen as a 'gendered' performance that is 'learnt' through repetition, then it has implications for a concept such as 'care', which can also be understood as a 'performance'.

Beverley Skeggs (1997; 2004) described how gendered access to social capital and power places women in female-dominated and suppressed groups within the gender relations and hierarchy of organizations, maintaining the social construct of gender difference. Traditionally their capital has been symbolically limited at the local level compared to the institutional backing of masculinity, conforming to expectations traditionally associated with femininity. These expectations also affect access to respectability which is formed in social groups' discourse. Femininity is something women do rather than something they are, and women seem to consciously stage their femininity rather than express an inherent femininity (Skeggs, 1997).

Masculinity studies have been inspired by the feminist approach to gender as socially constructed. Scholars explore the construction of manhood and masculinity and challenge discourses of hierarchical power and how privilege is constructed. Hegemonic masculinity, the most valued form of masculinity in a Western context, is a socially constructed pattern of practice. Raewyn Connell (2005) described masculinity as a fluid concept, considered superior to femininity, and over other marginalized and suppressed men.

2.6 Approaches explaining multiple connections and invisibility

Susan L. Johnson's (2011) ecological model of workplace bullying sheds light on how the nursing profession and nurses' work is embedded in and connected to multiple

health care systems at different levels. Nurses' role in the health setting is determined by managerial and individual factors and make them vulnerable to power dynamics and to expectations of working in unacceptable conditions, such as chronic retrenchment which affects overall work-related health.

In a similar vein, Davina Allen (2015) points out in her work on organizational labor that despite the critical role they play, nurses often have their work undervalued and made invisible due to the gendered nature of the profession and power relations in their workplace, such as the care-cure dichotomy. When nurses perform tasks that overlap professionally with the work of doctors, this work is less visible because of nurses' lower status (Allen, 2015, p. 143), although the treatment/care divide is often unclear and more symbolic than functional. In addition, nurses do organizational work and a wide range of background activities other than direct care delivery, which also is largely invisible and undervalued work (Allen, 2015, p. 3).

The limited autonomy and professional independence inherent in the working conditions of nurses is understood by Patricia Valentine (1996) as ghettoization of the nursing profession. Inhabitants of a ghetto—a subculture with its own norms and traditions—often stay there even after the actual confinement is over, because the culture and norms inside the ghetto keep them together; it has become self-perpetuating. In terms of women's movement through space, Valentine (1996) argues that 'women's inhibited use and occupation of public space is a spatial expression of patriarchy'. She claims that the predominance of women in professions such as nursing has led to their identification with that other domain of female exclusivity, the housewife, and has reduced rather than enhanced choices for women.

3 Literature Review

In this chapter, I review research and literature relevant to the aim and scope of the dissertation. Section 3.1 and its subsections focus on nursing from a gender perspective, the feminization of the profession and an overview of feminist perspective on nursing, as all three of the articles in the dissertation cover these topics. Section 3.2 addresses stereotyping (and discourses) of genders. Section 3.3 discusses the health care hierarchy. Section 3.4 and its subsections focus on nurses' work-related well-being, including risk factors and negative workplace behavior. Finally, section 3.5 gives a brief overview of leadership and support.

3.1 Nursing from a gender perspective

The idea of gender as a hierarchical social construct has greatly impacted individuals' opportunities. In situations where traditional ideas of gender dominate, subjugation and disadvantage of women affect their life conditions including education achievement, career and health outcomes (World Health Organization, n.d). As in other professions, gender has had significant social and historical implications for nursing. Performative gender roles and norms influence the profession in various ways in education and science, possibly limiting diversity and innovation (Burton, 2020).

3.1.1 The feminized construct of caring

Nursing has long been linked to vocation and altruism, where the commitment to help and care for others is considered one of the most salient attributes of the profession's identity (Carter, 2014; Kenny, 2010). Vocation means a calling, an occupation to which a person is especially drawn, and altruism stands for a genuine desire to alleviate another's suffering. These ideas have throughout history become associated with terms such as subservience, obedience and sacrifice (Kubsch et al., 2021; Muller, 1985). The idea of vocation and altruism has changed from a spiritual connotation to culturally based and ethical and humanistic discourse (Carter, 2014; Kenny, 2015). The concepts of altruism and vocation do not always reflect nurses' motives but rather the culture and arrangement of work in the organization, and as such can conceal staffing shortages and unsupportive management as these align with received images of the profession (Carter, 2014). Many scholars argue that the idealization of nurses as caring and heroic has been used by healthcare systems to ignore nurses' unhealthy working situations (Gill & Baker, 2019; Kubsch et al., 2021; Mohammed et al., 2021; Stokes-Parish et al., 2020; Teresa-Morales et al., 2022).

Vocation and altruism are contrasted to professionalism and paid employment (Slettmyr et al., 2017), and this creates a paradox between the professional self-image of nurses as central professionals in the health care system and the public image of them generated by stereotypes. As caring is seen as feminine and professional advancement and assertiveness are characterized as masculine, there exists a conflict between being in a profession and being a woman nurse (Apesoa-Varano, 2007; Burton 2020; Girvin et al., 2016; Zhang & Liu, 2016).

Recognition for nursing's responsibilities and expertise has been slow, possibly because of nurses' socialization to the female role and discourses of vocation and submission, which are considered damaging to their professional identity, status, and societal perception (Gill & Baker, 2019; Marquis & Huston, 2017; Tomkins, 2021). Scholars (van der Cingel & Brouwer, 2021) contend that nurses themselves reinforce some of the stereotypes and images of the ever-available assistants, which have kept them powerless in setting boundaries in physical and psychological working space and coworking.

Regarding the ideas of vocation and altruism, women students' expectations are, more than the males', influenced by ideas of virtues and altruism, and by encouragement from their families. Male students put more emphasis on economic factors following stereotypical masculine ideas (Hoffart et al., 2019; Prosen, 2022; Zysberg & Berry, 2005).

3.1.2 Nursing and feminism

The gender imbalance in the nursing profession has long been the subject of feminist researchers. They point out that due to entrenched notions of women as self-sacrificing and protective, the gender imbalance has impeded the profession's rights and shaped and maintained its identity and place in the patriarchy (Green, 2012; van der Cingel & Brouwer, 2021). Becker et al. (2022) contend that wider structural factors in society, such as media and the persistence of misogyny in the health system, undermine nurses' autonomy by maintaining the image of the nurse as a submissive and self-sacrificing martyr.

Traditional roles and the patriarchal influence continue to be a part of the profession's daily reality: 'The subtlety of patriarchal power can obscure the experience of it' (Wall, 2007, p. 38). Despite the relevance of nurses' circumstances to feminist analysis, many nurses have been reluctant to work with feminists. It is partly because feminists have kept up the image of nurses as submissive and of their place in the hierarchy as a manifestation of oppression. Some nurses have seen feminists' position in a man's world of theory and power as inconsistent with their self-identities as women. They fear appearing uncaring, seeing theory as incompatible with care (Green, 2012). It masks the ability to think critically through a feminist lens, and therefore nurses accept their status as subjects in health service, not agents. They are 'likely to shy away from theory

that is political' (Wall, 2007, p. 42). By choosing a career that aligns with heteronormative gender roles, nurses themselves raise questions about female agency, counter-acting their years long struggle for autonomy and professional recognition (Lingel et al., 2022). For a profession shaped by gender politics and therefore inherently political, engaging in such aspects is crucial (Florell, 2021; Galbany-Estragués & Comas-d'Argemir, 2017; Lingel et al., 2022; Rasheed et al., 2020).

3.2 Stereotyping and gender

Stereotypes are learned and developed through socialization and often justify and legitimize power relations and roles (Hinton, 2019). An example of role stereotyping is when individuals are ascribed overgeneralized characteristics based solely on their gender (United Nations, 2014). The structure and nature of ideologies that maintain gender inequality can be explained, in part, by gender stereotypes, regardless of the diversity of individuals in a certain group (Casad & Wexler, 2017; Ellemers, 2018; Rippon, 2019; Sánchez-Rodríguez et al., 2023; Stewart et al., 2021). Instead, binary categories of femininity and masculinity should be replaced with more fluid constructs of gender (Abed et al., 2019; Wickham et al., 2023).

As mentioned in section 3.1.1, some of the dominant stereotypes related to femininity are those associated with nursing and caring ability as innate. Despite the noble goals of theorists on caring discourse, such framing undermines nurses' professionalism (Girvin et al., 2016; Kubsch et al., 2021; Prosen, 2022; Slettmyr et al., 2017), casting nursing, and women's work outside the home, as an extension of housework. The emphasis was on nursing as the crowning achievement of true femininity—not a job or profession but rather an embodiment of women's supposedly innate drive to care. The deep-rooted identification with the female sphere has had a detrimental effect on the respectability of the profession, sustaining the image of subservience (Valentine, 1996). It is therefore important to examine the ways in which gender, its norms, and performative roles have affected the profession throughout history, and to consider why these effects still influence the nursing profession.

Those men who choose to become nurses go against the expected gender norms and face various challenges. They experience stigmatization and distrust by colleagues, clients, and larger society at large. Because they do not fit the standard nurse image and feel pressured to adapt to the existing female-dominated culture, many of them choose to seek employment elsewhere (Sedgwick & Kellett, 2015; Warming, 2013; Zamanzadeh et al., 2013; Zhang & Liu, 2016). Common prejudices and stereotyping directed at them are that they are often assumed to be gay, effeminate, or lacking the intelligence and ambition for medical school. They experience social isolation, and lower job satisfaction rates than their female counterparts. Being constantly called a man nurse, rather than simply a nurse, further increases feelings of marginalization (Kim & Lee, 2019; Sasa, 2019; Warming, 2013).

These descriptions also apply to male nursing students' experiences, as traditional binary gender roles and norms are supported within nursing education and science (Burton, 2020; Meadus & Twomey, 2011; Zhang & Liu, 2016). To cope, men nurses often seek work more congruent with the masculine image and establish relationships with male colleagues and doctors (Miller, 2004; Younas et al., 2022). The regular experiences of marginalization and discrimination are explained as related to essentialized ideas of masculinity and institutionalization of femininity within nursing. Men often experience feelings of bruised entitlement and loss of patriarchal privilege when they enter the feminized world of nursing (Kimmel, 2010; Sedgwick & Kellett, 2015), which calls for role-models they can identify to challenge stereotyping (Teresa-Morales et al., 2022; Terry et al., 2020). This is important as roles and norms supported within nursing education and science, which contradict traditional masculine roles are also often obstacles (Baker et al., 2023; Salamonson et al., 2023; Teresa-Morales et al., 2022; Younas et al., 2022; Zeb et al., 2020).

Choosing nursing and nursing specialties is partly related to gender, and gender differences in choice of career reflect stereotypical ideas. Influencing factors not related to gender include illness of a loved one or self, past work experience, and having a family member or a friend in nursing (Larsen et al., 2003).

3.3 The Hospital Hierarchy

Nurses in their female-dominated profession provide care for others in a dominant patriarchal medical system, noted for its institutionalized misogyny; modern nursing and its history are rooted in male supremacy that continues to affect nurses and nursing, diminishing the profession (Allen, 2015; Burton, 2020; DiPalma 2004; Kellet et al., 2004; Lewis, 2022; Nogueira et al., 2023; Stake-Doucet, 2023). That the nurses are connected to multiple systems at different levels in the hierarchical structure of the workplace increases their vulnerability to inherent power structures. The organizational structure and chronic retrenchment, with staff shortages and increased workloads, are found to negatively affect the work environment (Johnson, 2011). Gender binarism is embedded in the nurses' workplace: in the hierarchical structure, the opposite of the 'feminine' trait of caring is the 'masculine' characterization of assertiveness and professional advancement. Entrenched gender binary ideas need to be replaced and reconstructed ccording to the meaning of professionalism (Apesoa-Varano, 2007; Burton, 2020; Zhang & Liu, 2016). As discussed in section 2.5, Skeggs (1997; 2004) described how women's situations in female-dominated professions are sustained by accepted norms and taboos. They are placed in a hierarchy according to the discourse of genders' socially accepted behavior and occupations and have limited access to power.

Halford & Leonard (2003) and Muller (2019) describe the sociospatial role of gender; how it reinforces and/or challenges dominant norms and relations through acting.

Gendered space is produced by and productive of gender norms and relations and has material and symbolic consequences for people's mobility, sense of identity and trust, such as gender differences in access to hospital spaces. Because of staff shortages, nurses' work arrangements rarely provide the opportunity to leave the ward. Their confinement to their wards can lead to a strong spatial identification with their ward, and they may have negative feelings toward other spaces within the hospital and toward the occupational policy. Confinement also provides limited opportunities to relax and is associated with errors and resigning from the job (Halford & Leonard, 2003; Muller, 2019).

One manifestation of hierarchical order is how societal institutions are structured by 'feeling rules' set by the management and encouraging individuals to manage and render their feelings socially 'appropriate' to a given situation, often contrasting the individuals' feelings (Ahmed, 2017; Cooper, 2018; Gagen, 2019; Hochschild, [1979] 2012, p. 89).

3.4 Work-related well-being

3.4.1 Risk factors

Despite high educational requirements and professional expertise, in Iceland as well as worldwide, nurses' working conditions are stressful and often present health hazards, burnout, and high turnover rates (Brynjólfsdóttir, 2018; Donnelly, 2014; Happell et al., 2013; Johnson, 2011; Lu et al., 2019; Marc et al., 2019; Simard & Parent-Lamarche, 2021), contradicting some of the Global Gender Gap Index factors that produce a gap between the genders (World Economic Forum, 2025). As work-related events, such as musculoskeletal injuries, are an ongoing problem in the nursing profession, and even expected, only a fraction of such injuries are reported (Vendittelli et al., 2016). The culture of healthcare organizations often lacks a channel for support and complaints from nurses regarding work-related stress and injuries. Despite their work-related injuries, which they seldom report, nurses generally come to work because of loyalty to co-workers (Mullen, 2015).

The COVID-19 pandemic highlighted in many ways the importance of strengthening health systems to mitigate the work-related harms staff members are subjected to (Amin et al., 2021). The hero discourse became prominent in the COVID-19 pandemic (Boulton et al., 2021; Stokes-Parish et al., 2020); nurses were classified as frontline workers, facing risk of viral infection and death (Sim, 2020). During the COVID-19 outbreak in Iceland, the well-being of nurses as well as of nursing students was of concern. Studies conducted with the participation of nursing students in Iceland reveal that during the pandemic their stress level and academic and personal burnout increased, suggesting that nursing educators need to consider the well-being of students and the stress they endure and provide support through preventive measures

(Svavarsdóttir et al., 2023; Sveinsdóttir et al, 2021). Another Icelandic study on nursing and midwifery students' well-being in the pandemic described their experiences of fear and loneliness. Few of them knew of or took advantage of the resources available at the universities, highlighting the importance of sufficient support from study counselors and teachers (Svavarsdóttir et al., 2023).

It is important to note that the World Health Organization (2021) defines some work-related illness symptoms, such as burnout and chronic workplace stress, as occupational phenomena rather than individual medical conditions. Those syndromes result from incidents and workplace behavior nurses experience that have not been successfully remedied.

3.4.2 Negative workplace behavior

Among those occupational situations mentioned above are negative workplace behavior, which includes workplace aggression, incivility, bullying, harassment and horizontal/lateral violence. Due to the high-stress work environments and high level of personal involvement, healthcare workers are particularly prone to abusive behaviors (Shorey & Wong, 2021; Waschgler et al., 2013). Nurses are the most vulnerable and affected health professionals for workplace violence (WPV), causing poor mental and general health outcomes (Cheung et al., 2017; Li et al., 2020; Liu et al., 2019; Stahl-Gugger & Hämmig, 2022; World Health Organization, 2022). According to Hawkins et al. (2022), Karatuna et al. (2020), and Mammen et al. (2023), women nurses face oppression and horizontal violence from other nurses as well as various forms of violence from supervisors and doctors. Abusive supervision is defined as leaders' continuous verbal and non-verbal aggression (Tepper et al., 2011). Emotionally destructive behavior such as contempt and disgust causes a suspicious and negative attitude toward interpersonal communication in the workplace (Bhattacharjee & Sarkar, 2022; Pradhan et al., 2020), and nurses' background experiences may increase their vulnerability and neglect of their own needs (Evgin & Sümen, 2021; Özdemir & Buzlu, 2019; Parker et al., 2003). In a meta-analysis, Roberts et al. (2009) have argued that because of the power imbalances and as an oppressed group within the larger system, nurses tend to turn their anger and frustration to their own group members. To avoid conflict, they are found to use both silencing and passive aggressiveness to cope with oppressive situations. This behavior has been identified as horizontal violence (Fanon, 1963) and is explained as a mixture of inability to confront the authority directly, fear, and low self-esteem. According to Akella & Seay (2022) women nurses with less developed professional identities and assertiveness skills are reported to rely more on passive-aggressive behaviors to gain some sort of control and autonomy in their work.

When serious crises reach unprecedented heights, such as in the COVID-19 pandemic, underlying power structures are often revealed. In the pandemic, the hero discourse became prominent; it is a glorification of caring and it has been asserted that the

discourse has been used by health systems as a regulating tool to ignore workload and understaffing, while nurses experience health-hazards, ongoing stereotyping, and impediment of their professionalism (Kubsch et al., 2021; Mohammed et al., 2021; Stokes-Parish et al., 2020; Teresa-Morales et al., 2022).

One aspect that discloses a discrepancy between the nurses' expectations for the job and the reality is the theory-practice gap. The experience of this gap or disparity arises when theoretical knowledge and skills do not match clinical settings because of cultural and institutional barriers, such as downplaying of nursing practice expertise and ideas of nurses as handmaidens to doctors. This gap is described by both nursing students and nurses as a reality shock characterized by experiences of bullying, anxiety, humiliation, and a lack of support for professional development (Bahlman-van Ooijen et al., 2023; Chekerwa, 2023; Gassas, 2021; Harvey et al., 2020; Risjord, 2010; Salah et al., 2018; Salifu et al., 2018). The gap also relates to increased job turnover rates and patient-care errors (Al Awaisi et al., 2015; Bahlman-van Ooijen et al., 2023; Salifu et al., 2018; Takase, 2010).

3.5 Leadership and support

The well-being and working conditions of nurses affect the entire healthcare system due to the large number of both nurses and clients under their care. Various studies reveal that supportive leadership is a key element in nurses' well-being and that there is a strong association between leadership behavior and positive employee health outcomes and stress management (Harvey et al., 2017; Marquis & Huston, 2017, p. 71-73; Worringer et al., 2020). This is important, as absence due to illness and staff turnover in nursing due to increased workload is a growing issue worldwide. Such situations call for supportive and embracing leadership (Hølge-Hazelton & Berthelsen, 2021; Salmi et al., 2020; Simard & Parent-Lamarche, 2021).

When employees can trust that their contribution is fully appreciated, it is a channel for them to contribute their best and be positively committed. A relationship embodied in a psychological contract that employees believe they have made to their employer is a sign of mutual trust and respect, and it leaves its mark on quality of work performance and employee well-being. Breach of the contract reduces the perceived support and can produce feelings of anger and resentment. For the employees, it indicates the organization's disrespect and reluctance to honor expectations and mutual obligations and has a negative effect on progress at work (Agarwal & Avey, 2020; DeWitte, 2005; Gupta et al., 2016; Tabassum & Ghosh, 2022).

3.5.1 Summary

In this chapter, I have presented a review of the literature relevant to the dissertation's focus on gender, a central factor in nurses' work life. I described how the feminized construction of caring through images and stereotyping affect nurses' potential for

autonomy, occupational health and access to various resources in the work settings. Then I presented a few feminist writers' arguments on how nurses' opposition to feminism has harmed the development of equality in their profession. The influence of the hospital hierarchy on maintaining the restricted feminized position of nurses was touched on, and I presented a brief overview of leadership and support for nurses.

4 Data and Methods

In this chapter, I discuss the methods and implementation utilized in the dissertation, data collection and analysis. Ethical considerations are also discussed, along with the strengths and limitations of the study. Finally, I will reflect on my positionality as a researcher.

4.1 The qualitative approach

The aim of feminist studies is to address academic biases that reinforce patriarchal ideals, and to empower women. The focus of these studies has been on applying qualitative research to undo positivist approaches, and to privilege individual, diverse and multiple perspectives (Hawkey & Ussher, 2022; Kingston, 2020). Emphasis of feminist qualitative research is, for instance, the understanding that knowledge is situated in the subjectivities and lived experiences of both researcher and participants (Freeman, 2019). For that reason, qualitative research relies on researcher reflexivity and values subjectivity, *for* the benefit of research participants rather than an authoritative perspective *about* them (Hawkey & Ussher, 2022; Lokot, 2021).

The thesis consists of three separate studies, all based on interviews. The qualitative design allows for discovering and exploring direct experiences as the participants describe them within a real-world context (Bogdan & Biklen, 1998; Kahlke, 2014; Percy et al., 2015). The data collection is carried out in the most familiar and safe environment for the participants, and the research format is not fixed at the beginning. In this way, new ideas and questions can emerge in the process. A kind of cooperation exists between researcher and participants, and the aim is often to empower participants to communicate their unique experiences and perspectives (Creswell, 2013). Personal communication between researchers and participants can lead to vulnerability for the participants. However, researchers can influence responses and thus must be aware of their own preconceived ideas about the subject and their possible effects. Interviews are open to contradictions, and themes and ideas which are constructed from the data can change in the writing process (Kvale, 1996).

4.2 Data Collection and Analysis

4.2.1 Interviews

Interviews with 31 nurses were conducted between the years 2019 and 2023. The nurses, 24 women and 7 men, were either working or had previously worked at the

National University Hospital of Iceland. Recruitment of participants took place three times, and for all three articles the study was introduced in two closed Facebook (Fb) groups for nurses in Iceland, with about 3500 nurses in each group, and the entry requirement was being a registered nurse in Iceland. The Icelandic Nurses' Association (2023) has approximately 4500 members. The studies were described as research on working conditions and health of nurses, gender equality in their working environment, and interactions and cooperation at the hospital. Nurses interested in taking part in the study were encouraged to contact the author through Fb Messenger or by phone. Of the 31 participants, eight were recruited by snowballing (Stratton, 2024).

The participants all had multiple years of working experience in nursing. At the time the interviews were conducted, 23 participants were working at the National University Hospital of Iceland, while the remaining eight had either quit nursing, were on sick leave or had changed to less straining jobs. Participants' ages ranged from 25 to 65 years. Most had experience working in acute care wards with critically ill patients, and those who were currently employed were all employed at least 60%. Over half of the participants had managerial experience and held master's degrees or other further studies providing a degree. The largest proportion of the women nurses worked at general inpatient wards with no men nurses, while the male participants worked at more specialized and gender-mixed wards.

