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Gender and nursing in Portugal: The focus on men's double status of dominant and dominated[1]

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Abstract

This article presents a study that sought to identify the gender dynamics prevailing in a health-related context of tokenism – nursing – in which the members of a dominant group in society – men – are proportionally scarce. Specifically, this study aimed to consider how men experience their integration into a feminized profession. Furthermore, the individual experiences and professional dynamics were placed in perspective with the results of other studies focusing on male populations in high-status professions, in particular medicine, to analyse the intersectionality of status and power. This study involved individual, semi-structured interviews with twelve male nurses, aged between 40 and 58 years, from across the six existing nursing specialties in Portugal. Analysis of the results, obtained through the Alceste software and thematic study carried out according to the social constructionist

perspective in gender studies, indicates that tokenism dynamics interweave a double power asymmetry: the professional asymmetry between male doctors and male nurses, and the gender symbolic asymmetry between men and women. In the nursing profession, this double asymmetry proves beneficial to male nurses.

Resumo

Este artigo apresenta um estudo que procurou identificar as dinâmicas de género predominantes num contexto de tokenism *relacionado com a saúde – a enfermagem – em que os membros de um grupo dominante na sociedade – os homens – são proporcionalmente escassos. Especificamente, este estudo teve como objetivo considerar como os homens vivenciam a sua integração numa profissão feminizada. Além disso, as experiências individuais e as dinâmicas profissionais foram colocadas em perspetiva com os resultados de outros estudos centrados nas populações masculinas em profissões de elevado estatuto, particularmente a medicina, de modo a analisar a interseccionalidade do estatuto e do poder. Este estudo envolveu entrevistas individuais, semiestruturadas, com 12 enfermeiros do sexo masculino, com idades compreendidas entre os 40 e os 58 anos, das seis especialidades de enfermagem existentes em Portugal. A análise dos resultados, obtida através do software Alceste e da análise temática realizada de acordo com a perspetiva social construcionista nos estudos de género, indica que a dinâmica do* tokenism *cruza uma dupla assimetria de poder: a assimetria profissional entre médicos e enfermeiros e a assimetria simbólica de género entre homens e mulheres. Na profissão de enfermagem, esta dupla assimetria revela-se benéfica para os enfermeiros.*

Keywords

nursing

tokenism

gender

symbolic asymmetry

double status

male advantages

Palavras chave

enfermagem

tokenism

género

assimetria simbólica

duplo estatuto

vantagens masculinas

Introduction

This article seeks to portray how men live out their integration in feminized professions – in this case, in nursing. As men currently constitute a small minority in this profession (Evans 1997; Drange and Karlsen 2016; Meadus and Twomey 2007), including in Portugal (17.91 per cent, Order of Nurses 2017), we can consider that they occupy a 'token' position, and may thus correspondingly suffer the negative consequences that, according to Kanter (1977, 1993), are inherent to this kind of context. In fact, according to this author, in a context involving 'skewed groups', workers who are proportionally scarce (i.e., the 'tokens', whenever constituting less than 15 per cent of the entire group for a salient

category such as sex) are subject to greater difficulties in the workplace than their peers, the 'dominant'. According to Kanter (1993: 210), the proportional rarity of tokens thereby becomes associated with three 'perceptual tendencies' – higher visibility, the polarization of differences by the dominant and the assimilation of the stereotypical roles associated with their group – and these generate typical token responses that may lead to negative consequences, including reducing their performance-related pressures, social isolation or marginalization and 'role encapsulation', a kind of role imprisonment (Kanter 1993: 212).

However, when approaching gender relations, the literature states that men occupy dominant positions (e.g., see Amâncio 1989, 1997), displaying several social advantages compared to women (Floge and Merrill 1986; Laws 1975; Ott 1989; Simões and Amâncio 2004; Williams 1992, 1995a, 1995b; Yoder 1991, 1994; Zimmer 1988). In fact, studies analysing gender relations in terms of asymmetrical power (Lorenzi-Cioldi 1998) and symbolic relations (Amâncio and Oliveira 2006), for instance, clearly show that men, perceived both as individuals and as universal references of human beings in general, receive advantages in the 'feminine professions' and are left unaffected by the dominant 'culture' of the profession. Contrarily, women, as a dominated group, referent only to their own group, remain seen as women and are correspondingly subject to the norms of female stereotypes (i.e., limited to the domestic sphere, family care and education). Therefore, due to this symbolic asymmetry in society, male tokens are better placed than female tokens and therefore experience fewer negative consequences and have more advantages in tokenism contexts.

It is also important to highlight how, due to their past group experiences (Barreto et al. 2004), male tokens react differently to female tokens to the tokenism dynamics (Heikes 1991). When men enter a feminine profession, they neither abandon their gender identity

nor lose their gender-based privileges (Williams 1992, 1995a) because, according to Amâncio (1989), masculinity remains fused into the dominant values of the respective profession. Thus, instead of the 'glass ceiling' that generally prevents the rise of women into top positions in masculine professions, men often find a 'glass escalator' that facilitates their rise to the most prestigious, powerful and best paid positions in feminine professions (Williams 1992, 1995a, 1995b).

Thus, how do these two statuses, a priori lower and higher (as tokens and as men, respectively), actually articulate? How do male nurses accommodate themselves? What strategies do they develop to justify and value their place in a feminized profession?