As the focus in the second article was on the different working experiences in terms of gender, the aim was to recruit similar numbers of men and women, but the result was considered sufficient (ten women and seven men). For the third article, only women nurses offered to participate, which suited the articles on the working culture in a group of women nurses. Twelve of the 14 participants in the third article shared that they grew up in families where, from a young age, they took responsibility for relatives with various illnesses, and eight participants had had periods of being single mothers struggling to make ends meet.

The interviews were conducted in Icelandic at the participants' place and time of choice, and they found it is important for them to plan the interviews on their day off. The interviews lasted between one hour and two and a half hours; they were recorded and transcribed verbatim and translated by the author. Participants were given foreign-name pseudonyms that are uncommon in Iceland. In small societies like Iceland, anonymity can be a delicate issue; the small number of men in the profession, 4% at that time, required extra consideration, but the large nursing population was considered to reduce the likelihood of being exposed. The participants gave their written informed consent, and they were informed about their right to withdraw from the study at any time without further explanation. They were assured that their personal and working background would be disguised or skipped entirely from the text, and the recorded interviews would be erased when the research is completed. Only my supervisor and I had access to the data which was stored safely.

When the participants were asked why they were interested in taking part, they all shared that they had experience of working conditions and management- and communication styles unfavorable to their well-being and professional development. This held true regardless of whether they had managerial experience or not. They were willing to share their experience to contribute to knowledge in the field and found the matter of work-related well-being neglected. In the first two or three interviews, I got an overview of what the participants were most interested in communicating and how it aligned with the research aim. This developed a kind of interview framework that was also tailored to each participant in the spirit of the interviews being collaborative. The topics the interviews revolved around were the participants' reasons for choosing nursing, prior ideas about the job and how those ideas matched daily reality. Working arrangements, such as support and health-related aspects and the gender imbalance in the profession, were important issues, as were aspects of cooperation with colleagues and managerial staff. Professional development, recognition and respect were also topics of discussion. As almost all the interviews were very comprehensive, and their content and topics covered aspects that touched on more than one article, some interviews used in article 1 were also used in article 2 and some of those used in article 2 were also used for the third one. The sampling was considered purposive.

My background in nursing produces both strengths and weaknesses which may affect the relationship with participants and their expectations. I was required, to some extent, to set aside my personal experience, opinions and ideas and see the participants as co-workers who are willing to share their stories and contribute to a constructive discussion for their profession. The insight and experience of the researcher can facilitate co-operation, trust, and effectiveness. That the participants know about the researcher's professional background may add to the sense of teamwork. I will elaborate on this in the sections on ethical considerations and positionality.

4.2.2 Reflexive thematic analysis

4.2.2.1 Researcher reflexivity

As a method, reflexive thematic analysis is a useful research tool that offers an accessible and theoretically flexible approach to analyzing and provides a rich and detailed yet complex account of data (Braun & Clarke, 2020; Clarke & Braun, 2021). The method rejects the notion that coding can ever be accurate and recognizes that the author is a key resource in the analytic process, actively shaping the data by interpreting and constructing themes from the data. By highlighting the practice of thematic analysis as inherently subjective and the author's subjectivity, creativity and reflexivity as a resource for research, positivist notions of researcher bias in the analytic practice are rejected (Braun & Clarke, 2022). Through a set of continuous, collaborative, and multifaceted practices, researchers self-consciously critique, appraise, and evaluate the influence of their subjectivity and context on the research

processes (Olmos-Vega et al., 2022). Within qualitative and particularly feminist research, reflexivity is well known as a core practice (Bott, 2010; Finlay, 2002) whereby researchers situate themselves *within* the research and 'explore and expose the politics of representation' (Pillow, 2003, p. 176).

4.2.2.2 The method

The method emphasizes researcher reflexivity and the importance of theoretical transparency to ensure rigor; that data analysis is trustworthy and credible, considering the researcher's and participants' personal positioning in relation to the topic, as well as the difference in power between them (Braun & Clarke, 2022). In addition to tell about the practices of generating 'evidence' and analytic processes, researchers must be transparent about their role in shaping the analysis and acknowledge how their theoretical framework, assumptions, and decisions influenced the final narrative (Tuval-Mashiach, 2017). Representing participants' quotations in a transparent way adds to the credibility of findings and contributes to the trustworthiness of the research (Côté & Turgeon, 2005).

As advised by Braun & Clarke (2022), an informal member-checking, or participant validation of analysis, was carried out during the interviews. The purpose of this is to control for or correct subjective bias and validate the findings by asking the participants for their input on whether the analysis faithfully or fairly represented their experience (Braun & Clarke, 2022). I sought to make sure that there was mutual understanding in the interviews by reflecting simultaneously on the participants' stories and giving them the opportunity to correct and rephrase. Through this method, the interpretations were made as appropriate and conscientious as possible.

The first of six phases in the analyzing process recommended by Clarke & Braun (2021) is familiarization with the data, through reading and re-reading interview transcripts, which enhances overview of the data while keeping in mind the aims of the study. Interpretation occurred both during and after the interviews and notes were taken following each interview about topics that seemed to be of interest. Familiarization continued throughout the transcription process. The second stage involved generation of initial codes from the participants' stories, looking for possible patterns and writing down the first ideas. Codes which seemed to be consistent with the purpose of the article were created from the participants' stories. After this, the search for potential themes began, which focused on how accurately and relevantly the themes represented the participants' experiences. It was followed by a review, defining, and naming of the themes. The findings were then written up. Phases 3-5 resulted in main themes, which were discussed in the findings sections of the articles.

4.3 Ethical considerations

Ethical integrity is a crucial aspect of conducting research, and researchers are expected to follow institutional guidelines and legislative contexts to ensure their studies are ethical and conducted in a responsible manner. Codes of ethics in research should ensure the participants' rights, dignity and safety in the relationship with the researcher in the process (Creswell, 2012).

The following ethics are based on fundamental values (University of Iceland, 2020):

1) Respect: The research process should be guided by respect for the participants, for their autonomy and privacy, providing them with detailed information about the content, risks, benefits and confidentiality and purpose of the research so that they can give informed consent. The concept of confidentiality includes anonymity; hiding the participant's identity in writing, and the information from the participant in a study that the researcher chooses not to present in the report. Absolute anonymity does not exist because the researcher possesses the knowledge (Saunders et al., 2015). Thus, the researcher's responsibility is beyond doubt. The participants were informed of their rights (see section 4.2.2), and of how the results would be published. It can happen that participants may find it difficult to quit participating once they have started, and therefore I reminded them of the informed consent in the process. The fact that the participants knew of my nursing background and the ways my experiences resonated with theirs may have fueled their sense of duty to participate and contributed to a positive feeling of teamwork.

2) Welfare: Researchers should reduce the risks of the participants as much as possible, maximize the benefits of the research, and make sure that the weight of benefit and risk from the research is acceptable (University of Iceland, 2020). The participants hoped that their participation would possibly benefit their field of work and profession. Corbin & Morse (2003), and Pilbeam et al. (2022) have noted that it is often overlooked that ethically conducted interviews can be beneficial to participants. They have an opportunity to narrate and process their experiences and emotions and prioritize their own constructions. In my opinion, it was encouraging and maybe empowering for the nurses to contribute knowledge of their working situations for critical and constructive evaluation. The participants often shared in the interviews that by telling their stories and experiences, they realized how the experiences had affected them.

Taking part may have been helpful for some, but still I was aware of my role and responsibility in the interviewing process, following the guideline which mandates doing the best one can in an investigation while doing the least amount of harm. Roles need to be well defined, and my background in nursing created both opportunities and challenges. I needed to at least partly set aside my experience, opinions and ideas and see the participants as co-researchers who are willing to share their stories. My insight

and experience can facilitate co-work, trust and effectiveness, but may also be overshadowed by memories from work. My task was to maintain a moderate neutrality while also showing understanding and building trust with the participants, so they feel comfortable sharing their insights with me.

3) Harmlessness: Above all, researchers should avoid causing harm. Risks must always be within acceptable limits and benefits sufficient to justify the research (University of Iceland, 2020). In qualitative research, the assessment of risk is different from quantitative. The depth and proximity in interviews, participants' vulnerability, the influence of the researcher and unpredictable factors due to changing topics throughout the interview can induce risk. Visibility of participants in data presentation has increased in the world of research. Therefore, it is advised to reassess informed consent and keep ethical considerations in mind throughout the process. In research, the general understanding is that the researcher has a certain authority over the participants in leading and managing the interview, but the authority of the participant lies in the informed consent (O'Reilly & Kiyimba, 2015).

I tried to convey trust during the interviews and do my best to guarantee confidentiality. The participants were reminded at the start of each interview that they did not have to discuss anything that made them feel uncomfortable. But it was my understanding that both the participants and I expected that a sensitive discussion would lead to discomfort and emotional upheaval, as the nature of the topics often led to the recall of difficult, sensitive and hurtful experiences. Finding the acceptable limits and benefits sufficient to prevent risks or harm is the goal. Participants may be vulnerable because of sensitive topics, and some of their stories often were emotionally disturbing, revealing frustration and experiences of abuse and grief. They are not always aware of or prepared for these revelations even though they have given their informed consent and usually they trust that their safety is looked after. I heard many stories of lateral violence and disrespect which the participants experienced. It was a challenge for me to remain somewhere between neutral and supporting, as I recalled incidents of abuse and lack of support from my own work at the hospital. I felt that because the participants knew about my background and knew I was researching their experiences, they assumed I had both understanding and experiences like theirs. Due to the proximity in interviews, researchers may experience emotional distress, for example when hearing stories of serious incidents. In her article on ethical risks to researchers as an understudied experience, Stahlke (2018) writes of the discomfort she often felt when conducting interviews, listening to distressing stories, responding to disagreeable participants' statements and expectations for outcomes of the research. 'It shook the foundations of my ethical principles', she relates (p. 3).

4) Justice: In this code, researchers are among other things required to ensure that the benefits and burdens of research are distributed fairly and that they do not abuse their position towards vulnerable individuals (University of Iceland, 2020)**.** As in code 3 on

harmlessness, boundaries in the relationship can be blurred. I can identify with Stahlke (2018) in terms of the distress she experienced. The stories of my participants reminded me of the powerlessness I remember from work. That such interviews take place reflects the need for many improvements in the health system, and I was aware of the participants' vulnerability, which was part of the daily work of ensuring the well-being of their clients under difficult circumstances.

5) Honesty and good scientific practice: Research must be conducted honestly and according to accepted scientific methodology (University of Iceland, 2020).

To end the relationship with the participants can be difficult because it can feel like a friendship and some might expect to have ongoing ties (O'Reilly & Kiyimba, 2015). One can never fully know how participants are doing after the interview or if they regret sharing sensitive and important matters from their lives, both personally and professionally.

4.4 The Strengths of the Study

Interviewing both women and men nurses was a valuable contribution to the study. It gives the findings depth and insight into their strikingly different work lives, power positions and social image. The men nurses' experience of 'crossing the line' when entering nursing and their testimony about the conditions of their female colleagues is a liberating input into the equality development, benefitting all kinds of nurses. The study provides useful additions to the existing literature and can springboard further discussions in nursing, and the academic sources and theories that I relied on when writing helped to position the experiences of the participants as a contribution to the academic world.

The stories of the participants reflected their honesty and concern for their profession, revealing the strength of the interviewing method. The willingness of the participants to share their experiences shows their confidence that information from them would be handled appropriately and even be of use in challenging nurses' unhealthy and oppressive working situations. The interviews were relatively long and various information emerged as the interviews progressed, some of which were sensitive and emotionally difficult and would not have been shared within a more restricted time frame. As an insider, I'm more familiar with nurses' situations and have easier access to the culture and colloquial language than an outside researcher. This may have strengthened the participants' trust and a sense of cooperation.

The interviews suggest that many changes and reforms are needed in the personnel policy of the National Hospital of Iceland and raise questions about the competence of the hospital management. Such information would only be revealed in interviews where the participants can trust that anonymity is maintained. The results of the study indicate

that further research is needed on the discrepancy between the working conditions of the nurses and Iceland's reputation of gender equality.

4.5 The Limitations of the Study

Identifying and acknowledging limitations is important in shedding light on gaps and shortcomings and in suggesting how such limitations could be overcome in the future. Possible limitations of the study include my background in nursing, not sufficiently setting aside my own experience and opinions, and potentially overlooking important points in the participants' stories. How I analyzed the interviews may also have been biased. It is therefore important to keep a certain distance. In an interview, things happen quickly, and the researcher must stay focused and make decisions about the next steps. I may occasionally have been too close to the participants' culture, and too sympathetic, and perhaps given them the impression that we shared the same understanding and values. It is also possible that the participants kept sensitive information to themselves, knowing of my background, in case there was contact between us in the future. When difficult matters came up in the interviews, I found it a challenge to realize whether I was blocking or encouraging the flow in the interview. And perhaps the participants looked for approval or my opinion on difficult stories that can evoke mixed feelings for both.

I have not come across relevant Icelandic literature or research on nurses' working situations conducted from the poststructural feminist angle, but other studies were mostly relevant for the Icelandic context.

To preserve the anonymity of the seven men nurses in the small Icelandic community required careful handling of background information and the interviews. One of the limitations of this study is the low number of male participants. In can be said that the ratio reflects the gender imbalance in the profession, but more diverse perspectives and stories would have been possible with more males. For article 3, only women nurses volunteered, but it turned out to suit the topic of the article as they all worked in hospital wards where no men nurses worked.

4.6 Positionality

Whether they are the researcher or the participant, every individual looks at the social world in different ways. Discussing one's positionality as a researcher is a rejection of the idea that social research is separated from wider society and the individual researcher's background (Holmes, 2020); researchers are part of the social world they are researching, and this world has already been interpreted by existing social actors (Cohen et al., 2011; Grix, 2019). Developing a statement of positionality and being aware of one's position is a critical aspect of qualitative research, as it helps to explain one's personal and cultural background and suppositions and how this perspective may

impact all aspects and stages of the research. These assumptions are colored by values, biases and beliefs, for instance political stance, gender, ethnicity, (dis)abilities, social status and class (Marsh et al., 2018; Sikes, 2004).

As I mentioned in the preface, I had become familiar with the health care system before I went into nursing, both from working in various health settings and through my parents' professions. Deviations from 'normality' were a daily reality, and many of my father's patients were also family friends and often guests in our home. This experience, along with various sicknesses in the family, may have played a part in normalizing for me caring for sick and marginalized individuals and may have given me the ability to see their situations and the world through their eyes. In hindsight, some of these experiences have given me flexibility and tolerance but they also perhaps skewed my boundaries to my disadvantage later in life, for example while working in the hospital. But what I have taken from my background is a sense of justice and intolerance towards discrimination, both personally and in a societal context. From this point of view, I find consistency with my academic interest.

Working in care for several years alongside various less practical studies before my nursing studies was mostly characterized both by fun and by unprofessional work requirements for uneducated young people, and I therefore initially decided not to become a nurse. However, knowing nursing would be familiar territory for me and knowing that I had a family to support, I enrolled in a nursing studies program. I found being a nurse rewarding for years, and there was often a team spirit with my co-workers, every shift providing a learning opportunity in giving and receiving.

Various events and circumstances at work influenced my choice and interest in the research topic of this dissertation. I was soon aware of the discrepancy between study and work, the theory-practice gap, which has been described, for instance, by Bahlman-van Ooijen et al. (2023) and Chekerwa (2023); the teachers in the nursing department emphasized the academic aspect and its promotion, which was promising, but when it came to the job, the emphasis was on keeping the hospital afloat. Staff shortage was persistent, and the byproducts were nurses' work-related accidents and illness, and premature discharges of clients, often resulting in worsening of their health. I remember how I and most of my coworkers strived to adapt to the preferred expectations, working overtime in often dangerous situations. Occupational health and safety were not ranked highly on the hospital's list of priorities. As I discuss in the third article, the experience of the mismatch between expectations and work-life is an important reason for mistrust of institutional management and for leaving the job. After I quit my permanent job, I had the opportunity and freedom to watch from outside the hospital culture without commitment to a special department. From that perspective, I experienced how a vague feeling of something inappropriate, unjust and easily denied in power relations, can change into valid and helpful theoretical concepts.

I chose this subject for the dissertation because of my past working experience of the mismatch between the female-dominated nursing profession's unacceptable and oppressive working conditions and the alleged gender equality in the country, which Þorgerður Einarsdóttir (2020) contends is an intrinsic part of Iceland's national identity and has been used internationally for branding purposes. It appeared to me that the health care industry in Iceland upheld outdated, traditional gender roles, and the nurses did not have the means to change their situation. There was a power imbalance which the participants might shed light on, and the interviewing method was therefore appropriate. The approach of poststructural feminism was an easy choice as I agree with Wall (2007) who contends that the approach has a particular relevance for women and other marginalized groups, e.g. the nursing profession which is embedded in a gender-based hierarchy. The approach seeks to understand and expose power relations, patriarchal structures and underlying discourses that contribute to the marginalization and oppression of women, and how it is sustained by institutions (Arslanian-Engoren, 2002; Prasad, 2018). In addition to relevant theories, there was also a considerable amount of suitable literature to strengthen the study and shed light on the experiences of the participants.

In my position as a nurse insider in the interviews, I felt like I was walking a thin line, concerned that my background, values, experiences, and biases would affect the interviews and the whole research process. As I had some knowledge of the participants' working culture, the participants may have taken for granted that we had the same understanding and values because they knew about my nursing background and that I was investigating their work-life and well-being. They may also have kept sensitive information to themselves; in case we later came into contact.

The interviews were mostly about difficulties which the participants experienced at work or witnessed, although in the recruiting process I presented the research with rather neutral wording. As my experience of demanding working situations in nurses' workplace settings was one of the starting points for the dissertation, I had to be somewhat neutral but also show understanding and believe their stories. I may have implied understanding and knowledge with non-verbal cues. What we had in common may have equalized the power imbalance between us and fostered trust. The participants' stories caused me sometimes feeling stuck in two subject positions, both of which I could relate to. Carr (2021) described her experience of how shifting subjectivities and regimes of power became visible and created a sense of unease and discomfort when she was interviewing for her doctoral research. She felt 'unreadable within this discourse', (p. 28) and wanted to blend in. Looking into a world I used to belong to, I sometimes had the feeling I was trespassing as a representative of academic power. But the participants' power was to share their experience in confidence and contribute to knowledge. My conclusion is that this feeling of discomfort is a normal and essential part of interviewing. It alerts me to my biases and hopefully keeps me on an ethical path.

5 Summary of Articles

In this chapter, I will present a summary of the three research articles of this PhD study. The intention is to focus on how the work developed, how the articles are interconnected, and how they answer the research questions in section 1.1.2.

5.1 The first article

Writing the first article, 'Power dynamics within Icelandic nursing: Walking the fine line', was the first step in my PhD thesis. It was published in the journal *Nordic Journal of Working Life Studies*. Considering the demanding working conditions of the female-dominated nursing profession in Iceland—at that time men were 2% of the profession—I was interested in how nurses experienced this imbalance, and its effect on interactions and cooperation with colleagues and other professions. My approach was also influenced by Iceland's alleged status as fairly gender equal; I saw a discrepancy between that status and nurses' overall working situations. The aim of the article was to examine the power dynamics within the nursing profession in Iceland. Fifteen nurses were interviewed, 10 women and 5 men. In the recruiting process, the research was described as a study of the working conditions and health of nurses.

The original plan for the analysis was to apply Joan Acker's (2006) theory of gendered organizations to explain the daily reality of nurses as a female-dominated profession and to use Judith Butler's (1990) work on performativity to shed light on how the nurses take on their roles according to social and hierarchical norms. Following the advice of one of the anonymous reviewers, I omitted these theories and added Davina Allen's (2015) and Susan L. Johnson's (2011) perspectives. Both authors emphasize the multiple tasks of nurses, making them vulnerable to power dynamics. The way nurses' work is organized, their placement in the hospital system, and their connecting role in the health setting makes them exposed to expectations and escalating workload (Johnson, 2011). As Allen (2015) points out, the organizing work of nurses and background activities are a significant part of their work, as are a wide range of other tasks beyond direct care delivery.

As caring has historically been considered a natural ability and womanly instinct, organizing work and network building, often referred to as glue work, is to a large degree invisible and undervalued, affecting power relations between nurses and other professions within healthcare. Johnson's (2011) emphasis on the multileveled and complicated connections in nurses' work, as well as their socialization, explains the slowness and deep-rooted traditions that impede the development towards gender

equality. Both perspectives help to clarify aspects in the participants' stories; the findings reveal that the nurses experience various power imbalances in the workplace. This is evident, for example, in how colleagues and other professionals underestimate and ignore the nurses' professionalism. A woman nurse was worried about a patient who had pneumonia symptoms and asked a doctor for an opinion: 'The doctor just said, 'Come on, this is probably just a nursing infection.' Like I was dramatizing, you see.'

Due to managerial constraints such as staff shortages and lack of health policy and support, the nurses are constantly short on time, thus they often must prioritize their clients' safety and neglect other duties. Keeping a balance is often done by compromising against their own sense of justice to fit organizational norms and expectations, which sometimes results in risking their physical and psychological health and the clients' safety.

The restricted working space, which is both symbolic and spatial, is not clearly recognized by other professions, and it makes keeping the balance a struggle: 'There is always someone interrupting, even if you are in the middle of some delicate matter with your clients' (A woman nurse). van der Cingel & Brouwer (2021) have argued that nurses themselves reinforce some stereotypes by setting unclear boundaries. The participants describe how they are seen as accessible, responsive, and unshielded against expectations, but at the same time some of their work is invisible and their working boundaries are blurred, which is consistent with the traditional view of nursing as a woman's work (Allen, 2015; Slettmyr et al., 2017). These power imbalances the participants experience are consistent with the perspectives of Allen (2015) and Johnson (2011), who have described nurses' work life as characterized by confinement and restrictions, both symbolically and in daily routine. The high workload which characterizes daily work is closely connected to a longstanding staffing shortage, adding to managerial neglect and lack of support the participants describe they miss from their supervisors. The nurses strongly believe that a more balanced gender ratio would enhance equality and the work ethic. This quote echoes the women nurses' views: 'Somehow, the men have the freedom and license to express themselves more uninhibitedly than women have, and that transmits into the environment.' The men nurses' assertiveness is for the women nurses a liberating experience in coworking, but they had few suggestions for change, and gender equality usually is not discussed at work.

These findings answer the research questions where they ask about professional respect and autonomy, including health protection, managerial support, and essential ideas of gender differences. The nurses' work and professional lives are characterized by a lack of respect, from other professions and hospital management, for their knowledge, responsibility, and health. As the nursing profession is female-dominated, this is, in my opinion, contrary to the principles of gender equality.

In hindsight, I could have in the interviewing process put more emphasis on how the participants saw their chances and resources for making changes to their working conditions and relationships, but at that time I felt that such questions were not appropriate. Instead, I might have presented the research in the recruiting process as a study on nurses' possibilities and mindset for change, improvement and empowerment. The women participants described their lack of consensus and mutual support when their rights are violated or they were subjected to inappropriate behavior, which was rather unexpected. It showed their feeling of being invisible and a fear of standing up for themselves and contradicts the public image of nurses as a highly educated, independent professionals, central in the health sector in fruitful cooperation with other health professions. The men nurses' strong opinions of their female colleagues' powerlessness was also important information, shedding light on the gendered atmosphere and culture, especially when combined with the women nurses' conviction that more men in nursing as role models would equalize the situation. These were also unanticipated findings.

While the perspectives applied helped to put the participants' experience into a theoretical context, in my opinion Butler's (1990) approach of performativity would have been interesting to help explain how the participants perform their roles as the only way to fulfill their professional responsibility within the hierarchy of fixed prescribed binary and gendered rules. I also might have written more literature on gender binarism and social constructs into the article, which played a role in the next article. Both Skeggs's (1997) as well as Valentine's (1996) writings on the restricted resources and space regarding female professions would also have been appropriate for the analysis in this article. In the next articles, the nurses' stories of stereotyping of the profession and hierarchical restraints will be discussed.

5.2 The second article

The second article, 'They're doing their own kind of nursing': Challenging the gender bias, has been published in the journal *NORA - Nordic Journal of Feminist and Gender Research* and explores some of the themes analyzed in the first article and discussed above. In researching for that article, I was getting familiar with nurses' working life in the hospital. Some important findings from the interviews needed inspection, for example various restrictions and power imbalances in the women nurses' cooperation both with the men nurses and other professions. The women nurses' expectations that correcting the gender imbalance with more men nurses would earn them more respect, equality and autonomy, were unanticipated. Focusing on more men nurses could shed light on the role of gender in power relations, and on what affected nurses' choice to enter the profession.

The study was introduced in two closed Facebook (Fb) groups for nurses in Iceland, as a study of cooperation, well-being, and equality in nurses' working environment. Data

consisted of seventeen semi-structured interviews with ten women and seven men. It soon became clear in the interviews that the participants, both women and men, had dealt with deep-rooted ideas and stereotyping affecting their choice to enter nursing, and so the aim of the article focused on what role stereotyping ideas about masculinity and femininity may play in the work life of nurses.

To confront stereotypical depiction of nurses and their profession, a poststructuralist feminist approach was applied, emphasizing the social construction of gender and seeking to understand existing power relations (Prasad, 2018, p. 87). The approach of Butler (1988; 2008), which challenges the binary oppositions of men and women, is relevant for this article, as well as how Skeggs (1997; 2004) outlines how the social capital and access to power of women in female-dominated and suppressed groups is by tradition restricted in gender relations and hierarchy of organizations. Hierarchical power, men's dominant position in society, and how privilege is constructed, are also challenged in masculinity studies (Connell, 2005).

The analysis revealed that while the participants chose nursing following their wish 'to make a difference', and their backgrounds and motives were important, gendered expectations and stereotyping were a dominant factor: 'You know you are going to swim against the stream, you must be self-confident' (A man nurse). For the women nurses on the other hand, the choice was a 'natural' channel for their talents, which may reflect the linking of nursing with femininity as altruistic and an inborn quality, as has been suggested by various authors, for instance Kubsch et al. (2021); Prosen (2022), and Teresa-Morales et al. (2022). A woman nurse shared how her choice to enter nursing was a 'natural' continuation of her background: 'It was always clear when I was growing up, to find a channel for a strong sense of care and justice for everyone.'

It has been suggested that ignoring hegemonic masculinity image by entering a female field such as nursing is risky for men's masculinity (Baker et al., 2023; Connell, 2005, p. 78; Harding, 2007). According to the male participants they had 'crossed the line' and started nursing studies after preparing for stereotyping obstacles of deep-rooted ideas and norms. Some of them felt that their heterosexuality protected them from stereotyping of men nurses being gay: 'It is silly to say but as I have a girlfriend, I think it protects me from the doubts people have of my sexual orientation' (A man nurse).

The men nurses were of the opinion that their privilege and respect in the working environment was partly related to their bonding with male doctors, a group higher in the hierarchy. The difference between the men and the women considering respect was manifested, e.g., in how the men nurses depicted their female colleagues' situation of silencing and lack of support: 'The female nurses go to any lengths to keep the surface smooth, maybe it is not nice to use the old word submissive.' And: 'They do not defend themselves when they are abused, always watch their steps. If a male doctor approaches me and the female nurses, he always talks to me, not even looking at the women.' For the men nurses this indicated the protecting role of their gender in the

hierarchy: 'And I am maybe walking down the corridor and meet a male specialist, we say good morning, and it is my feeling that they notice me and show me respect only because I am a man'. As the women nurses entered the profession more 'naturally' than the men they did not experience the men's struggle and preparation. That preparation process may be related to the fact may be that the men nurses seemed to prioritize their professional boundaries, self-care, and nursing competence, which were protecting factors for them in the hospital hierarchy. This approach emphasizes professional autonomy; by disconnecting nursing from femininity in the meaning of powerlessness, it rejects classification and prejudice. By chance, some of the males entered nursing by working in similar positions and finding that caring for people suited them well. Men nurses with stories of such experience could be positive role models for young people: 'And see if it opens the world for them. Stereotyping is so silly, it has been hard for us, driven many away and divided the work force' (Man nurse).

Both women nurses and men nurses experienced daily work as a powerfully gendered hierarchy; the women nurses described oppressing working situations and lack of support, while the men nurses ranked themselves higher than their female co-workers in respect and opportunities, such as bonding with male doctors, to which the women felt they did not have access. The women nurses' limited access to power in the gender relations of the organization has been explained by Skeggs (1997, 2004). van der Cingel & Brouwer (2021) argue that their inability to set clear boundaries in their physical and symbolic place plays a part in reinforcing stereotypes. The management culture seems to have no strategies or programs in place to tackle work-related stress, or the lack of support experienced by nurses. The women nurses see their male colleagues as role models for assertiveness and say they create a healthier co-working atmosphere. So, the women nurses believe that correcting the gender imbalance would be a step to improve the status of their profession and thereby promote greater gender equality in practice. The findings highlight the need to recognize and tackle stereotyping which helps reproduce inequality in the workplace and sustains the profession in a position inconsistent with Iceland's image of gender equality. The gender imbalance, stereotyping, and nursing's image as powerless deter young people from nursing. Educational and health systems need to act to change the situation, such as by promoting gender studies.

These findings answer the research questions on the widespread effects of stereotypical ideas on the nurses' choice to enter nursing and their everyday working relationships with respect to work-related well-being and power relations.

5.3 The third article

As my research progressed, I became increasingly aware of many contradictions in nurses' work life. Their lack of support and image as subservient was at odds with their

educational requirements and central role. In their work and interactions, they experienced unexpected and distressing discrepancies between their aspirations and daily working reality. This contradiction led to the question for the third article: How do nurses' initial expectations for the job conform with their everyday work life? The title of the article is Hierarchical restraints and contradictions in nurses' work life: 'Like the hospital assumes we're robots.' It was submitted to *NORA - Nordic Journal of Feminist and Gender Research*.

The study was introduced in two closed Facebook (Fb) groups for nurses in Iceland and was introduced as a study of work-related health and well-being, related to communication and working conditions. Data consisted of fourteen semi-structured interviews with women nurses at the National University Hospital of Iceland. The analysis is guided by Beverley Skeggs's (1997; 2004) and Patricia Valentine's (1996) writings, both of which shed light on how institutional gendered cultural ideas mark the social status of female professions. Skeggs (1997) describes how individual respectability is formed in social groups' discourse, and that throughout history women in female-dominated and oppressed groups have had limited access to power in the gender relations of organizations compared to men and have used their femininity as social capital. In Valentine's (1996) approach she describes how territorial space of female professions such as nursing can lead to confinement and isolation, which can be normalized, limiting nurses' independence and autonomy. It affects nurses' chances to interact in tangible and subjective public spaces of the hospital (Valentine, 1996), with space as a metaphor for power relations in the hospital.

When nurses start their career, they generally believe that there is a mutual contract that their supervisors, as role models, will keep, and they take for granted that their well-being will be looked after and respected as a part of their professional development. Unexpected and confusing behavior and instructions from their supervisors contradict these expectations for support and guidance, referring to the psychological contract (Gupta et al., 2016). A woman nurse described her experience of lack of support: 'When we are young: we feel how awesome this job can be. Then the tank starts to leak because there is no contribution of good energy from the organization and management.' The nurses experience distance, unclear boundaries and role incongruity between nurses and their supervisors. Often the results are that the nurses take over their supervisors' duties, and due to workload, guarding their personal and professional boundaries is not always possible. The nurses feel that the supervisors and the hospital management appeal to their professional ethics and conscience.

Due to a long-standing staffing shortage, the nurses have adapted to spatial restrictions in their working situations, and they are not supposed to leave the ward during the shift. This arrangement has been normalized, partly explained (and justified) with professional responsibility. Still, it can be overwhelmingly tiring to stay the whole shift without a break in the stimuli that accompany the multi-layered and diverse job of the

nurses. As a result, they miss opportunities to attend lunch meetings and lectures available for hospital staff but try to make the best out of it and create a 'cozy corner'. These findings relate to both Skeggs's (1997) and Valentine's (1996) presentations on traditionally female professions' restricted power and access to equal participation in the hospital. As contradictory as it may seem, the nurses are stuck in a normalized self-sustaining civic-duty-like situation that has developed as one of the characteristics of the profession and should not be confused with professional responsibility. One participant mentioned 'we cannot leave our patients alone', referring to understaffing on her ward. The participants admit that they often find it complicated to identify and label oppressive behavior they encounter in the workplace. They often relate this to their background experiences; they think they may not have learned to set normal boundaries, and in that way, they blame themselves. According to Evgin & Sümen (2021); Özdemir & Buzlu (2019) and Parker et al. (2003) nurses' former experiences and background factors may cause difficulty with boundaries, vulnerability, and neglect of their own needs.

The gap between nurses and hospital management also manifests in how the hospital culture is characterized by a manipulative boosting style that the managers apply to enhance nurses' performance. It can be seen as an appeal to essentialist norms and glorification of the martyr figure. This is done through the discourse of nurses as heroes while ignoring their health, and common consequences of these experiences are work related illnesses, attrition, and increased risk of mistakes, often involving their clients. More serious effects are the lack of respect and empathy the nurses experience towards themselves, the opposite of their original aspirations for the job. During the COVID the previously existing situation became more visible: 'There were glossy images in the media of how helpful, heroic, and sacrificing we were, but some of us felt like dirty floor rags, best hidden away. The picture was beautified because the situation was horrible. I could not have imagined that this was happening in Iceland' (A woman nurse).

If nurses are to be able to perform their duties effectively, then hospital management must make occupational health policy reforms and revise the qualification requirements of managers and supervisors.

From the background stories of the participants, I could have written more of how they 'normalized' illnesses when growing up and were responsible for their family members, and how that may be related to their working relations. The idea was to connect participants' backgrounds to career choice, working relations, and their boundaries. I decided not to go into further detail about those matters in the article; I don't think I had the knowledge to do that, and it wasn't in my power. Important results were how some participants continued working despite abuse and breach of the psychological contract, the purpose of which was often to adhere to their professional responsibility to their clients. Many of the participants had been or were single mothers

at the time of the interviewing process, which added to the workload. The findings suggest that there is a kind of discrimination and class division within the profession if compared to those nurses who have good family support and do not have financial worries.

The supervisors of the nurses are not the only ones to 'blame' but are part of the power chain and belong to the hierarchy, outlined by Tomkins (2021) as restricted by traditional values and discourses of vocation and submission. When supervisors, being nurses themselves, ignore complaints, they silence the nurses but may still themselves be adhering to the rules and demands of the hospital to get things done, relying on the nurses' professional ethics. They prioritize meeting the needs and demands of an organization rather than the needs of their staff. Here the focus shifts from looking directly at relationships between individuals (nurses and their supervisors) to the managerial culture and how nurses' contribution is abused through a combination of flattery and guilt tripping. The hospital demands that nurses live up to a certain standard which is unattainable.

I realized while writing this article how powerful the hospital hierarchy is and how harmful and disruptive the gap between the staff 'on the floor' and the hospital management is. That experience contradicts the nurses' expectations for the job. There are hierarchical restraints built on social construction of genders that oppress nurses and hinder them from enjoying themselves at work, both professionally and personally. It is important to research these situations that keep nurses oppressed. Hospital managers' and supervisors' stories would add important angles to the working conditions and group relations.

These findings answer the research questions on the autonomy and professional respect the nurses enjoy, opportunities for occupational health and safety, managerial support, and professional growth. Further research on the nursing profession's overall working conditions is needed beyond the dissertation.

6 Collection of Articles

Article I

Power Dynamics within Icelandic Nursing: Walking the Fine Line

Power Dynamics within Icelandic Nursing: Walking the Fine Line[1]

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ABSTRACT

Like other Nordic nations, Iceland has a reputation of gender-equality, despite 98% of the country's nursing profession being women. This paper examines power dynamics within the profession. Fifteen semi-structured interviews with nurses were analyzed with a thematic analysis. Our theoretical framework draws on an ecological perspective highlighting nurses' vulnerability to power dynamics, and Allen's work on organizational labor and the invisibility of nurses' 'glue work'. The findings reveal that the nurses experience power imbalances when their autonomy is restricted in cooperation with other professionals, demanding their time and disrespecting their professional workspace, and they miss support from their supervisors. They feel their professionalism is belittled, and that the gender imbalance hinders equality. For coping and meeting norms and expectations, the nurses use silencing, which with time pressure and unclear boundaries preserve and enhance stereotypical images. Attracting more male nurses could enhance equality, but additional effort at multiple levels is needed.

KEYWORDS

Gender equality / management / occupational health / organizational labor / power dynamics / professionalism

Introduction

The shortage of nurses in Iceland is a longstanding situation, even though foreign workers have brought some temporary relief (Icelandic Ministry of Health 2020). The Covid-19 pandemic has brought the issue up again with nurses being called in from their summer break to work in acute hospital wards. Their contribution has been honored and applauded for, but as Wood and Skeggs (2020) argue, the re-evaluation and appreciation of care labor takes more than clapping. The nursing work environment is a challenging one, the strong hierarchical organisational structure of the hospital and chronic retrenchment, with staff shortages and increased workloads, lead to high workloads, occupational stress, poor job satisfaction, burnout, and high turnover rates (Brynjólfsdóttir 2018; Donnelly 2014; Happell et al. 2013; Johnson 2011; Lu et al.

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2019; Marc et al. 2019; Simard & Parent-Lamarche 2021). Within the nursing profession, there has been a call for stronger leadership, mutual trust (Salmi et al. 2020) and supportive and embracing management (Hølge-Hazelton & Berthelsen 2021; Simard & Parent-Lamarche 2021), but the position of nursing within the healthcare field, defined by power imbalances, makes this a challenging task. As trained nurses are sought after in the labor market, they have little difficulty finding alternative employment. In that way, they also get rid of moral distress when facing ethically difficult situations and not having appropriate managerial support when institutional constraints make it impossible to provide the desired patient care (Hart & Warren 2015; Kristoffersen et al. 2016).

Nursing has indeed long been linked to the meaning of vocation and altruism, where the need to help and care for others is considered one of the most salient attributes of the professions' identity (Carter 2014; Kenny 2010). Altruism is then associated with a genuine desire to alleviate another's suffering (Eley et al. 2010), and to put the needs of others before one's own (Kubsch et al. 2021). The concepts of vocation and altruism are still contrasted to professionalism and paid employment today (Slettmyr et al. 2017). Professionalism is commonly established by a list of traits, among which are included *possession of a distinct body of knowledge; esoteric skills; occupational control over qualification; a code of ethics; a corporate body or association; [and] social prestige* (Hugman 1998:180). The more traits the profession lives up to, the higher it can be placed on the ladder of professionalism. The field of nursing has been struggling with creating its own distinct position as it shares the field with the medical profession. This situation, in which vocation and altruism are not recognized as professionalism traits, creates a paradox between the professional self-image of nurses as a key player in the health care system and the public display of nursing through stereotypes (Girvin et al. 2016), such as being trained handmaidens to physicians. While it has been argued that defining nursing as 'new professionalism' could be a solution to this problem (Davies 1995), as long as caring is seen as feminine and professional advancement and assertiveness characterized as masculine, there is a conflict between being in a profession and being a female nurse (Apesoa-Varano 2007; Burton 2020; Zhang & Liu 2016).

The feminised construct of care may also well be what is discouraging men to start a career in nursing, accounting for the low numbers of men in the profession. They are frequently stigmatised and distrusted, by colleagues and clients, and there is the pressure to adapt to the existing female-dominated culture. As they are often considered to lack the necessary female skills for nursing, many of them choose to seek employment elsewhere (Warming 2013).

Attempts to increase the number of male nurse students in Iceland by taking care of their school fee (an experimental project run since 2018) have so far not led to a turnaround (Icelandic Ministry of Health 2020), indicating that the inequality runs deeper than paying the school fee.

Although nurses have gradually come to be viewed as professionals, they have been slow in representing their responsibilities and expertise possibly because of their socialization to the female role (Marquis & Huston 2017). This is considered damaging to their professional identity, status, and societal perception (Gill & Baker 2019), as it keeps the social construct of the nursing identity in place. While hierarchies in health care offer stability, predictability, and productivity, the behaviors can become gender inequal and arrogant. This reinforces the image of nursing as women's work with enduring views of subordination, having no professional mandate, and being in a subservient

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role to physicians. It is often a barrier to interdisciplinary collaboration, and can directly affect patient care while undermining the role of the nurse (DiPalma 2004).

Cingel and Brouwer (2006) argue that nurses reinforce some of the stereotypes by setting unclear boundaries in their physical and psychological working space, and by simultaneously attempting to control and define their workspace and their role within it as their 'expert' field (Curran 2006). Skeggs (1997) holds that because women in female-dominated and suppressed groups have limited access to power in the gender relations of the organization, they use and stage their femininity as social capital, in tactical rather than strategic ways (Skeggs 1997). Many nurses have been reluctant to participate in that fight with feminists, partly because feminists have kept up the image of nurses as submissive, having ideological problems, and their work as a manifestation of oppression and sustained by hierarchical structures. Therefore, the gendered side of power relations is of importance when investigating institutions and professions (Green 2012). In this article, we will be focusing on power dynamics, which we define as the manner in which power differences display itself within a certain setting, in this case the nursing work environment. Related to this are gender imbalances which Connell (1987) describes as a part of the social norms, historical praxis, and political policies, which are deeply rooted in a society and institutions.

Theoretical perspective

In our theoretical framework, we draw upon an ecological perspective (Johnson 2011), which emphasizes that the profession of nursing is embedded and connected to multiple systems at different levels, which makes it vulnerable to power dynamics. Scholars have identified the nursing profession as 'doubly oppressed' as gender imbalances exist as part of social norms, historical praxis, and political policies that are deeply rooted in society and institutions (Connell 1987) as well as because of their socialization as nurses (Roberts et al. 2009).

Societal, organizational, departmental, and individual factors keep power dynamics in place and contribute to the way in which nurses are experiencing their work environment. A strong hierarchical organizational structure and chronic retrenchment, with staff shortages and increased workloads, are found to negatively effect the work environment (Johnson 2011). Moreover, Hutchinson et al. (2010), by drawing on Clegg's circuit of power framework (1989), explain the complexity of power dynamics within the nursing profession by conceptualizing power as flowing between interacting circuits of microlevel interactions, and organizational routines, rules, regulations, and incentive systems. As a result of the power imbalances, Roberts et al. (2009) have argued that as an oppressed group within the larger system, nurses tend to turn their anger and frustration to their own group members. This behavior has been identified as horizontal violence (Fanon 1967) and is explained by a mixture of inability to confront the authority directly, fear, and low self-esteem. In the same meta analysis (Roberts et al. 2009), nurses are found to use both silencing and passive aggressiveness in order to cope with the oppressive situation and to avoid conflict (DeMarco 2002).

We also draw on Allens's (2015) approach of organizational labor. She argues that while nurses are focal actors in health systems, much of their work is undervalued and invisible due to nursing's gendered nature and power relations in their workplace. Allen

acknowledges and legitimizes organizational labor as a part of nurses' work, and argues like Roberts et al. (2009) that elements of nursing are in need of revision. The focus on nurses' holistic treatment of patients based on the knowledge of individual patient care needs is often contrasted with the centrality of the physicians' 'cure' discourse. When nurses perform tasks that overlap professionally, this work is less visible because of nurses lower status to physicians (Allen 2015:143), although the treatment/care divide is often unclear and more symbolic than functional. Therefore, to conceptualize nursing primarily as care-giving creates an unhelpful identity, as it disempowers the importance of organizing work of nurses. To a significant extent, nurses do organizational work and a wide range of background activities other than direct care delivery (Allen 2015:xi). Coordinating relevant information, network building, and safe patient flows throughout the hospital and beyond is largely invisible and undervalued work (Allen 2015:3). This work is often referred to as the 'glue' in health care systems and has not been noted at a policy or strategic level, considered a bureaucratic exercise or 'paperwork' meant to distance nurses from their 'real jobs'. The aim of this article is then to examine the power dynamics within the Icelandic nursing profession and relate it to existing theoretical perspectives and literature on power imbalances.

The situation in Iceland

Like other Nordic nations, Iceland has a long tradition of democracy and egalitarianism, with women supposedly participating in the workforce in the same way as men. Values of gender equality are important in theory but may be overshadowed by actual behaviors, creating the illusion of equality (Sund 2015), or what Pétursdóttir (2009) has referred to as the aura of gender equality. Recent COVID-19 related studies have indeed been pointing toward a backlash in equality development in Iceland (Iceland's Directorate of Equality 2021). Notably, 2% of nurses in Iceland are males (The University of Akureyri 2021). This is very low in comparison to, for instance, the situation in Norway, where in 2021, about 10% of nurses were men (Statistic Norway 2021). While the literature does not provide many clues on why this is the fact, data from Statistics Iceland (2021) show that Norway invests a higher percentage of its GDP on health care than Iceland does. The same accounts for the UK, which also employs more men (11%) in nursing positions (Farrah 2021) than Iceland. Nursing in Iceland has been taught at the university level since 1973, with a Bachelor of Science degree earned after 4 years or a Master of Science degree after 6 years (The University of Iceland 2021). The places for the program are however limited (The University of Akureyri 2021; The University of Iceland 2021). Iceland's alleged high standard of gender equality in the global context, examined by the Global Gender Gap Index (World Economic Forum 2021), is explained by its successful women's rights movement and solidarity campaign against discrimination (e.g., sexual harassment and abuse) and for women and men sharing power and decision-making. Considering the gender bias in the nursing profession, it is of relevance to keep these Index results in mind when it comes to the equality experiences of nurses in Iceland, not in the least regarding feelings of well-being. Various studies reveal that women value their health condition less than men do, and the traditional attitudes toward gender equality and gender roles may have something to do with this (Tesch-Römer et al. 2008).

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Method and data collection

The data are derived from 15 semi-structured interviews with nurses in Iceland conducted in 2019 and 2020. Through the lens of social constructionism, we examine how the professional identities of the participants are constructed and how they give meaning to their gender-related experiences. Social constructs can be so ingrained that they appear as natural constructs instead of being shaped by cultural and historical contexts. According to Crotty (1998), meaning and truth are constructed through our interactions with the world, meaning is created but not discovered. In this way, an agreement is reached on the reality of certain social interactions and contexts. No one meaning is therefore truer than another one and individuals give different meanings to their experience of the same phenomenon. The mutual understanding that develops within the study derives from individual experience, values, culture, and circumstances of both participants and researchers (Crotty 1998).

The study was introduced in two closed Facebook (FB) groups for nurses with about 3500 members each. It was described as a study of the working conditions and health of nurses, and nurses interested in taking part in the study were encouraged to contact one of the researchers through FB Messenger or by phone. Fourteen nurses initially responded of whom 12 participated in an interview. Three more participants were recruited by snowballing. The interviews were conducted outside the workplace, within the participant's or the researcher's home, whatever place was preferred by the participant. It was a part of acknowledging and respecting their contribution to knowledge, and a way for building trust. For some, it was convenient to come to the researcher's home after dayshift, as it is located near their workplace. None had the facility for privacy in their workplaces. Conducting the interviews in the participants' homes was for some because of their health reasons, and others just invited the researcher into their homes, and offered coffee and cakes. The interviews lasted between 1 hour and 2 and a half hours. The interview frame revolved around topics such as why they were interested in taking part in the research, the reasons for going into the nursing profession, career development, the work environment, collaboration, how they thought they managed their professional duties, and working in a female-dominated profession. The interviews were recorded and transcribed verbatim. To protect the participants' anonymity, they were given pseudonyms. In small societies like Iceland, anonymity can be a delicate issue, but the relatively large nursing population in this case reduced the likelihood of being exposed. Only the two researchers had access to the data. The participants gave their written informed consent, and they were informed about their right to withdraw from the study at any time without further explanation.

Ten participants were women and five were men, with an age span between 25 and 65 years (See also Table 1). Twelve participants worked at hospitals and three in related fields. All participants had nursing experience in acute care wards with critically ill patients, and they were all occupied for 60% or more. Ten had management experience, and seven hold master's degrees or other further studies providing a degree. Three nurses were about to retire or change to less straining jobs because of health reasons. At the beginning of the interviews, the participants were asked why they were interested in taking part. All of them, whether they had managerial experience or not, shared that they had some experience of lack of support from their supervisors and wanted to contribute to knowledge by telling about it. A common opinion was that the issue is neglected and should be investigated.

Table 1 An overview of the participants

	Age 25–30	Age 30–35	Age 35–40	Age 45–50	Age 55–60	Age 60–65	Work ratio %	Retiring = R Disability = D Illness = I	Years of work	Master's degree/ diploma	Manage-ment experi-ence Before = B Now = N
Annie						X	100	R, D, I	40		
Betty				X			100		20	X	N
Carl					X		100		25		N
Carly		X					60		5		
Dave			X				100		15	X	N
Debbie						X	80		40		
Eve		X					80		10	X	B
Fay						X	100	R, I	40	X	B
Grace					X		80		40	X	B
Helen						X	80	R, I	40	X	B
Irene		X					80		10		
Joe	X						100		5		N
Josie	X						100		2		N
Steve		X					100		5		
Tom						X	80	R	35	X	N

Data analysis

The data were analyzed using thematic analysis in six steps, outlined by Braun and Clarke (2006). The purpose was to look for core expressions and themes, describing participants' shared experiences, keeping in mind the research aim and theoretical framework. For analyzing qualitative data, thematic analysis is a useful research tool, as it offers an accessible and theoretically flexible approach to analysing and has the 'potential to provide a rich and detailed, yet complex account of data' (Braun & Clarke 2006:78). The transcribed interviews were read with focus on becoming familiar with them and to look for possible patterns, and writing down first ideas. Codes of interest for the purpose of the article were created from the participants' stories. There was also a progress in the interviews; the first interviews gave rich information of interactions with other professionals, and codes identified were, for instance, *interruptions*, *work-load,* and *devaluation*. Although these concepts occurred more or less in all of the interviews, they became more focused on strategies the nurses use for setting boundaries and defending their working space, literally and metaphorically. This gave codes like *enduring* and *compromising*. Themes were gradually formed, refined, given names, and reviewed to examine how they support data (the experiences of the participipants) and

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whether the analysis was in line with the research question and theoretical perspective. Power dynamics turned out to be a recurrent theme, manifested in how nurses prioritise their work and try to make compromises to keep the peace, and adapt to the working culture. This will be discussed in the finding section through the following subthemes: time management, space as a disciplinary tool, lack of support and advocacy, the invisibility of the profession, gender imbalances as a disability, and compromising and enduring the traditions.

The study can be labeled as intimate research (Taylor 2011), as Klara has an extensive background in the nursing profession. For investigator triangulation, the role of Thamar was to apply a more detached mode to the data analysis. In this way, we believe we are optimizing the credibility of the study.

Findings

As being part of a female-dominated profession, the nurses experience that they are caught up in power relations stifling their professionalism. Fighting against this situation is perceived as extra workload and a contrast between the nurses' professional vision and the working culture. They experience power dynamics regarding time management, their actual physical working space, a lack of support and advocacy, and the invisibility of much of the gluework they take care of as a profession. The participants also describe how they prioritize their work in the busy environment to defend their professional and ethical obligations, and compromise to fit accepted gendered organizational norms and expectations. This can happen against their own sense of justice. Being conscious of these contradictions, they try to resist these, while anticipating gender equality. It can be tricky to navigate through the day in this complex system of hierarchies and traditions. Table 2 gives an overview of the themes, codes, and quote example, while these will also be discussed in more detail here below.

Table 2 Themes, codes, and quote examples

Theme	Definition	Codes	Quote examples
Time management	Not having enough time to meet professional standards, unreasonable demands and daily work circumstances force the nurses to prioritise their clients' safety and neglect other duties	Danger, anxiety, workload, exhaustion, powerless	– I have to keep danger away, there is nobody else – We eat on the run – Like the whole hospital is a slow-motion train crash – There is always something left
Space as a disciplinary tool	The nurses' working space is not clearly recognised by other professions, nurses are seen as accessible and responsive at all times	Interruptions, strain, mistakes, distraction, disrespect, frustration	– Like it is always okay to interrupt you – I am still learning to build up the courage to say no

(*Continued*)

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Table 2 (*Continued*)

Theme	Definition	Codes	Quote examples
Missing support and advocacy	The participants love their job and care for their clients, but miss having a trusting relationship with their supervisors. This increases the sense of being rejected and not worth much	Sadness, rejection, disloyalty	– I can't let it destroy me. So, I quit – I just feel that I made a terrible mistake reporting it
The invisibility of the profession	The nurses' academic disipline and professional opinion is not always recognised or appreciated	Justifying, defending, prejudice, belittled	– I know nurses who have been asked if they did not have the ability or brains to be a doctor. – I was so naïve to believe that my supervisor and the manager were idealists, thirsty for new knowledge
The gender imbalance as a disability	A female-dominated profession is seen as having flaws and hindrances for development and for the team spirit. Fixing the gender imbalance is considered crucial for a healthier working culture and to empower the profession	Complaining, gossiping, backstabbing, female sacrifice, oppressed, avoid conflicts	– Somehow, the men have the freedom and licence to express themselves more uninhibitedly than women have
Compromising and enduring the traditions	The nurses realise that they must adjust and compromise, often against their own sense of justice; a conscious strategy meant to save energy, protect professionalism, create a positive mood, and avoid conflicts	Compromising, saving energy, balancing	– The biggest challenge is to keep up the positive energy and professional interactions with dignity – This is not my job

Time management

Allen (2015) argues that nurses are focal actors in health systems, but emphasizes their tough and long-lasting undervaluation due to power relations in their workplace. This becomes apparent when the participants describe the scope they have for fulfilling their professional standards, which is limited by lack of time. Daily work circumstances force the nurses to prioritize their clients' safety and neglect other duties: 'Even though I just do the necessary things, there is always something left' (Carly). As Johnson (2011)

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explains, the way the nurses' work is organized, their placement in the system, and their connecting role makes them vulnerable to expectations and escalating workload. Some participants have tried to address the workload with their supervisors, but often hit a dead end, as complaints of working conditions are disregarded: 'It is extremely difficult to be the one who swims upstream and speaks the truth; such a nurse is too difficult for the supervisor' (Eve). While the organizational culture neglects the nurses' professional mandate and obligations, the nurses are caught between management decisions and work ethics. They consider the psychological contract (Gupta et al. 2016) a breach, and not a mutual obligation, where there should be given respect and develop mutual trust with their employer. Roberts et al. (2009), however, explain the marginal position nurses in management positions find themselves in. In order to create the change, they feel they need to identify with the dominant group, but by doing so, they create a distance between themselves and the other nurses, which leads to what some of the participants describe as breach.

Due to staffing shortage, the nurses prioritize their clients' needs over their own, which literally eats up their time: 'We eat on the run, and sometimes not at all. There is no time' (Josie). The nurses describe how they cannot go to the bathroom for hours and feel their blood sugar going down because they cannot leave the patients and grab a bite. Working shifts affect the ability to recharge: 'The only days I feel well rested when I show up for work is when I have had a couple of days off' (Annie). The organization's expectations take their toll on the nurses' health and well-being. Attending to lectures and refresher training is a rare opportunity. Irene describes the overwhelming and unreal effects of the workload: 'Because you meet unreasonable and absurd demands each day, you feel like: I have to keep danger away, there is nobody else'. The destiny of the clients seems to depend on individual nurses' judgment and ability rather than the hospital management. Irene adds: 'When you have a human life in your hands, it is like the whole hospital is a slow-motion train crash, and nobody seems to be doing anything about it'.

These stories do not conform to what DiPalma (2004) reports about collaboration, which is carried out outside of hierarchial expectations, and gives most job satisfaction and positive outcomes for patients. Even though workload and demands can be exhausting, a supportive management is likely to prevent nurses from quitting the job (Hølge-Hazelton & Berthelsen 2021).

Space as a disciplinary tool

Distribution and access to space in the working environment reflects power relations and is a situation the participants describe as restricting their autonomy, or the control they have over their work. Their own working space is not clearly recognized by other professions: 'There is always someone interrupting, even if you are in the middle of some delicate matter with your clients' (Betty). Interactions like this are a constant challenge. Defending professional territory and clients' rights for privacy is a daily challenge and a sign of the discrepancy between the nurses' expertise and their status as submissive assistants. It has been argued that nurses themselves reinforce some of the stereotypes by setting unclear boundaries (Cingel & Brouwer 2006). These blurred working boundaries have been explained by the traditional view of nursing as woman's work (Allen 2015; Slettmyr et al. 2017), the hierarcical order which reinforces this image and of having

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no professional mandate (DiPalma 2004), and by Johnson (2011) on the vulnerability of being multiconnected. It can take years to learn to handle interruptions from co-workers: 'They were always barging in. There was never any, "Am I interrupting you?" But of course, I should have done something about it, and as years go by, you learn to deal with it'. (Fay). The participants have not had formal training in setting boundaries with co-workers, and their access to defined working space reflects the symbolic image of being accessible and responsive at all times for others' needs and demands, as pictured by Carly: 'It is like everyone expects me to be available all the time, and I don't have any kind of sacred time, whether I am eating, preparing medicine doses or concentrating on something, like it is always okay to disturb you'.

The nurses admit going along to a certain extent, as some find this easier than adding quarrels to the workload. The ethical aspect of protecting their clients and positive work atmosphere creates emotional strain when facing organizational expectations, which are at times impossible to identify with. Energy and time is spent on responding to the image of them as tireless and self-sacrificing. When Josie started to work after graduation, she was shocked about how much extra work it was for her to respond to co-workers' interruptions and how complicated it turned out to be for her to keep focus on her own duties. She admits that her own boundaries are unclear and how she is a part of the culture as being always accessible, and that she lacks the skills to keep professional boundaries that are safe and healthy for her and her clients, as this is a source of strain:

> I am still learning to build up the courage to say no, or wait, like today, you know, I was busy with something, and a co-worker came and said, 'Can you help me with something?' And I just said yes, and then I got distracted and was too late with the other task. But it is still, hey, I must run and do something else, so you are stacking things on you. Yes, it builds up stress in me, and I am not surprised that many accidents happen in this turmoil.

What Josie describes can be related to what Johnson (2011) depicts as being the one of many in a system. In her working space, she is stuck in the hierarchical organizational structure and she is on the verge of being unable to handle the tasks.

Another manifestation of power-related access to space is related to the long-standing staff shortage. Most of the participants are obliged to stay on their wards the whole shifts, missing opportunities to attend to lunch-break lectures which other professions attend, or to have a rest break. This adds to their professional isolation and lack of well-being.

Missing support and advocacy

When starting their jobs, the nurses expect a workplace well-being policy in their favor. However, the participants share stories of their supervisors being unsupportive and distant when they voice concerns or seek support. Their well-being is subordinate to their work, and there has been a breach of the psychological contract (Gupta et al. 2016). Eve describes the consequences when she told her supervisor about a sexual assault she suffered from a co-worker:

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> Ever since then, she has been freezing me out, this has really destroyed the opportunities I have had in my work and has seriously disturbed my job satisfaction. I just feel that I made a terrible mistake reporting it. It made it all worse for me. …You don't see much caring for us, to help us flourish at work. This is such a huge part of your life. If you don't feel well in the working place, it affects your private life, and the other way round – a complete interplay. If I am happy at work, somehow everything else solves itself.

Eve experienced assault again when she was expecting support from her supervisor. When Dave was sexually harassed at work, he reported it to his supervisor: 'And she just laughed, nothing else, but I could hardly drive home after work, I was so numb'. In his case, having been harassed is seen as something he should take 'as a man' and get over. Eve, on the other hand, was punished for what happened to her. While this behavior seems absurd and goes against any rules and regulations, identified as horizontal violence (Fanon 1967), rather than backing each other up, frustrations due to experienced powerlessness are sometimes projected at own group members.

To quit the job is a way out, and is a common consequence of unsupportive and disrespectful management styles (Brynjólfsdóttir 2018; Donnelly 2014; Happell et al. 2013; Lu et al. 2019; Marc et al. 2019; Simard & Parent-Lamarche 2021). Annie took a half-year sick leave after exhaustion and a work-related accident: 'There was not even a goodbye when I left for home. This is what makes me sad and tired and has forced me to leave my job many times'. Although the participants love their job and care for their clients, they miss having a good and trusting relationship with their supervisors. This increases the sense of being rejected and not worth much. Fay chose to prioritize her own well-being: 'For years, I fought against leaving because I loved my job, and I am a competent nurse. Then, I thought, "No, I can't let it destroy me." So, I quit. If you can't trust that you are cared for, you don't want to be there'. Irene told of a situation in a job interview with her supervisor:

> I said, 'You know, the workload has increased immensely, and it is getting very demanding for me.' And then, she just said, 'What? You are the only one complaining about it. What is going on with you?' And that I should not take up too much space because I was so … when I was commenting on how strenuous the work was now when others were listening. And then, she gave me a long lecture about how everyone has to take their share: 'They all have. Are you really going to be the only one not taking your share of the load?'

When Irene discussed this with other nurses on the ward, some said they also had complained to the same supervisor about the situation. This reveals expectations of nurses by their supervisors as obedient and sacrificial and this hinders well-being. If there are troubles, the nurses get the message to look for reasons within themselves and find the fault there, instead of in the workplace. This reflects lack of recognizing the nurses' professional mandate, and of how hierarchies in the health care can become gender inequal and arrogant, as described by DiPalma (2004).

The invisibility of the profession

It is the nurses' responsibility to monitor their patients' situation, but their professional opinion is not always recognized or appreciated by other professions. Josie recalled when she asked a doctor to examine a patient she was worried about:

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> I had a patient with pneumonia symptoms, and the doctor just said, 'Come on, this is probably just a nursing infection.' Like I was dramatising, you see. I find it insulting because I am with the patient the whole shift, and whether a change in the patient's condition is serious or not, you must make sure.

The invisibility of nursing as an academic discipline presents itself in the participants' feeling that their education, scope of work, and skills are not valued from a professional point of view. That nurses are an important link in the working environment, but their work, which is still stereotypically seen as one for which few skills are required (Smith 2019; Wolfenden 2011), is explained by Allen (2015:4–5) with long-lasting views of caring as natural for women; work that is not direct caring is not clearly seen. Subsequently, the nurses feel silenced and devalued and feel a gap between themselves and the institutional management. In addition, justifying and defending the importance of their profession and their choice to enter nursing is a part of the nurses' daily reality as well, reflecting hierarchial expectations (DiPalma 2004). Most of the participants have been asked why they did not study medicine instead, and they have had to defend their choice. Carly said, 'I always have to speak up and make myself clear when people start asking me about my choice, and I have even been asked, "And then you are going to study medicine?"' To meet such attitudes and lack of knowledge of one's own profession can be frustrating, as Betty explained,

> I know nurses who have been asked if they did not have the ability or brains to be a doctor. In my opinion, it is the rudest and most hurtful thing to say to us nurses. And I am completely convinced that if nurses had more opportunities to give the clients emotional support – that is why many of us enter the profession, for the emotional attachment – then not so many of us would leave the job and burn out.

That emotional work is often underestimated is one important part of Allen's (2015) approach. Another sign of nursing's invisibility is related to their academic knowledge. Grace wants to have the opportunity to do some research on her ward, but has not received encouragement or the opportunity to put that into practice: 'I was so naïve to believe that my supervisor and the manager were idealists, thirsty for new knowledge to make the world a better place'. The hierarchical order (Allen 2015; DiPalma 2004) is still ranking the nursing discipline-specific knowledge lower than medicine. The nurses describe this situation as one of the main reasons for their discomfort and stress at work, and as Godsey et al. (2020) argue, this detains professional development.

The gender imbalance as a disability

In the nurses' opinion, being a part of a female-dominated profession has certain flaws and hindrances for their development and opportunities and affects the team spirit. When male nurses are a part of the team, differences become visible in many ways.

> Just having a guy working with you, it changes the interactions in the workplace. Somehow, the men have the freedom and licence to express themselves more uninhibitedly than women have, and that transmits into the environment. They take more risks, do and say

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things, but we women are more oppressed. And the guys get away with behavior we would not, and they are respected for it. It would be positive for both patients and staff if there were more guys, for the working spirit. (Eve)

A more balanced gender ratio is described by the nurses as a liberating experience: 'You get rid of the backstabbing and gossip; the communication is much more open and cheerful' (Debbie). This may reflect what scholars have identified as being 'doubly oppressed' because nurses are socialized as both nurses and women, and nursing is considered woman's work (Allen 2015), and views of subordination and traditions of being in a subservient role to physicians have been enduring (DiPalma 2004; Johnson 2011). Hierarcy and traditions are strong, and Cingel and Brouwer (2006) have argued that nurses themselves strengthen some of the stereotypes by setting unclear boundaries. The female nurses argue that men are more assertive and claiming better working conditions and that they are used to their male status: 'It is of huge importance that they enter nursing; then, all this female sacrifice would end' (Grace). In the nurses' opinion, inequality in nursing came to expression by the two-sided hindrance for equality: that many men avoid nursing because of its stereotypical and feminized construct of caring. This is consistent with a significant amount of research on men in nursing, for instance, works of Sasa (2019); Meadus and Twomey (2011); Sedgwick and Kellett (2015).

The men are believed to be able to serve as role models for the female nurses when it comes to dealing with disagreements. 'If there are conflicts in the cooperation between female nurses, then the guys do not listen to it. They can't be bothered to' (Fay). Steve echoes experiences of other male participants of how the working culture does not allow for opportunities for the female nurses to solve agreements or to act out: 'They are complaining and gossiping over a cup of coffee, but they do not stick together, and they really are oppressed, but if you discuss it with them, they do not agree'. But when Betty started to set clear boundaries to her coworkers, she was asked why she was always getting everyone against her. There is a general presumption among the nurses that fixing the gender imbalance is crucial for a healthier working culture and to empower the profession. In their opinion, the idea of femininity and deep-rooted cultural meanings chase the men away from the profession, as many of them seek work opportunities within fields with more traditional masculine emphasis. 'It has to do with their distorted ideas of nursing before they try to find out what it is. It may not match their self-image and can hurt their ideas of masculinity' (Eve). Many of the participants echoed her sentiment, realizing that changes in cultural values is a slow social process.

Compromising and enduring the traditions

Being a link in a large chain, the nurses realize that they must adjust and compromise, often against their own sense of justice, while hoping for changes in interactions and expectations. This is a conscious strategy meant to save energy, protect professionalism, create a positive mood, and avoid conflicts. This appeared in several ways in the interviews, and may be understood as an endurance, and that the nurses, mostly women, are staging their femininity as social capital (Skeggs 1997), typical for women, which have

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limited access to power in the gender relations of the organization. Johnson's (2011) emphasis on the multileveled and complicated connections in nurses' work, as well as their socialization, explains the slowness and deep-rooted traditions that detain the equality development.

The pressure to adjust to the working culture contrasts with the nurses' professional identity and commitments. Irene has been met with attitude when prioritizing her own responsibilities: 'If you say, "I can't do it now", you often get that look of, "Okay, uhm, she is one of the difficult ones"'. The nurses understand the deep-rooted ways of interactions between the professions that help with tolerating unreasonable expectations of nurses as doctors' assistants. They know that the older doctors 'were trained to have the upper hand'. Fay described her ways of refusing to be an 'errand boy' for the doctors:

> I have answered, 'I am busy, and this is not my job.' And then, they just respect that and go themselves. You know, you don't run around the house for the doctor to find some bandage or stuff; he knows where to find it.

To endure deep-rooted traditions, Betty prepares herself mentally and emotionally for interactions with other professionals who do not view nursing as an academic discipline. She plans her interactions carefully to get successfully through the day:

> The biggest challenge is to keep up the positive energy and professional interactions with dignity with other groups, to set the starting point for the day, holding on to warmth, joy, and courtesy, even if you do not get it in return, and do not let others' bad temper ruin my relationships or my nursing. Sometimes, I get so exhausted from this, always having to guard my own territory to be able to do what I was employed to do. The price I pay for this is keeping everybody happy.

Enduring possible conflicts and finding the balance adds an extra workload. A generation shift is visible in the interactions between nurses and doctors. Betty described her strategy of softening and easing the process of change:

> Women are now most of the doctors, and they interrupt me just as much as others do. So, it has nothing to do with gender. But I bother them just as much as they interrupt me, but I interrupt the male doctors less. The female doctors are more tolerant and patient than the men when being interrupted.

Balanced and mutual interruptions between the professional groups are seen as a sign of increased equality and reciprocal respect. Being conscious of ruling expectations and making compromises as needed, walking the fine line, the nurses feel they have developed a way for advancement while defending their professionalism. Still, there seems to be a long way to go to the visibility and legitimizing of of nurses' work as central to the health care system as presented by Allen (2015:44–45). As compromising is considered a way to get through the day, there is also the risk of lowering professional standards, maintaining hierarchy, putting a lot of pressure on nurses, and taking its toll on their well-being, and as a result, the well-being and safety of clients is jeopardized. Besides, it enhances the image of nurses as selfless and at all times available.

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Conclusion

This article set out to examine the power dynamics within the Icelandic nursing profession and relate it to existing theoretical perspectives and literature on power imbalances. In the participants' stories, factors emerge that prevent them to fulfill their professional obligations, as they are constantly striving to find a balance between their professional conviction and the hierarcical expectations of the organization. This is closely connected to longstanding staffing shortage, with high workload as result. Sacrifices are made, as the nurses' physical and psychological health and the clients' safety is sometimes jeopardized. Therefore, the consequences of this can in some ways be described as a devaluation of professionalism. Working conditions of nurses in this paper reflect multifaceted financial and managerial angles. One is the relationships the participants describe they have with their supervisors, they experience a gap between themselves and the institutional management, a lack of support, and sometimes an attitude characterized by blaming the victim. Whether it is categorized as horizontal violence, or just poor leadership skills, there is something in the culture, which allows such conduct to take place. The consequences not only affect the nurses' and clients' wellbeing, but the entire institution, with workforce reduction and increased costs. Such circumstances must change, with honest institutional introspection and dialogue.

For more gender-equal nursing profession, changing stereotypes surrounding nursing and how nursing is viewed by the public is important. The conception that nursing is better suited to women due to innate abilities can be well eradicated with strong male role models, promoting and emphasizing the interpersonal caring aspect of nursing and highlighting that the profession should reflect diversity of society. This is not only the responsibility of the education system but also the media. Counseling and training for nursing students may be a helpful tool to make the equality topic more widely discussable. Introducing gender studies and the comprehensive research literature into both nursing education and the workplace could further help to shed light on the underlying power structures and ideally make nursing a more gender-equal profession to work in.

This study is not without limitations. It may well be that the nurses who were ready to participate were the ones with most on their plates and with an urgent need to ventilate on the matter. Nevertheless, their experiences bring useful insights into the power dynamics still occurring within the nursing profession. While the nurses in the study may have been more aware of power dynamics and gender issues because of Iceland's position on the Global Gap Gender Report Index, there appears to be enough room for improvement when it comes to these issues. Judging from their stories, many nurses suffer from working situations, which are both health-threatening and often professionally unacceptable.

Future research in the field could help to explain why men are only 2% of the nursing profession. It is also relevant to study from a viewpoint of gender studies how individuals make their choice to enter nursing and how nursing is promoted to attract young people. Exploring how individual's background and life events affect the choice of nursing as a career is also of interest.

To conclude, it is disappointing that Iceland's rank on the Global Gender Gap Report and having nursing education taught at the tertiary level, is not reflecting itself by means of a more gender-equal work culture even though theoretical work on power imbalances largely explains why this is. The effect that power dynamics and stereotypical views have

on the nurses' health, wellbeing, and job satisfaction is worrisome and paradoxical, as working in health care apparently does not necessarily relate to working in a healthy work environment. Instead, what this study has shown is that the gender imbalances prevent the nurses' working place from becoming more healthy, as it is gets caught up in a negative spiral that is difficult, although not impossible, to turn around. This study reveals the importance of supervisors and managers being aware of their own position within the larger system and the impact that negative working conditions have on the welfare of nurses and their clients. Moreover, from the situation in Norway and UK, it can be extrapolated that it is possible to attract more men to the nursing profession. This then in turn can contribute to diminishing gender imbalances within the nursing profession, although the study findings show that quite a bit more effort, at multiple levels, is needed for a change to actually take place.

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Article II

'They're doing their own kind of nursing': Challenging the gender bias

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“They’re Doing Their Own Kind of Nursing”: Challenging the Gender Bias

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ABSTRACT

Despite Iceland's reputation as a gender equal country, men make up about 4% of nurses which is low in comparison with similar countries. To shed light on what determines the choice of nursing and on cooperation at work, interviews with ten female and seven male nurses were analysed with reflexive thematic analysis. Drawing on poststructuralist and feminist theories, focusing on power relations and gender in the workplace, the analysis revealed stereotypical gender differences. Choosing nursing was for the female nurses a “natural” channel for their talents, the males were conscious of crossing a line and prepared for stereotyping obstacles. A powerful hierarchy characterized daily work, female nurses described suppressing working situations and lack of support, males ranked themselves higher in respect and opportunities, prioritized their professional boundaries, self-care, and nursing competence, free of gender labels. This difference is an important and self-sustaining part of nurses’ image as powerless, deters young people from nursing education and leads to distance between genders in the workplace. The findings highlight the need to recognize and tackle stereotyping, which maintains inequality, prioritizing diversity instead is a task for educational and health systems, and the debate on gender equality in Iceland.

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Introduction

As Iceland has been at the top of the Gender Gap Index for several years when measuring aspects on economic opportunities, education, health, and political leadership (World Economic Forum, 2023), the gender imbalance in the nursing profession is a concern, with 4% males that percentage has risen slightly in recent years (The Icelandic Nurses’ Association, 2023). In 2021, about 10% of nurses in Norway were men (Statistics Norway, 2021). Globally, 70% of the health and social workforce are women, compared to 41% in all employment sectors (World Health Organization, 2023). Statistics show that male nurses in the European Region are 16%, in South-East Asia, Western Pacific region and Eastern Mediterranean, the rate is on average 20%, in the African region 35% and the Americas 14% (World Health Organization, 2019). Attracting men to the profession in Iceland is without much success, such as an experimental project run since 2018 to take care of male nurse students’ school fee (Icelandic Ministry of Health, 2020). For the promotion process, additional research and emphasis on nursing’s academic studies are needed (Karlsson et al., 2017).

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While the Global Gender Gap Index overlooks important variables such as social norms and values, the idea of equality is an integral part of Iceland's national identity and has been used internationally for branding purposes (Einarsdóttir, 2020). This has been referred to as the Nordic gender equality paradox, while for instance Iceland and Norway rank highly in gender equality on a societal level, there may be a hindrance in transferring societal values to individual-level values and practices (Minelgaite et al., 2020). That care work and teaching are female dominated professions is considered a sign of this paradox (Lähteenmäki-Smith et al., 2023).

Stereotypes are fixed (or oversimplified) and often unfair or untrue beliefs, cognitive structures and behavioural expectations about a type of person and social groups. They are learned and developed through socialization and often justify and legitimize power relations and roles (Hinton, 2019). An example of role stereotyping is when individuals are ascribed overgeneralized characteristics based solely on their gender (United Nations, 2014). The structure and nature of ideologies that maintain gender inequality can be explained by gender stereotypes, regardless of the diversity of individuals in a certain group (Casad & Wexler, 2017; Ellemers, 2018; Rippon, 2019; Sánchez-Rodríguez et al., 2023; Stewart et al., 2021), while overlooking to replace binary categories of femininity and masculinity with more fluid construct of gender (Abed et al., 2019; Wickham et al., 2023).

Some central images related to femininity are associated with nursing and caring ability. Altruism, the unselfish concern for other people and for alleviating their suffering (Eley et al., 2010), and vocation, play a crucial role in power imbalances (Kubsch et al., 2021; Prosen, 2022), contradicting professionalism (Girvin et al., 2016; Slettmyr et al., 2017). It has been claimed that healthcare systems depend on idealization and glorification of the caring concept and of nurses as heroes, to ignore workload and staffing shortages. The results are sacrificial acts, health-hazards, reinforcing of stereotypical ideas and undermining and impeding nursing's professional development (Gill & Baker, 2019; Kubsch et al., 2021; Mohammed et al., 2021; Stokes-Parish et al., 2020; Teresa-Morales et al., 2022). A byproduct is oppressed group behaviour and the risking of patients' safety (Hawkins et al., 2022; Karatuna et al., 2020; Mammen et al., 2023). The hero discourse became prominent in the COVID-19 pandemic (Boulton et al., 2021; Stokes-Parish et al., 2020); in fact, nurses were classified as frontline workers, facing risk for viral infection and death (Sim, 2020).

A significant barrier for men choosing a career in nursing is the association with the feminized construct of caring, and roles and norms supported within nursing education and science, contradicting traditional masculine roles (Baker et al., 2023; Salamonson et al., 2023; Teresa-Morales et al., 2022; Younas et al., 2022; Zeb et al., 2020). Choosing nursing is partly related to gender; female students' expectations are, more than the males', influenced by ideas of virtues and altruism and by encouragement from their families. Male students put more emphasis on economic factors following masculine ideas, e.g. job security and technical aspects (Hoffart et al., 2019; Prosen, 2022; Zysberg & Berry, 2005). Influencing factors not related to gender are illness of a loved one or self, past work experience, and having a family member or a friend in nursing (Larsen et al., 2003).

In the working environment, gender discrimination causes male nurses lower job satisfaction than female nurses, for example, regarding their sexuality and intelligence, leading to feelings of marginalization (Kim & Lee, 2019; Sasa, 2019). To cope, they seek work more congruent with the masculine image, and establish relationships with male colleagues and physicians (Miller, 2004; Younas et al., 2022). Having a male nurse role-model they can identify with can challenge stereotyping (Teresa-Morales et al., 2022; Terry et al., 2020). Resisting the undermining of males' caring, emphasizing values of care regardless of gender, and promoting diversity is essential to tackle nursing's gendered stigmatization (Elliott, 2016; Sasa, 2019; Stewart et al., 2021; Younas et al., 2022).

The article asks what stereotyping ideas about masculinity and femininity may play in the work life of nurses. In the context of theory and literature, which suggest fundamental and important gendered differences in nurses' work-life, constructed and maintained by stereotypical ideas, the findings are discussed.

Theoretical Perspective

The poststructuralist feminist approach emphasizes the social construction of gender and seeks to understand existing power relations (Prasad, 2018, p. 187). From that viewpoint stereotypical depictions of nurses and their professions are confronted, focusing on stereotypes as social constructs made real by interaction, expectations, collective agreement, and power structure (Searle, 2010). Judith Butler (2008) challenges the binary oppositions of male and female and their inborn different qualities, and how societal scripted expectations are met through active re-enactment, or performativity, in which they are maintained. Nursing's female identity then stems from socially and culturally constructed ideas, giving ways for roles not accepted by tradition. Throwing light on women in female dominated and suppressed groups Beverley Skeggs (1997, 2004) theorized on how their social capital and access to power is by tradition limited within the gender relations and hierarchy of organizations. They stage their social capital at the local level to conform to expectations traditionally associated with femininity (Skeggs, 1997, p. 38).

In masculinity studies, discourses of hierarchical power and how privilege is constructed are also challenged. Hegemonic masculinity is defined as a pattern of practice which legitimizes men's dominant position in society and justifies the subordination of other marginalized ways of being a man and considered superior to femininity (Connell, 2005). Ignoring hegemonic masculinity image by entering a female field such as nursing, "crossing over", is risky for men's masculinity (Baker et al., 2023; Connell, 2005, p. 78; Harding, 2007). Distancing themselves from the feminine caring image may be interpreted as an assertion of patriarchy (Connell, 2005). That men increasingly challenge traditional ways of being should reduce stigmatizing for those men wanting to enter traditionally women's jobs, as Anderson and McCormack (2017) argue in their approach of "inclusive masculinity". According to Elliott (2016) concept of caring masculinities, this means redefining gender roles.

Method and Data Collection

The study design of the qualitative approach allows for discovering and exploring direct experiences as the participants describe them within a real-world context (Kahlke, 2014; Percy et al., 2015). Seen through the lens of social construction of gender their stories are interpreted and presented. The data derive from 17 semi-structured interviews with nurses in Iceland conducted in the years 2020 to 2022. The Icelandic Nurses' Association has approximately 4500 members (The Icelandic Nurses' Association [INA], n.d.). The study was introduced in two closed Facebook (FB) groups for nurses in Iceland, as a study of cooperation, wellbeing, and equality in nurses' working environment. There are about 3500 nurses in each group, and the entry requirement is being a registered nurse in Iceland. Twelve participants were recruited through FB and five by snowballing, seven men and ten women, aged 25–65. At first, the aim was to recruit a gender equal ratio of participants, but this result was considered sufficient and that data saturation had been reached. They all had years of working experience in nursing, and at the time the interviews were conducted they all worked at the National University Hospital of Iceland at a 60% employment rate or more. Three female nurses were about to retire or change to less straining jobs. The female nurses worked in general inpatient wards with no male nurses, and the male nurses were occupied in more specialized and gender-mixed wards. Twelve participants had advanced degrees and management experience, and six nurses held management positions when the interviews were conducted. When the participants were asked about their interest in taking part, all shared that they had experience of working conditions and management - and communication styles unfavourable to their wellbeing and professional development. They were willing to share their experience to contribute to knowledge in the field and found the matter neglected. The sampling was considered purposive.

The interview frame revolved around the participants' reasons for choosing nursing, their experience of the gender bias, their wellbeing, autonomy, and access to support in the workplace.

The interviews were conducted at the participants' place and time of choice which was both a way to respect their contribution and for building trust, and it was important for them to plan the interviews on their day off. The interviews took place at the first author's and the participants' homes, lasted between 1 hour and 2 and a half hours and were recorded and transcribed verbatim. They were conducted in Icelandic and translated by the first author. Participants were given pseudonyms; these are foreign names (not common in Iceland). The small society of Iceland and the small number of men in the profession, 4%, required extra consideration, but the large nursing population was considered to reduce the likelihood of being exposed. The participants gave their written informed consent, and they were informed about their right to withdraw from the study at any time without further explanation. They were assured that work field and background would be disguised or skipped entirely from the text, and the recorded interviews would be erased when the research is completed. Only the first author and her supervisor had access to the data.

The fact that the first author has a background in nursing involves both strengths and weaknesses. It requires, partly at least, to set aside experience, opinions and ideas and see the participants as co-workers who are willing to share their stories and contribute to a constructive discussion for their profession. The insight and experience of the researcher can facilitate co-work, trust, and effectiveness. That they know about the researcher's nursing background may add to the sense of teamwork. The researcher may also be too attuned to the working environment to ask about or notice important points in the participants' stories because of her background in nursing.

Reflexive thematic analysis (Braun & Clarke, 2020; Clarke & Braun, 2021), was applied to interpret and construct themes from the data, recognizing that the authors are a key resource in the analytic process and actively shape the data. The method rejects the notion that coding can ever be accurate, it will always be infused with researchers' subjectivity. It highlights their personal reflexivity to the analytic practice (Clarke & Braun, 2021), and rejects positivist notions of researcher bias. A reflexive approach ensures that data analysis is trustworthy and credible, considering researcher's and participants' personal positioning in relation to the topic, and the difference in power between them. As advised by Braun and Clarke (2022), an informal member-checking, or participant validation of analysis, was carried out during the interviews. The purpose is to control for or correct subjective bias and validate the findings by asking the participants to input on whether the analysis faithfully or fairly represented their experience (Braun & Clarke, 2022). The author sought to make sure that there was mutual understanding in the interviews by reflecting simultaneously on the participants' stories and giving them the opportunity to correct and rephrase. By this, the interpretations were made as appropriate and conscientious as possible.

The first phase of six in the analysing process recommended by Clarke and Braun (2021) is familiarization with the data, through reading and re-reading interview transcripts, considering and keeping in mind the aim of the study. Interpretation occurred both during and after the interviews and notes were taken following each interview about topics which seemed to be of interest. Familiarization continued throughout the transcription process. Secondly, initial codes were generated, looking for possible patterns, and writing down first ideas. Codes that seemed to be consistent with the purpose of the article were created from the participants' stories. Important gender differences soon became apparent. Codes from the female nurses were for instance *special qualities, interruptions, danger, compromising*, which mirror their socialization, work-related stress and lack of support and examples of codes describing how they see their male colleagues' freedom to express themselves and make demands were *uninhibited, taking risks, positive*. The male nurses' codes indicated their experience of stepping over the line of stereotyping, justifying and claiming their space and rights to nurse: *self-reliant, a human trait, sensitivity, protect, human relations, hierarchy, boundaries*, and comparing their situations with that of their female colleagues, which they see as oppressed and powerless gave for instance codes like *female sacrifice, submissive, complaining* and *gossiping*. After this, the search for potential themes began followed by a review of the themes, their defining and naming. After that, the findings were written up. Phases 3–5 resulted in three main themes, which will be discussed in the findings section.

Findings

Based on the interviews with 17 nurses in Iceland, the article asks what stereotyping ideas about masculinity and femininity may play in the work life of nurses. The themes expressing the participants' experiences are: *Making a difference in a binary context*, *A palpable hierarchy*, and *Expanding the meaning of caring.*

Making a Difference in a Binary Context

The participants' stories of choosing nursing revealed their inspiration "to make a difference". Their different backgrounds and motives were important in their work-life and cooperation. On their journey into nursing, all participants experienced gendered expectations and stereotyping (e.g. from family and clients), but important factors varied by gender, indicating a built-in gender-classification. The female nurses shared how they had moments when they realized that nursing was considered their "talent" and "destiny", often encouraged by relatives which they respected, and hearing stories of female relatives from previous generations who were thought to have special supernatural healing qualities. Linking nursing with femininity as altruistic and an inborn quality has been the subject of various authors, for instance, Kubsch et al. (2021); Prosen (2022). For some female participants, nursing was a "natural" continuation of their background, ability, and desire for the job, as Susan related:

> It was always clear when I was growing up, to find a channel for a strong sense of care and justice for everyone, could never see anyone suffer, always had to react. I was good to people, and I was praised for this.

The male participants described how they, after careful consideration, stepped over a line of deep-rooted ideas and norms to enter nursing. Because of dominant masculine hegemony (Connell, 2005; Connell & Messerschmidt, 2005) they made an extra effort to feel at home there. Coincidences often played a part in their choice, having experience from traditional male fields, rescue teams or mental wards, with role models serving as a bridge. It gave them insight into the job, they found out if it suited them, which they otherwise would have missed, and the experience of being a conspicuous minority exposed to prejudice: "I would never have thought about nursing without the experience from the rescue force, the first aid work, and how it feels to make a difference for people." (Carl). Tom's choice was independent and reflective: "Maybe I was rebelling against the norms; I think many guys do that." Dave's choice had to do with his self-image and self-confidence: "You know you are going to swim against the stream, you must be self-confident, I think it is the thought: 'this is something I want to belong to', and maybe the ambition to cross the line."

According to, for example, Baker et al. (2023); Smith et al. (2023) nursing education and science are traditionally gender biased. When the male nurses crossed the line to nursing, they often felt unqualified because of negative stereotyping. A current topic was having to justify their choice and legitimacy and that their choice was on their own initiative. "The hardest part for guys is to sign up for the studies, to get past these ideas of femininity and find out that the ideas are just ideas, social fabrication." (Joe). For him, the meaning of nursing was not about gender but human relations. Elliott (2016) points to the need for integrating values of care and positive emotion in nursing, regardless of gender. For Joe, the sensitivity and talents of older female nurses he worked with in a nursing home were eye-opening: "When I saw how they did something extra for the patients it fell into place for me, I just wanted to be near the patients and do my best for them."

The general lack of knowledge about what nursing entails and ideas of masculinity and what jobs are appropriate for men were a part of the struggle with stereotyping in their daily work:

> In the binary, I always have the feeling that I am located in between a nurse and a doctor. Society sorts you and puts you in boxes and there are always two boxes, like the carpenter image: you think: a man, nurse image: you think: women and their nature. So, you are stuck there. When I introduce myself to a client: "Hi, I am Joe and

> I am a nurse," the clients often say: "ok, a guy in nursing, how nice". Like a grade. But because I am a guy I am often asked to fix like broken televisions, but I am a nurse, not a cable guy. (Joe)

As Kimmel (2010) and Sedgwick and Kellett (2015) have claimed male nurses' experiences of marginalization are related to institutionalization of femininity within nursing and the essentialized ideas of masculinity. The stereotyping and gender bias was discomforting when they were treated as or expected to be feminine or ignored: "Men must be highly independent and strong persons to enter this peculiar world." (Mike). Andy had similar stories, the unasked attention and demands from female co-workers used to bother him. The males agreed on that deep-rooted norms chase young men away from nursing, so they chose to follow the stream. "It is strange, we think there is equality everywhere, but still young people struggle to stand out, somehow equality has not succeeded in professional awareness in our profession." (Dave). It reminds of Minelgaite et al. (2020) suggestion of the barrier between societal and individual-level values in the Nordic countries. Tackling the hierarchy of stereotyping was for the male nurses a daily reality, both inside and outside of work. The pressure of constantly defending their choice of nursing has felt humiliating: "I was always explaining for my friends what I was doing at work, defending myself, no wonder many male nurses quit or find a job in management or where they are self-reliant." (Steve). Andy also had to face conservative views in his family: "I think my father would have preferred me to join a monastery, he did not tell anyone about my nursing studies at first, he used to say it was some hospital thing." Clients would pry cunningly into the male nurses' private lives to locate them according to heteronormativity: "Maybe I am asked if I have a family: yes. Are you married? yes. And if I have children: yes, and ok I am accepted as a heterosexual, I always perceive a little homophobia." (Andy). With their gender constantly in focus and strong traditions of speech, it took strength and humour to cope, being at the same time confident of being in the right place, but still having one's situation at odds with society's norms: "It is silly to say but as I have a girlfriend, I think it protects me from the doubts people have of my sexual orientation." (Dave). Carl was mostly the only male nurse on his ward: "And you sort of get used to: 'Well girls let's get going', if you have been taking a break, then I used to joke about it: 'Ok, so you mean I can sit longer?' For me, this was not prejudice on their part, just a habit."

The experience of stepping over the line brought with it an air of self-determination, respect and a clear statement of what nursing is about. The female nurses had "slipped more naturally" into the profession and missed out the males' struggle which prepared them as a minority from the start, having to take care of themselves, define and stick to their professional ethics and working space. Feminine traits as a social construct are sustained by accepted norms and taboos (Butler, 2008; Skeggs, 2004), nurses are placed in the hierarchy according to expectations and ideas of the working environment, linked with stereotyping and their own possibilities for autonomy.

A Palpable Hierarchy

The female nurses' scope of work in the workplace hierarchy used to be evaluated as being constantly responsive and accessible by other professions. It caused them a sense of humiliation and rejection, contrasting with their responsibility and professional knowledge. As van der Cingel and Brouwer (2021) contend it relates to the image of the always available nurses, powerless in setting professional boundaries: "Like it is always okay to disturb you, even when you have patients or relatives in vulnerable situations." (Mary). Having limited access to power in the gender relations of the organization (Skeggs, 1997, 2004), and their inability to set clear boundaries in their physical and symbolic place may have played a part in reinforcing stereotypes, as van der Cingel and Brouwer (2021) argue. It may relate to attempting to fulfil the image of the nurse as first and foremost caring (Kubsch et al., 2021; Teresa-Morales et al., 2022). As has been suggested by Apesoa-Varano (2007); Burton (2020); Zhang and Liu (2016), it is challenging to be both a female nurse and be considered a professional.

Both female and male nurses perceived the linkage of gendered working culture to femininity in the meaning of powerlessness. The male nurses mentioned the unwritten gendered hierarchical rules for what is acceptable and how the working culture allows for more opportunities for men to be self-confident: “The female nurses go to any lengths to keep the surface smooth, maybe it is not nice to use the old word submissive.” (Andy). To Joe, the unwritten rules demonstrated a “silly hierarchy”, distributing access to power unevenly, and holding back wellbeing, assertiveness, and solidarity amongst the female nurses as a dominant majority: “When a guy (man) is in the team it acts as a filter for the discussion, the atmosphere is more enjoyable and relaxed, there is the female nagging instead.” (Joe). Jenny expressed the female nurses’ attitude towards the male nurses as role models for empowerment and confidence: “They are freer to speak out and working with them changes the interactions in the workplace, it is positive for both patients and staff.”

The female nurses’ place in the hierarchy and the unwritten rules played a part in their vulnerability to oppression and horizontal violence from co-workers. Terry had opinions on that: “The victims are those nurses who do not have support from their supervisors, they know how to manipulate their staff, shutting off their complaints.” It relates to studies on oppressed group behaviour by Hawkins et al. (2022); Karatuna et al. (2020); Mammen et al. (2023). Steve described the unpleasant atmosphere on his ward:

> They do not defend themselves when they are abused, always watch their steps. If a male doctor approaches me and the female nurses, he always talks to me, not even looking at the women. It makes me sick; I always think: why does she not do anything about it? I am kind of waiting for this to happen to me, a moment when a specialist would, you know. But I am sure it would not happen to a male nurse; in the hierarchy I am considered more as a doctor than a nurse and I am therefore safer.

Stereotyping expectations and unsought attention had been the male nurses’ travel companion all the way as early as from nursing school, shaping their careers and was felt by them as inappropriate and unfair: “I think this culture may be involved in that most of the men in nursing I know have either quit working or switched to fields where they are more independent and are less likely to burn out.” (Steve). As a minority, they felt both more visible and higher ranking than the females according to the gendered hierarchy. Mike commented on the negative and disruptive effects on collaboration and how nurses valued their professional autonomy:

> The powerlessness can also show itself in the female nurses’ bitterness over the male nurses’ fast progress, in special fields and for often getting better along with the doctors. They feel like victims and that their work and contribution is not justly valued.

The ranking had its role in shaping the privileged image, as well as being confusing, and the males struggled to be qualified on their own terms. They were often subjects of scrutiny whether they were pampered or not: “In my case when I have been promoted, stories went viral that it was because I was a man, when the truth is I had more education and specialty than the women who applied.” (Andy). The working culture encouraged the male nurses to enjoy alliances with male doctors through guidance and attention, which according to Miller (2004); Younas et al. (2022) is a strategy to counterbalance gendered stigmatization.

> If the doctors show me that they trust me, more than the female nurses maybe, I never really know if it is because of some male bonding or they think I am just more able, or just because, and it always gets on my nerves when I am pampered just for being a male nurse, you think that maybe it is not your skills but just some hierarchy in ideas. (Dave)

As much as the female nurses missed not having more men in their workforce, Andy's opinion was that the females lacked the ability of defiance and will to fight: “If women want equality, they must realize that it must be reciprocal.” As the female nurses experienced the persistent deep-rooted culture, the best solution for them often was to adjust against their conscience. In the male participants’ opinion the female culture of powerlessness separated the two groups; they perceived a wall between them and a gendered and individually different understanding of self-esteem and

professional self-image. The way the male nurses depicted their female partners' situation of silencing and lack of support indicated the protecting role of the males' gender in the hierarchy: "And I am maybe walking down the corridor and meet a male specialist, we say good morning and it is my feeling that they notice me and show me respect only because I am a man". (Steve).

Expanding the Meaning of Caring

The male participants were constantly reminded of the stereotypical linking of nursing and femininity as obstacles to entering the profession. While the female nurses, based on their gender and culture, had licence and access to vulnerability of clients, the men told stories of their sensitivity and competence. They gave examples of bonding with clients and building trust: "Yesterday I was praised for being kind and the warmest." (Joe). Confirming this was may be a way to justify and prove their legitimacy. They described their ways of protecting clients in vulnerable situations to minimize being seen as a foreign object and inappropriate when breaking the prescribed rules of females considered naturally fit for caring for all clients. Dave shared his experience:

> Because I am obviously a man, nursing a young woman, maybe seriously ill and vulnerable, it feels so exposed and maybe I am wrong, or it is prejudice, maybe not the right word, to think it is too uncomfortable for her, crossing some boundaries could increase her discomfort.

When Steve worried about crossing boundaries inappropriately, it always helped to ease such situations by explaining clearly what he was going to do: "And I put on the professional face, and they trust me. It almost never is a problem, but just to offer them a female nurse instead builds trust." To put on "the professional face" is a consciously and professionally wise caring strategy used in accordance with the gendering of the work-environment, may be showing professional distance as a manifestation of power and knowledge. Joe shared:

> Still when I am doing some accurate interventions I was always taken for a doctor, and I was doing fine until some of the patients found out I am a nurse, then some said: "You will never be a good nurse." Because I am a man. But now it sure has changed for me when I make a professional distance, then they trust me more.

To build trust with his clients and gain credibility, Joe performed, put on an act, a formal role with a distance, more like an image of a doctor. It is one of the advantages and resources the males have over the female nurses and may maintain the gender stereotypes, as "crossing over" is seen as a threat to masculinity (Connell, 2005; Harding, 2007).

The built-in gender-classification regularly reminded the nurses of deep-rooted ideas. Scrutinizing the male nurses, they were exposed to also had to do with their sexual orientation, as a factor related to stereotyping and their qualification as caring individuals. Joe explained how he thought that being a gay male nurse gave him credibility as having some alleged female qualities for caring and that it categorized him nearer to women on the stereotypical spectrum:

> The job is much easier for me than for the straight guys (men), when I am asked by clients and staff: "Are you a nurse? Yes. Are you gay? Yes. Ok." But with the straight guys it might be: "Are you a nurse? Yes. Are you gay? No. What?" So, I get an easier pass, I am categorized nearer to a female nurse, and as a gay man I am considered more trustworthy in some ways, with delicate matters, nudity and such, there is the image that men nurses are more hard-handed and insensitive. (Joe)

Joe's place in the female group could have been seen as more normal than the hetero guys' status. But extreme gendered differences appeared in the maternity wards and a feeling of not fitting in, not trusted, disturbing and invading a private space. It reflected deep-rooted ideas, not always visible or consciously perceived at work, of women with exclusive rights and skills for nurturing as Dave shared:

> You enter a female world, and it is not the clients but only the staff that is suspicious of your involvement there, as they had to protect the space, I was a foreign body there, quite the opposite in psychiatry where you are equals.

Being a male nurse took a lot of identity work: “You are expanding the meaning of caring, in the meaning of being humanistic, you want to care on your own terms and not according to society's expectations of femininity.” (Dave). Refiguring their identity as male nurses towards core values of nursing was for them a channel for gender equality in nursing. Separating the image of the profession from gender and removing the feminine veil would serve to improve the public image and emphasize diversity. To be a nurse meant for them to find a channel for caring and agency at the same time, and as Elliott (2016) asserts gender roles can be redefined by stepping out of the institutional hierarchy to be free of stigma and incorporating values of care. It was important for the males to promote the nursing faculty and be role models for young men who would want to give nursing a try:

> And see if it opens the world for them. Stereotyping is so silly, it has been hard for us, driven many away and divided the work force. Showing affection and kindness might scare some, but men are doing their own kind of nursing, it is about being human. (Carl)

In the males’ opinion promoting nursing through masculine images such as in acute fields, as has been done in Iceland, has proved ineffective. That way nursing images were presented in a gendered manner, may be discouraging those not looking for such. In Andy's view public image also has damaged nursing's reputation and perpetuated stigma by sending out inappropriate and negative images to young people, such as of low pay and staffing shortage: “We forget to tell them about the fun aspects and how meaningful the job is and how it influences your personal growth and educates the young in equality.” They emphasized the individual difference, deconstructing the myths: “You may meet a male nurse, very warm and kind, and then some female nurse who is a bit of a jerk, you see, all kinds of people.” (Andy). Tom added to this: “How cool it is for guys to be a nurse, some people just want to be themselves, some rough around the edges, others kind and gentle, there should be a place for all these kinds, all genders.” Carl mentioned the importance of challenging the stigma and stereotyping male nurses have been subjected to when they “come out”: “Just like gay people did with their suppressive labels and name calling, instead of being ashamed they gave those words their own empowering meaning. You are a nurrrrse!”

Conclusion

In this paper, it is explored what stereotyping ideas about masculinity and femininity may play in the work life of nurses. Analysis revealed that the interaction of pressure from socialization and resilient societal ideas of gender differences as inborn qualities played an important part in the choice to enter the profession and on the professional lives of participants. Due to socialization and traditions, the female nurses glide more easily than the males into the profession, while the males are faced with various obstacles and make their decision after reflection, and often seek jobs with clearer autonomy. Various research has shown similar findings, but significant additional factors came up in the interviews which threw light on the difference that exists (in addition to the obstacles they have met in stereotyping and prejudice) in terms of access to self-care, resources for support, and professional boundaries and recognition.

The males describe the oppression and powerlessness of their female colleagues in the hierarchy, and how they are more subject to stress and blurred professional boundaries in interactions. It causes them discomfort to witness this, while they themselves are protected by their gender inside the hierarchy, and this is a part of a separation between the genders. Having experienced barriers and stepped over lines the females have not, the male nurses speak more freely about power relations, contrasting the females’ lack of helpful concepts to clarify their situation, whether it is related to having permission to critically express opinions. The female nurses are not prepared for the hierarchy, and when they experience work-related stress and lack of support, the management culture seems to have no strategies or programs to tackle this on an institutional level. Stereotyping female nurses as heroic and always available is a self-sustaining inheritance which may be a major factor in how the

profession appears to the public and affects their well-being. Understanding the gendered difference in nurses' professional self-image is of importance for health care management. The nursing profession serves more people as the population ages and grows. Staffing shortages and attrition have been persistent in the nursing profession in Iceland, which requires that managers and human resources reassess working conditions, health protection and factors that maintain binary ideas.

Limitations of the study may be that the researcher has a background in nursing and is not setting aside her own experience and opinions, may be overlooking important points in the participants' stories. The nurses who were ready to participate felt it was important to share their stories but may have had different experiences from other nurses. Their stories reflect their honesty and concern for their profession, revealing the strength of the method. Nursing educators and nursing managers have the chance to break the vicious circle by encouraging the use of gender-inclusive language, the introduction of gender studies, strategies for recruitment and ensuring gender diversity. Their knowledge of gendered language needs further research. Conducting surveys among college students on their ideas about nursing could give insight into norms and language on gender qualities, as would experiences and attitudes of clients (patients and their families) towards nurses and what they think is important in their work. In addition to the healthcare and educational systems, media and politicians are responsible for contributing to public debate on what perpetuates gender bias in professions.

With the increased participation of men in nursing, the image of femininity in the sense of being oppressed fades, and the core of nursing as a profession and a human trait is in the foreground, bridging the gap between theory and practice and reflecting society´s diversity. The power of language, dominant words and concepts used by old habits is invisible and deep-rooted and calls for raising public awareness of the matter as an important part of equality in Iceland, where there may exist a barrier between societal and individual-level values of gender equality which sustains the image of the equality paradise.

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No potential conflict of interest was reported by the author(s).

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Data Availability Statement

The data that support the findings of this study are available on request from the corresponding author, Klara Þorsteinsdóttir.

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Article III

Hierarchical restraints and contradictions in nurses' work life:
'Like the hospital assumes we're robots.'

Hierarchical restraints and contradictions in nurses' work life: 'Like the hospital assumes we're robots.'

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The author has no conflicts of interest.

DATA AVAILABILITY

The data that support the findings of this study are available on request from the author, Klara Þorsteinsdóttir.

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Abstract

This paper examines how nurses' prior expectations for the job conform with their everyday work life. Semi-structured interviews with 14 women nurses at the National University Hospital of Iceland were analyzed with reflexive thematic analysis. Theoretical framework draws on poststructuralist and feminist theories. The analysis reveals unexpected and distressing discrepancies between participants' aspirations and daily reality. According to them they do not get the support and guidance they expect from their supervisors, resulting in unclear boundaries and role-incongruity between the groups. To ensure the safety of patients the nurses often take over the duties of their supervisors. Spatial and symbolic exclusion keeps the nurses from socializing and participating in educational and recreational activities in the public and gender-balanced spaces of the hospital, which sustains nurses' subculture and segregation. The participants experience that the hospital management culture is characterized by a manipulative boosting style applied to enhance nurses' performance, through the hero discourse while ignoring nurses' health. Common consequences are work related illnesses, attrition, and increased risk of mistakes. The findings suggest that the hospital management needs to revise occupational policy and qualification requirements of managers and supervisors. Questions about the persistent gender imbalance in nursing in Iceland are raised, for discussion of gender equality.

Keywords: hierarchy, hospital management, occupational health, professional boundaries, professionalism, supervisors

Introduction

As a female-dominated profession, nursing has contradictions between its high educational and professional standards and the hierarchy of gendered traditions and expectations. The fact that women make up 96% of nurses in Iceland (The Icelandic Nurses' Association, 2023) may be related to deep rooted traditions of gender roles. The idea of gender equality is an intrinsic part of Iceland's national identity and has been used internationally for branding purposes (Einarsdóttir, 2020). While for instance Iceland and Norway rank highly in gender equality on societal level, transferring societal values to individual-level values and practices may meet obstacles,

referred to as the Nordic gender equality paradox (Minelgaite et al., 2020). Gender imbalance in female-dominated professions is considered a sign of this paradox (Lähteenmäki-Smith et al., 2023). Gender biases are partly maintained by gender stereotypes (Ellemers, 2018; Rippon, 2019; Sánchez-Rodríguez et al., 2023; Stewart et al., 2021); oversimplified or untrue ideas, justifying and legitimizing power relations and roles (Hinton, 2019). Stereotyping associated with nursing relates to ideas of femininity, innate caring ability and vocation. Historically it contradicts professionalism, despite noble goals of theorists on caring discourse (Girvin et al., 2016; Kubsch et al., 2021; Prosen, 2022; Slettmyr et al., 2017).

Gill and Baker (2019) and Tomkins (2021) argued that nurses' socialization to feminization and discourses of vocation and submission has damaged their professional identity, status, and societal perception. One manifestation of hierarchical order is how societal institutions are structured by 'feeling rules' set by the management, encouraging individuals to manage and render their feelings socially 'appropriate' to a given situation (Hochschild, [1979] 2012:89). Some feelings, such as anger, passion and imbalance, are considered inappropriate in certain situations, and managing them according to the culture is preferred, often contrasting the individuals' feelings (Ahmed, 2017; Cooper, 2018; Gagen, 2019).

The idealization of caring and of nurses as heroes has been used by health systems as a regulating tool to ignore workload and understaffing. In the COVID-19 pandemic the hero discourse rose became prominent, while nurses experienced health-hazards, ongoing stereotyping, and impediment of their professionalism (Kubsch et al., 2021; Mohammed et al., 2021; Stokes-Parish et al., 2020; Teresa-Morales et al., 2022). Such a crisis can reveal underlying power structures and how nurses' prior expectations for their job conflict with reality. The theory-practice gap or disparity arises when theoretical knowledge and skills do not match clinical settings because of cultural and institutional barriers, such as downplaying of nursing practice expertise and ideas of nurses as physicians' assistants. This gap is described both by nursing students and nurses as a reality shock; an experience of bullying, anxiety, humiliation and lack of support for career development (Bahlman-van Ooijen et al, 2023; Chekerwa, 2023; Gassas, 2021; Harvey et, al., 2020; Risjord, 2010; Salah et al., 2018; Salifu et al., 2018). The gap also relates to increased job turnover rates and patient-care errors (Al Awaisi et al., 2015; Bahlman-van Ooijen et al, 2023; Salifu et al., 2018; Takase, 2010).

Due to high-stress work environments and high level of personal involvement, healthcare workers are particularly prone to abusive behaviors (Shorey & Wong, 2021; Waschgler et al., 2013). Nurses are the most vulnerable and affected health professionals for workplace violence (WPV), causing poor mental and general health outcomes (Cheung et al., 2017; Li et al., 2020; Liu et al., 2019; Stahl-Gugger & Hämmig, 2022; World Health Organization, 2022). Women nurses are exposed to oppression and horizontal violence from other nurses, and to various forms of violence from supervisors and doctors (Hawkins et al., 2022; Karatuna et al., 2020; Mammen et al., 2023). Abusive supervision is defined as leaders' continuous verbal and non-verbal aggression (Tepper et al., 2011). Emotionally destructive behavior such as contempt and disgust causes a suspicious and negative attitude toward interpersonal communication in the workplace (Bhattacharjee & Sarkar, 2022; Pradhan et al., 2020), and nurses' former experiences may increase their vulnerability and neglect of their own needs (Evgin & Sümen, 2021; Özdemir & Buzlu, 2019; Parker et al., 2003). Supportive leadership is associated with positive employee health outcomes and stress management (Harvey et al., 2017; Marquis and Huston, 2017:71; Worringer et al., 2020). Starting a new job an employee assumes that there is a psychological contract with the employer, indicating mutual trust and respect. Breach of the contract can produce feelings of anger and resentment, indicating the organization's disrespect and reluctance to honor expectations and mutual obligations (Agarwal & Avey, 2020; Gupta et al., 2016; Tabassum & Ghosh, 2022).

This paper focuses on how Icelandic nurses experience the reality of work compared to the expectations they had for the job. The analysis of the interviews is conducted with reflexive thematic analysis (Braun & Clarke, 2020; Clarke & Braun, 2021) and was discussed in the context of poststructuralist feminist theories and literature.

Theoretical background

Feminist scholars apply the perspective from poststructuralism that gender difference is a social construction, formed and maintained through interactions with other individuals. The approach seeks to understand existing power relations and how they are sustained by institutions (Prasad, 2018:187). Poststructural feminist theories challenge gender categories as dual and fixed, arguing instead fluid and multiple categories (Cheek, 2000; Cornwall, 2007). Building on the literature, I argue in this paper that nurses' situation in the hospital hierarchy is related to feminization of nursing, causing assignment of gender stereotypes, traditional female roles and limited

access to power and decision-making, which is consistent with Kubsch et al. (2021) and Prosen (2022). As a background to explore how daily work matches nurses' prior expectations the analysis is guided by theories on how institutional gendered cultural ideas mark social status, resources and power of female professions.

Beverley Skeggs (1997; 2004) is one of the scholars who has written on the social construction of gender difference and how individual respectability is formed in social groups' discourse. She claims that individuals are placed in a hierarchy according to the discourse of genders' socially accepted behavior and occupations which are sustained by accepted norms and taboos. Certain groups of women use traits traditionally associated with women, or femininity, as social capital. Because women in female-dominated and suppressed groups have limited access to power in the gender relations of organizations, they use and stage their femininity as social capital, which is symbolically limited, compared to the institutional backing of masculinity (Skeggs, 1997).

Another approach on how socially dominant norms and relations set rules for behavior of occupations is seeing gender as a sociospatial phenomenon. Gendered space is produced by and productive of gender norms and relations and has material and symbolic consequences for people's mobility, sense of identity and trust, such as gender differences in access to hospital spaces. While nurses' confinement to their wards can lead to having a strong spatial identification with their ward, they may have negative feelings toward other spaces within the hospital and toward the occupational policy. Confinement also provides limited opportunities to relax and is associated with errors (Halford & Leonard, 2003; Muller, 2019). Patricia Valentine (1996) described how the territorial space of female professions such as nursing has developed into a kind of ghetto, physically and symbolically. A ghetto is defined as a manifestation of the social reality of minority groups where the individuals are closely interconnected due to their long-lasting common experience of being outsiders in society. The 'inhabitants'' independence and autonomy is limited, which maintains their victim role (Valentine, 1996). Because of nursing's link with women's traditional sphere of home and caring, female spaces at nurses' disposal have prolonged and strengthened characteristics of the space and isolation from other areas of the organization. As power and space in men's power in nurses' interactions with other professional groups; restriction and separation from the hospital's tangible and subjective public space is a spatial expression of patriarchy. These arrangements are normalized as an inescapable and

self-sustainable arrangement, a state of a subculture with its own culture and traditions (Valentine, 1996:105).

Method and data collection

The data derive from semi-structured interviews with 14 women nurses, conducted in the years 2022 to 2023. The study was introduced in two closed Facebook (Fb) groups for nurses in Iceland, as a study of work-related health and well-being, related to communication and working conditions. There are about 3500 nurses in each group, and the entry requirement is to be a registered nurse in Iceland. The Icelandic Nurses' Association has approximately 4500 members (The Icelandic Nurses' Association, n.d.). Ten participants aged 28 – 65, were recruited through Fb and four by snowballing, all had years of working experience in nursing. The sampling continued up to data saturation and was considered purposive. At the time the interviews were conducted nine were working at the National University Hospital of Iceland, at a 60% employment rate or more on wards where only women nurses worked, and five had either quit nursing or were on sick leave. Twelve of the 14 participants shared that they grew up in families where they from childhood took responsibility for relatives with various illnesses. Eight nurses had had periods of being single mothers struggling to make ends meet.

The interviews were conducted in Icelandic at the participants' place of choice and lasted between 1 hour and 2 hours and 20 min, they were recorded and transcribed verbatim and translated by the author. For pseudonyms, participants were given foreign names not common in Iceland. They gave their written informed consent, were informed about their right to withdraw from the study without further explanation, that their personal and working background would be disguised or skipped entirely from the text, and the recorded interviews would be erased when the research was completed. Only the author and her supervisor had access to the data.

The participants all expressed that they wanted to share their experiences from working relationships which had had various unexpected and unforeseen consequences for their job satisfaction and well-being. Relationships and cooperation with their supervisors, which all were women nurses, was an important issue in the interviews. They were willing to share their experience to contribute to knowledge in the field and found the matter neglected.

The author has a background in nursing which is both a strength and weakness. She may miss important points in the participants' stories if she is too attuned to their working environment but seeing the participants as co-workers in balance with her own experience can facilitate trust and effectiveness.

For interpreting and constructing themes from the data, reflexive thematic analysis was conducted (Braun & Clarke, 2020; Clarke & Braun, 2021). The method rejects the idea that coding can ever be accurate but highlights researcher's reflexivity and role as a key resource in the analytic process, actively shaping the data and positivist notions of researcher bias are rejected (Braun & Clarke, 2021). To control for or correct subjective bias and validate the findings an informal member-checking (Braun & Clarke, 2022) was conducted during the interviews by asking the participants if the analysis fairly represented their experience.

The first phase of six in Clarke & Braun's (2021) approach is becoming familiar with the data by repeatedly reading the transcripts, which enhanced overview of the data. The analysis process is also guided by keeping the research question in mind. Familiarization continued throughout the transcription process. Interpretation took place both during and after the interviews and notes were taken following each interview about topics of importance. The second stage involved generation of initial codes from the participants' stories, looking for possible patterns, and writing down the first ideas. Codes expressing interactions with supervisors in terms of trust and support, and the feeling of ambivalence were for instance *feeling guilty, there is no one else, nervous, her responsibilities, always kind to me, I was the problem, always tired.* These codes described lack of trust and blurred boundaries with the supervisor. Examples of codes reflecting participants' experiences of the spatial culture restrictions, which they try to accept as an unavoidable fact, include: *sometimes not eaten at all, cozy together, make the best of it, all these bells.* Codes such as *elephant in the room, glossy images, robots, talk the hospital down, keep peace, slaves, humiliation,* described the experience of their supervisors' and the hospital management's motivational and pepping methods. Searching for potential themes focused on how accurately and relevantly the themes represented the participants' experiences, then the themes were defined and named, and the findings were written up. Phases 3-5 resulted in three main themes discussed in the analysis section.

Analysis

Based on interviews with 14 women nurses working at the National University Hospital of Iceland the article examines how nurses' prior expectations for the job conform with everyday work life, which may shed light on the participants' well-being and autonomy. The themes constructed to capture the participants' experiences are *Coping with foggy boundaries, Normalizing confinement, Pepping for the 'greater good'*.

Coping with foggy boundaries

When entering the profession, the nurses take for granted that their well-being will be looked after and respected as a part of their professional status. These expectations refer to the psychological contract with the employer, indicating mutual trust and respect (Gupta et al., 2016). Looking after their own personal and professional boundaries is not always possible for the nurses due to workload, and unexpected and confusing behavior and instructions from their supervisors contradict the nurses' prior expectations. In the stories of the nurses two main types of supervisors emerged. The former is the supervisor whose distant behavior causes the nurses insecurity, which they often interpret as a message that they need to do better, and that support is not to be expected. The other type is the supervisor who, with unclear boundaries and instructions, appeals to the professionalism and conscience of the nurse, who may take over the responsibility of the supervisor as a token of friendship and loyalty. It can be professionally challenging and even feel like a test of skills, dedication and importance. As Audrey recounts, she partly interprets her supervisor's boundary-crossing as needs for support and adds to her own work, feels insecure and frustrated, but also experiences a familiar connection:

> My supervisor, she was a very strange woman, and she told us she had to go to a lot of meetings at the hospital, but I know she often went to her physiotherapist instead. I know she was very tired, so I didn't want to make a big deal out of it because she is such a good person, she was always nice to me. So, I took on a lot of her management responsibilities, maybe she was taking advantage of me and my need for acceptance.

The emotional connection nurses have with their work and their need for support from their supervisors is often at odds with the latter's ethical stance or skills. Bridget's career was damaged after she complained to her supervisor about being bullied by a female colleague. It was hushed up; she felt that the blame was on her and went on sick leave:

'My supervisor was fully aware of the harassment but chose not to help me due to personal relationships with the perpetrator. It was a clear message from the hospital management that I was the problem.' In the foggy atmosphere and lack of support, fear of complaining about and reporting bad behavior is common, and many of the participants have quit working without getting help. Their experience of abusive behaviors and their vulnerability to such, is consistent with extensive research, for instance Stahl-Gugger & Hämmig (2022); World Health Organization (2023); Hawkins et al. (2022) and is one manifestation of the theory-practice gap (Chekerwa, 2023; Gassas, 2021). The participants experience the gap that exists as a symbol of conflicting interests, of the organization versus the silent individuals who are not expected to object: 'Like the hospital assumes we're robots.' (Eileen). The nurses' restricted access to resources is consistent with what Skeggs (1997) and Valentine (1996) theorized on female professions and female spaces in the hierarchy. In her interactions with her supervisor Bella did her best to meet her expectations: 'I often had the feeling that there is no one else, just like in my family'. Her supervisor isolated her with manipulative tactics, and Bella felt that she took advantage of her personality traits of feeling indispensable, important and 'the one'. Aurora mentions the coping strategies she brought with her into nursing from her family: 'For me it was normal, keeping the family together, and it had the effect of leading me into nursing, just to be able to be there for others.' Aurora has also questioned her 'need for acceptance', and that old solutions to the question of what is 'right' and 'normal' in meeting needs may complicate relations in the workplace. Boundaries and needs for self-care are easily manipulated and abused when the nurses are encouraged to meet the expectations of the hospital, which may be normalized even if unhealthy and unjust, which is consistent with the results of Evgin & Sümen (2021) and Hinrichs et al. (2011). Roles and responsibilities can be mixed up and despite the workload and lack of support the nurses respond to their patients' needs according to their work-ethics, neglecting their own well-being and 'choosing' to condone or put up with their supervisors' confusing behavior. Angie describes how her supervisor caused her insecurity and anxiety with her distant manner:

> I felt a wall between us from day one, always worried about going to work. Because I didn't know what I was getting into, I always felt she was somehow warning me, humiliating me in front of others, showing who had the power, but she was respected in the hospital, so I always doubted my competence when she was near.

On the surface, Angie seemed to follow the feeling rules and manage her feelings as socially 'appropriate' (Hochschild, [1979] 2012); but she didn't have the courage or was not sure she had the right to defend herself against the supervisor who had an aura of authority and respect, so she 'chose' to put up with the situation for four years. 'I see now that I was terrified that she would turn against me, and I would run away, but I knew that my patients trusted and respected me. But I had to quit because of one powerful person.' Angie's story reveals the often-neglected consequences of stress and trauma of experiencing breach of the psychological contract. Eileen shares the criteria she has for a supervisor who understands presence:

> But my best supervisors have been those who have allowed me to see their human side, their character, and have come down from the platform to me and said that you did a good job. 'My door is open; you can talk to me'. Even though it is closed, she has come down to my level. You have the feeling that she is maybe like a friend, she is not only your supervisor, but also the one who is likely to take care of you and say: 'I know, I've been through this too'.

Blurred boundaries and invisible power structures may be ignored, normalized or put up with to keep peace for the 'greater good,' and when the psychological contract is not there or automatically expires, the importance of getting support and processing work-related traumas becomes clear.

Normalizing (a self-sustaining) confinement

A routine/part/arrangement of daily work is that the nurses stay on their ward the whole shift. This theme describes how they have adapted to the spatial restrictions in their working situations. Due to staff shortage, it is not considered professionally acceptable to leave the ward, and even if rare opportunities of leaving the ward arise, they prefer to stay there: 'You are the only nurse who knows your patients' condition well, so you don't go out to the canteen to eat and come back, and everything may have changed in a minute'. (Aurora). Their focus is always on the health and well-being of the patient. Alice adds to this: 'If I attend to a patient for another nurse who is the primary one for the patient, it can be dangerous if I don't know the patient well enough, many patients are seriously ill and need continuous monitoring'. The situation has created a self-sustaining culture, and the nurses have to a certain extent normalized this confinement and insufficient staffing, usually without having a break during the shift and with no special room or time for resting or eating.

> There's not even a chance to go because you know, it's not even because of the poor staffing, it has become a rule, a tradition, but in fact the model I think is just set up that way, because according to the shift plan, no more nurses are expected to be working. (Alice).

When the nurses are faced with the incompatibility of their own well-being and their professional and ethical commitment, they feel they must adapt to the situation: 'The secretary usually goes to the canteen and gets food for us, but if we sit down to eat, we're always standing up, the bells, check on your patients, the ward phone, relatives and other professions need information'. (Aurora). She mentions that when she started to work there as a young nurse, she found nothing wrong with this arrangement, for her it was a part of her duties and a way to improve her skills: 'Just coming into some fixed culture, maybe you haven't started to realize it yet. Still, some of the older nurses just seem like they just don't care, even if they cannot sit down the whole shift'. Dana is one of the older nurses: 'Of course we have our cozy fun moments even if we don't go out. But if I worked full time like I used to, staying inside the whole shift 4-5 days a week would be exhausting'. For those nurses who financially need to work full-time and, in addition, take the extra shifts that are offered, this confinement is strenuous and contributes to work-related problems as Halford & Leonard (2003) and Muller (2019) have argued. The nurses describe how the hospital culture encloses them as an unescapable fact which neglects occupational health and endangers professionalism. They maintain the status quo with the traditions that have pushed them into and kept them in the female sphere (Valentine, 1996), with access to the female social capital that has been allocated to them (Skeggs, 1997). Staying the entire shift on the ward, without a chance to take a break outside, illustrates in a nutshell the spatial isolation that characterizes nurses' self-sustainable working conditions. Creating a cozy space to counteract confinement may be a relief while concealing the hospital's negligence towards nurses and the all-encompassing gendering of space.

Another manifestation of restricted access to the public space and other groups of the hospital is that due to the nurses' confinement on their wards they can't attend meetings or lectures that are available in lunchbreaks for health professions. For Aurora this separation from other groups and spaces is both a matter of missing out on opportunities to maintain their knowledge and unhealthy, downgrading and disrespect for their professionalism: 'If we had proper staffing, you would have more time for your career development and how to protect your own health'. Being cut off from socializing

in gender-balanced spaces in the hospital is a source of social and professional isolation, contributing to the sustaining of nurses'

subculture and segregation. According to Halford & Leonard (2003) and Muller (2019) it creates and maintains negativity and bitterness towards the hospital management, which the participants believe ignores their well-being.

Pepping for the 'greater good'

This theme captures how the participants understand their supervisors' motivational and boosting methods which are meant to enhance work performance. For the nurses their supervisors represent the institutional culture and the expectations of work contribution. When young nurses enter the profession, they are guided by positivity and ideals and are busy enhancing their professional skills. It takes time to grasp the work ethic and the unwritten rules about behavior, communication, and work style, how requirements for work contribution are presented and if they are consistent with the nurses' professional awareness and their preparation for the job. Alice: You enter some fixed culture; but haven't realized it yet. When you commit to some ward you just focus on practical aspects and to acquire skills and knowledge, you have not started to consider the work environment, the management.' While the institutional traditions may contrast with how the nurses feel at first (Ahmed, 2017) they decide to trust that they will be cared for by their supervisors, which they expect they are entitled to, as per the psychological contract (Gupta et al., 2016). Bella tells how she became aware of her supervisor's dishonesty with her:

> At first, I thought she was praising me because I was hardworking and smart, I thought I was helping her to keep things afloat. But when I complained about the workload and not getting a rest break, she said I was the only one who found the shifts difficult, but the other nurses also had complained to her and her manager. This is how she tried to get more out of me and create discord between us nurses.

Bella experienced the breach of the psychological contract as a personal betrayal and a discrepancy with her expectations, and she quit working. As a young nurse she strived to improve her performance, believing her work was important and valued. When supervisors ignore complaints, they silence the nurses but may still themselves be adhering to the rules and demands of the hospital to get things done, relying on the nurses' professional ethics. Being nurses themselves, they belong to the hierarchy,

outlined by Tomkins (2021) as restricted by traditional values and discourses of vocation and submission. These interactions are perceived with mistrust and as a power imbalance, contrary to the nurses' expectations for their career. Aurora had a similar experience to Bella when she was choosing a ward to work in:

> When I was a student in her ward she showed me her positive sides, if I wanted to apply for a job which I did, but soon she started to completely ignore me after I complained to her and her manager about insufficient rest between shifts, which happened every week and she had promised to prevent. I was very angry and hurt, but if you are always trying to hold on to some negative feelings, it destroys you. So, I chose not to quit, but to focus on improving myself.

For Aurora the breach of the psychological contract was a learning opportunity. In her opinion the subject of insufficient rest was avoided as tackling it was not consistent with the unwritten rules of having the interests of the organization as a guiding principle. Despite the injustice, she chose to consider her supervisor's stance: 'My supervisor is like this, it's just to ensure that everything goes well, which is of course her job and then, the staff is left out.' The emphasis on the overall benefit and performance of the hospital stands in the way of the well-being of individuals, and is manifested, among other things, in the fact that communication is ineffective and the needs of nurses for support and occupational safety are neglected. In the isolated female space (Valentine, 1996) the nurses have normalized their options. For Alice the working atmosphere in her ward reminds her of her past, when the focus was on illness and how it affected the family as a whole:

> I know it well from my family, we just go into what is already there, if certain rules have always been there, we don't make new rules, sometimes it is easier. And maybe you haven't learned in your upbringing to watch out for your boundaries, so it may take a while before you realize that your well-being does not come first.

While the nurses try to meet expectations and rules, in the belief that their well-being is being looked after, the fact that they do not seem to have had training or shown a channel to express their complaints remains hidden to them. It may echo the myth of the virtuous and selfless women (Kubsch et al., 2021; Prosen, 2022), inconsistent with occupational health and safety. This is the message that nurses take from their

interactions with supervisors, most of whom have been in the same position as their subordinates but have perhaps chosen over time to serve the interests of the organization and deny or avoid the situation. The lack of constructive communication and the distance between them leads to nurses' self-criticism, which can to a certain extent be understood as boosting and empowering. It can be tricky to distinguish between the well-meant pep and a manipulative tool of control. The feeling of being exploited grows in serious health conditions and unexpected situations, such as in the COVID pandemic, when specialized professions were called to the scene in a prolonged emergency and nurses' endurance was tested like never before. In that crisis, the veil was stripped of a situation that now came to the surface. Many nurses experienced that they were not respected as professionals with high-quality specialization, but that their contribution was taken for granted with the reputation of being constantly accessible and they would put the welfare of clients first no matter what. Esther shares her experience:

> I experienced it so strongly during the COVID how badly nurses were treated. There were glossy images in the media of how helpful, heroic, and sacrificing we were, but some of us felt like dirty floor rags, best hidden away. The picture was beautified because the situation was horrible. I could not have imagined that this was happening in Iceland. Staff were simply treated like slaves. The public has no idea what's going on in there, MPs and all those above us.

The nurses feel committed and vulnerable at the same time and in the hospital, persistence is a virtue. They are encouraged to overlook the dissonance they are aware of in the culture: 'Don't talk down our hospital' is a well-known managemental phrase: 'But the thing is that no one dares to speak out because you don't want your supervisor to turn against you, the hospital is such a small community, it would only hurt you.' (Esther). Managing frustration and anger according to the institutional culture is preferred in this situation, contrasting with how the nurse feels (Ahmed, 2014; Hochschild, [1979] 2012). If nurses continue to allow others to place them in the hierarchy of outdated discourses and silencing the system of power is maintained (Tomkins, 2021). The participants feel they have been duped, shanghaied into the profession, partly through the boosting methods, serving 'the greater good' at the expense of their well-being. Angie left nursing after having felt 'a shell' between her and her supervisor for four years:

> When we are young: we feel how awesome this job can be. Then the tank starts to leak because there is no contribution of good energy from the organization and management. I was just in my own shell. I wasn't going to abandon my clients and all the things I cared about, I had done so much for them, and I built a lot of trust and confidence. I miss it the most. I often feel like something is missing, there is a void that I don't quite know how to fill.

Health problems are side effects of workload and staff shortage and are contradictory and irrationally connected to the image of the selfless hero. The hero discourse (Kubsch et al., 2021; Mohammed et al., 2021; Stokes-Parish et al., 2020; Teresa-Morales et al., 2022) is experienced by the nurses as a distortion of reality and does not provide an image of occupational health and safety policy in the hospital: 'I can't bear to be compared to a hero, heroes take risks, and are put on a pedestal for sacrificing themselves, am I then, should I put myself in danger to please the hospital?' (Eileen). The way the participants describe the hospital culture indicates that not only are their health needs ignored, but the emotional aspect of their work is undervalued, which relates to their relationship with clients. As their professional and interpersonal skills are not respected, they have the feeling of being dehumanized and seen as robots, the opposite reality of how they envisioned, prepared and invested for their profession.

Conclusion

This paper explored how nurses' prior expectations for the job conform with their everyday work life. Analysis revealed that regarding important aspects of their work, they experience unexpected violations in interactions with their supervisors and the hospital management. The agreement on support and guidance from their supervisors, which they expected to be valid when they started working on a ward or as new nurses, does not hold up. This results in unclear roles, blurred boundaries regarding professional responsibility, and manipulative tactics to which the nurses are vulnerable because of their commitment to their clients; they assume unclear roles to strive to maintain professionalism. Another manifestation of how the working culture contrasts with nurses' ideas about their own development and participation in the hospital is related to the long-standing staffing shortage and their professional duties. The nurses are strictly confined to their wards and have no organized rest breaks. They are spatially and symbolically isolated in their female space and miss out on activities and participation in public spaces of the hospital which underlines their limited resources in

the hospital hierarchy. Through that status, coupled with their professional duty, the nurses have normalized this situation in some respects. Still, they experience such restrictions as undermining and disrespect for their professionalism and health protection.

Prior research highlights nurses' vulnerability working with their supervisors and in the interviews the nurses direct their disappointment, hurt and anger at their closest supervisors; the people they expected guidance from. It may be a part of the nurses' isolation in the hierarchy not having an opportunity or occasion to discuss those matters with the hospital's management. The supervisors are described as distant and lacking interpersonal skills which may have to do with personal incompetence, but there seems to be a missing link between the hospital management to the supervisors. They themselves may prioritize their duties to meet the expectations of the hospital management, from which they possibly lack support and guidance. The fact that the supervisors of the participants are all women nurses and have worked 'on the floor' before, can indicate that they are also subject to hierarchical rules. By looking at the performance of supervisors in the context of the hospital culture, the focus and responsibility shifts away from the individuals and there is more potential to address it in a wider context at the institutional level.

The COVID-19 pandemic when hero discourse in the media put nurses on a pedestal may have played a role in revealing a managemental pepping culture that had been silenced before, meant to enhance work performance, such as in staff shortage. Such manipulative tactics leads to the nurses' feeling of having been 'shanghaied' or duped into the profession, that their well-being is being sacrificed for the interests of the hospital, which increases the likelihood of work-related illnesses and resignation. The participants' experience is that idealization has contributed to and overwhelmed the fact that they are a marginalized group in the health system, marked by a self-sustaining inheritance which may be a major factor in how the profession appears to the public.

This study calls for research on how supervisors consider their preparation and duty to support their staff and welcome new nurses, and how the hospital's occupational health- and human resources policy is carried out on their wards. Addressing nurses' working situations outside nursing faculty and the hospital puts the challenges of the profession into a wider context; seen from the perspective of social and feminist theory may free it from the restrictions of the hospital hierarchy.

The stories of the nurses who participated are a valuable input for a critical discussion about a situation threatening them and their clients' health and well-being. They are also important for a reevaluation of exercise of power in health management. The manipulative tactics the participants experience contrast both professional ethics and active health and safety policy. Neglecting occupational health of the nursing profession degrades the quality of health care, causing health problems in many parts of society, for nurses, patients, and their families. Supervisors and hospital managers are responsible for hindering the rights and health of nurses with a lack of support, and unclear expectations. Nurses must stop controlling their anger and frustration and permit themselves to critically express opinions and implement a new culture of equality and occupational safety.

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7 Discussion of Findings and Conclusions

In section 7.1, I will discuss the findings and conclusions related to the overall aim of this dissertation and the articles. In sections 7.2 through 7.7 I will present some situations (rather randomly chosen) from the daily life of the participants. The contribution of the study is discussed in section 7.8, and finally in 7.9 I suggest some ideas for future research.

7.1 The findings considering the overall aim and assumptions

The overall aim of the dissertation is to explore the interplay between nurses' experiences of working conditions and gender equality ideals in Iceland, considering the gender imbalance in the profession and focusing on power relations and occupational well-being. The assumptions I presented for the dissertation are that a profession's gender equality status must be understood/examined in the context of working conditions, health protection, overall professional recognition, autonomy and respect. In chapter 5, I discussed how the articles answer their respective research questions, as well as how they answer the research questions presented in section 1.1.2. I will now briefly review the findings from the three articles for clarification and discuss how they correspond to the overall aim and the assumptions.

In the first article, the aim was to examine the dynamics of power within the profession, considering working conditions, interactions, and cooperation with other professions. Findings reveal that invisible threads appear that keep nurses bound by the ideology of sacrifice and always being available, but they are also expected to act in accordance with their professional knowledge and responsibility. Daily life is characterized by power imbalances, restricted autonomy and time, and undermining nurses' professionalism. To maintain professional standards and meet expectations of the hospital, they make compromises at the expense of their own health, and which often are endangering to their clients' safety. This reflects insufficient support from the nurses' supervisors and hospital management, as well as lack of tools for change. The women nurses hope for the males' help to enhance equality. Given the assumptions above, these findings reveal that the assumptions for gender equality do not hold about nurses' working conditions, health protection, and overall professional recognition and respect.

In article 2 the focus was on what role stereotypes about masculinity and femininity may play in the work life of nurses, and what forces maintain roles and norms that emerge in prominent gender roles and powerlessness that appear in the first article. The findings

reveal how stereotypical essentialist ideas and norms affect nurses' career choices, as well as sustaining hierarchical power in the hospital and nurses' powerlessness in terms of professional recognition and autonomy. The feminization of nursing manifested in a striking difference between the men and the women, with men experiencing better work-related well-being, general conditions, and resources. Stereotyping ideas about masculinity and femininity also play a part in discouraging men from entering nursing, which keeps the gender imbalance and inequality in the profession going.

For the third article, the focus was on how nurses' initial expectations for the job conform with their everyday work life, given the powerlessness of nurses in terms of professional recognition and autonomy, which was revealed in the first and the second articles. The hospital's managemental culture mirrors the hierarchical structure and how the nurses are symbolically yet physically tethered to their department. They have adapted to and normalized that situation in order to carry out their professional duties and to protect their clients and have given up on expecting support and guidance, which they initially expected from their superiors and the hospital management. According to the participants this working arrangement has detrimental psychosocial and physical health consequences and increases the likelihood of leaving the profession. In terms of the assumptions, these findings clearly indicate that the status of the participants' working conditions, health protection, and overall professional recognition and respect does not meet the standards for healthy working conditions, health protection, and overall professional recognition and respect.

The recurring themes in the participants' accounts of their working conditions, in all three articles, suggest systemic issues. Given the assumptions by which the nursing profession's equality status must be understood and the overall aim of this dissertation, the participants have not been able to enjoy the advancements in gender relations the way many other professions have in Iceland.

7.2 Relativity and normalization

To get a clearer picture of the gender equality status of nurses in Iceland, it is appropriate to examine factors that indicate health, professional and gender quality in work and professional development. Since the course of events is often fast and unpredictable in nurses' work environment, and the vulnerability of the clients is central, rest and well-being are relative concepts. Occupational and health matters of staff are therefore easily neglected, and professional and ethical boundaries get blurred. The Global Gender Gap Report's measurements do not assess those aspects, as they rely on statistical facts on gender equality markers (economic opportunities, education, health, and political leadership).

Considering the lack of work-related well-being implicit in the participants' stories, it is important for hospital managers to set up a realistic assessment of the workload to create a healthy work environment for nurses. In times of understaffing, work overload,

lack of rest and refreshments can become normalized, at least for a while, when the job is about taking care of the urgent needs of often helpless and weak individuals. The normalization process is, in a way, confirmation of the nurses' professionalism and loyalty, not only towards their clients but also towards their colleagues, supervisors, and management, until the nurses experience a breach in what they thought was an agreement of support and guidance. Most of the female participants were aware that factors from their background made it difficult to set boundaries in situations when they faced both fair but often unprofessional demands or when their personal boundaries were crossed. It can be assumed that nurses with such a background will remain in the nursing profession for years to come, which should be met and handled by occupational health and safety management of the hospital, empowering those individuals who otherwise could be harmed by inappropriate demands and interactions.

7.3 Safety and oppression

When comparing the working experiences of the male and women nurses there are striking differences. In the males' stories, various examples of gendered differences were shared. As 'deviants' by tradition, the male participants seem, from the outset of their studies, more cognizant than the woman nurses of the need to take care of their health and set professional boundaries. Since choosing whether to enter the profession, the men have been weighing pros and cons and have stuck to their decision despite hindrances they have met on the way. It is despite sanctions they meet at work, both negative and positive, ('get the hell out of here your homo' or 'the atmosphere is much more joyful working with the guys'). As they admit, they are protected by their gender as men in the hospital hierarchy. Their preparation is in my opinion what the women lack in terms of assertiveness and self-caring to be ready for the theory-practice gap, as their (the women's) entrance and choice is often based on traditions, glorification of nursing, feminization and pressure from upbringing. I think that the difference between the genders' backgrounds and choosing process is big factor in many of the work-related problems which the women nurses meet unexpectedly and unpleasantly, with adverse consequences for health and well-being. Ideal arrangements by the hospital management would be to take seriously how crucial caring for staff is in terms of health protection and support, not to mention reviewing the reasons for and maintenance of gender imbalance, which I will discuss in more detail in section 7.6, on future research.

One serious manifestation of the gendered differences in respect and safety at work is the rude and humiliating behavior the women nurses are exposed to, for instance from doctors, as well as not having the tools or support to defend themselves. Not defending oneself may stem from the belief that it is a virtue to rise above the hustle and bustle, and to fight for rights, such as with feminists for equality, which may be seen as the opposite of caring. A man nurse shared in an interview for the second article how he

witnessed on several occasions a male specialist (a doctor) verbally attack a woman nurse in a degrading way. He said: 'It makes me sick; I always think, why does she not do anything about it?'. Some interactions may give others the opportunity to behave oppressively. Thus, the question remains how the males' mindset, assurance, and decision-making processes can be of use for the women nurses as role modeling. Discussing useful and constructive methods in the educational and health systems may be successful, but deep roots of gender binary ideas block the way.

7.4 The professional face

In an interview for the second article, a man nurse described how he put on a professional face in vulnerable situations when trust from the client/patient was important. He felt that by doing this, he was seen more as a doctor, an authority figure, making use of his gender but at the same time applying the 'professional face' as an interpersonal bridge of trust and professionalism, based on intuition and sensitivity. As a man nurse, with this act, or performance, he considers gendered and feminine views towards caring, as the patient may feel more secure with a doctor than a 'deviant' man nurse. The professional face is a kind of a costume that the man nurse wears along with his skills and ideas of the environment about gender-related characteristics. He mixes it with sensitivity and insight into clients' vulnerability and adapts to the culture in a considerate and professional manner. In that way, the nursing relationship is situational, assuming hospital hierarchy and stereotyping ideas are still dominant. I think these 'acts/performances' are a sign of intermediate state of degendering or unigendering-process of the profession: 'You are expanding the meaning of caring, in the meaning of being humanistic, you want to care on your own terms and not according to society's expectations of femininity.' (Man nurse). With a more balanced gender ratio in nursing and disconnection and liberation from feminization, which maintains the binary, the focus will be on nursing as a human profession. The profession may then attract all kinds of people, reflecting society's diversity. Applying the men nurses' preparation strategies will probably help to bridge the theory-practice gap, since it involves a realistic vision without glorification of nursing which is not based on reality.

7.5 The relation between autonomy and respect

For the participants autonomy is one of the terms and conditions that define their profession, and generally it is believed that professionals are respected for their expertise. The assumptions for the dissertation, by which the profession's gender equality status is to be understood, include these terms, which are interconnected. Nurses often lack professional autonomy because their skills and capacities are not recognized by medical and institutional hierarchies. As an oppressed group in the medical hierarchy nurses have low degree of autonomy, decreased nurse self-advocacy, low self-esteem and inability and fear of confronting the authority (Roberts et al., 2009). A part of the nurses' (most of them were women) daily experiences was that

their expertise and professional space and mandate was belittled and symbolically disrespected and neglected by other professions. Incidents like these are strong symbols of power imbalances, and the women nurses believe that a more equal gender ratio will solve various oppressive issues in the profession and earn them more respect, equality and autonomy. It is one of the rather unexpected findings in the dissertation, but as the project progressed and I heard the same theme resurface often, I understood better how limited the opportunities for professional growth for women nurses were within the hierarchy.

7.6 The interplay of gender imbalance and ideas/ideologies of self-sacrifice

The ideas of vocation and altruism, wanting to help and care for others, are historically related to nursing identity, and have been related to obedience, sacrifice and ideas of innate caring ability. Through history nursing has contradicted professionalism. Feminist researchers have pointed out that due to entrenched notions of women as self-sacrificing and protective, the gender imbalance has impeded the profession's rights and shaped and maintained its identity and place in the patriarchy. It has been contended (Becker et al., 2022) that wider structural factors in society, such as media and the persistence of misogyny in the health system, undermine nurses' autonomy by maintaining the image of the nurse as a submissive and self-sacrificing martyr.

Stereotyping associated with nursing relates to these ideas, and stereotyping ideas about masculinity and femininity, in the meaning of powerlessness and subservience, are a significant barrier for men choosing a career in nursing, as it contradicts traditional masculine roles. The challenges that men who choose to become nurses meet often drive them away to other studies and workplaces, because of the pressure to fit the standard nurse image. It keeps the gender imbalance and inequality in the profession going.

The participants in the study, both men and women, perceived the linkage of gendered working culture to femininity in the meaning of powerlessness, but from different sides. The women nurses found the men nurses more assertive and claiming better working conditions: 'It is of huge importance that they enter nursing; then, all this female sacrifice would end' (woman nurse). A man nurse told of an incident when a male doctor insulted a female nurse who did not defend herself. The story captures the resilient culture which many nurses face every day. He said: 'It makes me sick; I always think: why does she not do anything about it? I am kind of waiting for this to happen to me, a moment when a specialist would, you know. But I am sure it would not happen to a man nurse.' The experience of witnessing both sides of the participants' work life added in my opinion important information about how unequal their opportunities are for work-related wellbeing, autonomy and respect.

7.7 Intended advocacy in the researcher – participant relationship

When choosing a research topic, a theoretical approach and a suitable method, various questions arise and the researcher's responsibility in this regard should not be underestimated. I do not think that I organized the process much when I started this project, but I wanted to use my interest and background to examine a field that I had knowledge of and that working conditions there were not always good. This is manifested, for example, in the discrepancy between the expertise of nurses and their working conditions. I enjoyed conducting interviews and analyzing them and believed I had the ability to do so.

Then came 'conscious' thinking about my position, and how and why my experience and knowledge led me to investigate the power relations that were at work in the work life of nurses. There is a clear connection and context between the approach I chose, for articles 2 and 3, and how I see the participants' position, their experiences and their need to communicate this through participation. I found the approach of poststructural feminism right, as it has relevance for women and other marginalized groups. Wall (2007) contends that the nursing profession is embedded in a gender-based hierarchy, and the approach seeks to understand and expose power relations, which are often hidden and taken for granted as 'normal'. The interviewing method was an obvious choice, which offered depth and sense of collaboration.

The topic of discussion and the reasons why the nurses volunteered for the interviews were that they had experience of working in unhealthy conditions where they felt their wellbeing had been neglected. The nurses knew of my nursing background, which may have increased their confidence that I believed them and had their best interests at heart, and they had expectations that their contribution would have a positive effect, for themselves and their profession. I did not tell them that I had similar experiences to them from my work, I believe that they assumed this, since I was researching this. They may have perceived that I had experienced injustices as a nurse, thus trusting me in the process and it increased a sense of solidarity and cooperation.

As a responsible researcher, I must trust my own judgment and ethical standards, things happen quickly in interviews, and I need to stay on track to read and follow the participants' priorities. There were moments when I doubted my abilities, but you can never be sure that you will succeed, I think it is part of the method to take certain risks, and trust that the researcher and participant will jointly create the results. For me, who have not always been careful about my own boundaries, it can be difficult to understand whether drawing conclusions in an interview based on my own experience is due to my intuition or due to an overestimation of my own abilities and sensitivity. Perhaps I have believed that a certain shared experience is a guarantee of the quality of the research.

There can be a feeling on both sides that expressing and hearing sensitive and difficult stories should create a channel for those stories to make positive changes, for justice to be served, and that I am a potential advocate for those seeking ways to achieve justice. The participants were aware that the results would be published and would hopefully have some positive impact. That is perhaps the general role of an advocate in this regard. For many who may be sharing their experiences for the first time, it can have the effect of giving the person a clearer picture of their experience and consequently being able to learn from it and use it constructively.

I assume that my own experience and attitude towards injustice affected the interviews and how I analyzed them. I believe that it was a mutual understanding of urgency and various emotions that drove me and the participants to do good work, hopefully for the benefit of all parties.

7.8 The Contribution of the Study

While working with the participants' accounts, analyzing, and writing in the context of literature and theories, interrelated topics have emerged, contributing to the nursing profession by advancing knowledge and informing its practice both in the hospital and in their education. The theories I have applied from a gender equality perspective have helped to shed light on the often-contradictory working situation of nurses in the National University Hospital of Iceland and on underlying power structures. The stories of the participants harmonized with various theories and literature that explain their constant struggle to balance their professionalism with the demands and traditions of the hospital. Relevant topics for the articles are discussed in literature chapter 3. The gender perspective and feminization of the profession and stereotyping play a big role in the dissertation, so does the health care hierarchy and nurses' work-related well-being.

As I mentioned in section 3.1.2, many nurses have been reluctant to work with feminists for their rights although feminist theory can shed light on nurses' oppressive working conditions. Nurses' hesitancy to embrace feminism has been linked e.g. to feminists' image of nurses as submissive, understood by some nurses as devaluation of caring. Therefore, I found the poststructural perspective well suited for analyzing the position of the female-dominated profession of nurses in the hospital hierarchy, as the approach seeks to understand existing power relations and how they are sustained by institutions (Prasad, 2018; Weedon, 1997). A substantive topic in the dissertation covers how nurses' experiences in the hospital hierarchy are related to the feminization of nursing, maintaining gender stereotypes, perpetuating traditional female roles, and limited access to power and decision-making. From the viewpoint of poststructuralism, stereotypical depictions of nurses and their profession are confronted as social constructs (Searle, 2010). Some central stereotypical images related to femininity are associated with nursing and caring ability and have played a crucial role in power

imbalances (Kubsch et al., 2021; Prosen, 2022), contradicted professionalism (Girvin et al., 2016; Slettmyr et al., 2017) and sustained the dwelling of the profession in the private (female) sphere (Walby, 1997).

If nurses' reluctance to apply feminist theories is hindering them from attaining professional rights and respect, empowering theories and literature should be a part of nurses' education and used by the hospital management as a basis for discussion on equality and working conditions for nurses. This can take the form of regular lectures and meetings at the hospital, where nurses can attend during working hours. Findings from studies on the experience of nurses working at the hospital should also be introduced in the hospital; bringing the stories into their original environment could lead to interesting and useful discussions for nurses and their supervisors and hospital management.

The role of hospital managers in such a revision demands that they are willing to take note of their nurses' experiences, and an honest self-examination would be appropriate. As stated in the dissertation, managers have been distant and have chosen to emphasize the benefits of the hospital. I believe that the participants' stories present a clear picture of daily reality to the managers.

One important contribution of the study is the striking differences between the stories of the men and the women regarding their overall conditions and resources. They describe how the women are oppressed and lack support, which may not be obvious to others without the males' participation. Women nurses do not have a channel or ability to speak out for themselves when their professionalism is belittled, which the men nurses notice and find shocking and inappropriate. This needs to be communicated as an occupational and health urgency. The same applies to stories of unhealthy working conditions and lack of support from superiors.

By emphasizing their view of nursing as a human trait, 'for all genders', the men nurses challenge conventional roles, which could reduce stigmas not only for those men wanting to enter traditionally women's jobs, as Anderson & McCormack (2017) argue in their approach of 'inclusive masculinity', but can also liberate nursing, and women nurses, from the feminized construct of caring. Their contribution can help to attract young people to the profession. While the males admit that they are protected in the hierarchy by their gender (Connell, 2005), being role models for women nurses regarding their self-care and professional boundaries contributes to equality in the profession. To change the situation, hospital management, health care, and universities must collaborate to revise and eliminate oppressive values about characteristics of genders. This requires the contribution and initiative of nurses who must have the courage and support to speak up. Finally, the research that has been done on the subject should be used for progress, with the voices of the nurses who have participated.

7.9 Future Research

My background in nursing helped me to gain important knowledge while working on the project, but it may also have caused me to miss out on important literature and research from other research fields. From the participants' stories, it is evident that various issues are important to study which would benefit the nursing profession. The knowledge about the conditions of nurses in the hospital which I have come by in the process should ideally lead to advocating for them and promoting change for the better by conducting effective research related to the findings. Given the resilient stereotypes and feminization of nursing which meets the participants, I find it important that research in this field is based on approaches that have social constructionism and poststructural feminism as a premise. It would shed light on what factors in the social structure of Iceland maintain conservative and essentialist ideas that keep nurses constrained by the conventional gender division of labor and maintain the gender imbalance.

The contribution of the findings to established fields of research:

Nursing research

Among the topics of research in nursing is investigating the health and well-being of nurses and substantial literature in the field is available worldwide. As it was common experience among the participants (in the dissertation) to have suffered various harms and consequences from inappropriate working conditions and the conduct of others, many research topics related to their experiences could be examined in collaboration between the hospital and the universities. **The Clinical Research Center (CRC)** is a partnership between the National Hospital of Iceland and the University of Iceland. Both institutions have extensive research experience, both domestically and internationally, working with collaborators worldwide. The CRC serves as a contact point for international collaboration in clinical research projects (Landspitali - University Hospital, n.d.). The Faculty of Nursing and Midwifery of the University of Iceland conducts research in collaboration with numerous foreign universities and scholars.

It emerges from interviews that the experience of a theory-practice gap is common and a major cause of leaving the profession. A preventive action could be to offer nursing students follow-up where they can discuss their experiences, get guidance to ask for support and to deal with frustrating incidents and discomfort at work. Such support should also be available for working nurses. Exploring the effects of such interventions could be conducted by the faculties of nursing and faculties of education of the universities, in collaboration with the human resources departments of the hospitals.

As it emerged in the interviews some men nurses had come across care work by chance and found a connection there. One way to attract (young) men to nursing is to encourage them to work in care so they can find out if caring for others suits them.

Sociology

The sociological aspect of the participant's experiences concerns how their position in society and the health system has been shaped by ideas about nursing as an inborn desire and ability of women and as an anomaly in the case of men. Sociological research is then about how these ideas have developed and been maintained in society, whose interests they serve, and how they are manifested in power imbalance and dichotomous thinking of the binary of men vs. women. Preparation for decision-making of study choice depends on the image of a profession in society; in the case of nursing, is it portrayed as the exaltation of femininity as a virtue or as a human approach regardless of gender. Considering the participants' experiences, research could focus on examining the structure of institutions such as hospitals regarding how the power structure is shaped, the interactions of groups within it and the possibilities for, for example, nurses to influence and shape working conditions in their favor. As experiences of oppressive behavior in the workplace were conspicuous in the findings, it would be useful to explore this in workplaces with relative equal ratios of women and men, as socially defined genders, as well as where there is gender imbalance in both directions.

The finding revealed that due to stress, work-related illnesses and family issues, there seemed to be a certain 'class division' within the nursing profession. Their social situations are extremely different from each other and the workload affects most those who do not have a support system and financial security. This is a sociological and gender-based topic for research.

For university students, conducting research in the educational system on how equality policy is implemented could be a part of their research papers and final projects. It can be conducted in collaboration with educational authorities, the faculties of education in the universities and **the Directorate of Gender Equality.** Results can be used to improve and implement gender studies courses, which are now offered in the Icelandic universities where nursing is taught, with the aim of promoting discussion about those resilient ideas and values.

In addition to these ideas, regular surveys should be conducted on the public's attitude to equality issues and whether there are essentialist ideas that maintain inequality in society.

The Administration of Occupational Safety (AOSH) is a government-appointed institution in Iceland. Its aim is to promote a safe and healthy work environment with an emphasis on prevention and monitoring of the work environment, as well as overseeing research in the field (AOSH, n.d.). Due to data protection laws, I was unable to obtain statistical information on illnesses and accidents as a reason for leaving work, either from the hospital's human resources department or from AOSH. My intention was to include in the dissertation statistical information about illness and accidents as reasons for employee turnover of nurses. According to the participants their reasons for leaving

and work-related accidents are often unreported to supervisors and hospital management. The participants often cited physical illness as a reason for quitting or changing jobs, when in fact the reason was communication problems, bullying, or discrimination. Other events and circumstances such as lack of rest breaks during shifts, insufficient rest between shifts, and not being able to leave the ward, are interesting and urgent research topics, as the nurses often face closed doors when seeking help from their supervisors and the human resources department of the hospital. Some of these work arrangements may be violations of the rules (law?) on occupational health and safety, which require review. There is a need for research into the outcomes of nurses who have left their jobs for these reasons and their real reasons for leaving. Research in this area could be carried out in collaboration of AOSH, the national hospital and university nursing faculties, if it is conducted in an impartial manner and ensures that the voices of nurses are heard and have a positive impact.

As said before, the participants have limited trust in the hospital's hospital management and human resources department. Examining how and whether the hospital's activities fulfill that role and provide preventive measures for nurses should be regularly investigated in an impartial manner, for example by the universities and the AOSH. Interviewing hospital managers on possible reasons for the gap the participants experience and seems to exist between the hospital management and nurses on the floor. Such research should also be aimed at institutional culture, occupational policy, and qualification requirements for managers and supervisors.

Gender studies are conducted widely, such as in the universities and by **The Icelandic Directorate for Gender Equality (n.d.),** which carries out various tasks such as providing instructions, assistance, and information activities in the field of equality issues, as well as supervising the implementation of the law on equality. Considering the gender imbalance in female-dominated professions, which contrasts with the image of Iceland as fairly gender equal, it would be interesting to conduct surveys on the extent to which young people are familiar with concepts related to gender-biased language, norms, and stereotyping related to characteristics and abilities of genders. Such studies can explain how people make their choices about education, how nursing is promoted to attract young people and whether gender stereotypes are more widespread than one might think, considering the image of equality and the Nordic gender equality paradox (Minelgaite et al., 2020). The question remains if the bias is related to men's fear of crossing traditional lines, to the small Icelandic population where they are more conspicuous than in larger populations, or to feminization as subservient and masculinity ideas. Many young men may choose a job with more autonomy in line with the breadwinner discourse, which is interesting to explore. Related to this is the urgent and ongoing issue worth researching and discussing namely how powerful, confusing and harmful some masculinity images are for young men; this said, young people in general are exposed to a flow of confusing information in social media.

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