Two studies recently carried out in Portugal within the scope of the same research project, with female politicians (Santos et al. 2016) and female and male medical specialists (Santos et al. 2015), concluded that 'tokenism dynamics' contribute towards preserving and reproducing the gender social order prevailing in society (Connell 2002; Williams 1995a) and thereby enabling men to maintain the same social privileges. Indeed, the politics-centred study (Santos et al. 2016) revealed the various strategies deployed by 22 female politicians to gain recognition in this 'man's world' including, for instance: valuing their own individual merits, fully investing in their political 'profession' while ensuring the management of their private and the domestic lives (i.e., the 'superwoman' model), minimizing the discrimination they are personally subject to (e.g., systematically proving both their competence and how well they deserve their place in the political 'profession') while simultaneously recognizing that women in general are often discriminated against because of their sex/gender (about this phenomenon, see also, for instance, Nogueira 1999).

Meanwhile, we have also published another study analysing the gender dynamics of tokenism within the medical profession (Santos et al. 2015) based on seventeen in-depth

individual interviews with nine female medical specialists practicing in specialties predominantly invested by men (e.g., orthopaedics and urology) and eight male medical specialists practicing in more feminine specialties (e.g., gynaecology and paediatrics). In line with the gender symbolic asymmetry perspective (Amâncio 1997; Amâncio and Oliveira 2006), this article contemplates how symbolic gender meanings influence the dynamics unfolding in this context of tokenism and contribute towards the advantages of men even when in token positions as regards women. The results convey how the competencies of female medical specialists are indeed regularly questioned – and not those of male medical specialists even when making mistakes – that they only progress up the medical hierarchy with greater difficulties, and that family care and housework remain obstacles to their careers – but not to those of their male colleagues.

Hence, from this point of departure, the aim of this article also involves understanding whether the dynamics remain the same for male nurses as for male medical specialists, with both practicing in feminized contexts even while knowing that male nurses occupy a lower position than their male medical specialist peers in the medical hierarchy internationally (e.g., Carpenter 1993; Porter 1992) and nationally (Carapinheiro 1993). In other words, the second issue addressed by this article's problematic framework approaches the interrelationship between gender and medical hierarchies: should male nurses be in a dominant position in gender relations and in a dominated position in hierarchical relations within the hospital, how do these two opposite statuses play out in terms of guiding and shaping their career choices and progression?

As regards the first question, international research demonstrates how, as a predominantly female profession, nursing is more closely associated with the feminine stereotype, linked to nurture and care and, thus, less valued by society (Evans 1997). Male

nurses appear to attempt to solve this issue by distancing themselves and choosing specialist fields more associated with the masculine stereotype, connected to domination. Indeed, gender variations prove quite visible with male nurses clustering in certain specialist fields, such as intensive care, psychiatry and surgery, identified as more 'masculine' and 'manly' (Williams 1995a). In Portugal, when studying nursing and its specialist fields, the existence of certain inequalities is also quite visible (Escobar 2004), with persisting gender asymmetries that place men at an advantage in comparison with women (Laranjeira et al. 2008; Simões and Amâncio 2004). This becomes still clearer when looking both at leadership positions (e.g., although men represent a minority in nursing, in 2015, 345 men occupied management positions, i.e., 28%, Order of Nurses 2015) and at specialty fields, with men more concentrated in the specialist fields related to masculine roles and stereotypes – rehabilitation (28.7%), medical–surgical (24.3%) and psychiatric and mental health (29.2%) than in those interlinking with feminine roles and stereotypes – community (14.3%), maternal and obstetric health (4.9%), and paediatric and child health (6.8%) (Order of Nurses 2017).

Despite these visible advantages of male nurses, when compared to female tokens, international research findings also depict how male tokens sometimes experience discrimination in female-dominated environments, with male nurses often perceived as effeminate and homosexual (Heikes 1991; Williams 1992, 1995a), a sexual orientation that, as a consequence of the strong normativity of heterosexuality in hegemonic masculinity (Connell 2002), experiences marginalization in society in general and in nursing (Harding 2007). According to Williams (1995a), in these cases, beliefs about male sexuality form a kind of double-bind dilemma: whereas men who behave according to the male stereotype may be perceived as sexually abusive, those who behave counter-stereotypically may get

perceived as homosexual. Together, these beliefs may lead to the sexualization of male nurse practices involving physical contact within the framework of intimate care, leading patients to suspect men as caregivers (Evans 2002; Harding et al. 2008). In Portugal, although there is some research on gender and care, in particular about the male experience of informal care (e.g., Ribeiro 2007), empirical research involving gender, male nurses and male doctors remains practically non-existent. We are only aware of the studies carried out by Simões and Amâncio (2004) and by Laranjeira et al. (2008) even while these do not discuss the dual status of male nurses. Thus, we also sought to bridge this gap by carrying out this study based on interviews with male nurses.

Method

Participants

Twelve male nurses from seven hospitals and one health centre located in and around Lisbon participated in this study. Among them, there were two male nurses from each of the six specialist nursing fields existing in Portugal: community, maternal and obstetric health, medical–surgical, paediatrics and child health, psychiatric and mental health, and rehabilitation; six of the interviewees hold leadership positions, with three in feminine specialties (three are also members of the Order of Nurses); six were married, five cohabited, and one was divorced; and ten had children. Their ages ranged from 40 to 58 years (*M*=47.8, *Median*=45; SD=6.30).

Instruments

Within the scope of the same research project as the two studies mentioned in the introduction, with female politicians (Santos et al. 2016) and with female and male medical specialists (Santos et al. 2015), we applied the same data collection techniques – in-depth

individual interviews with a semi-structured methodology – and a similar interview script. Therefore, while this script is not based on the results of the two already published studies (i.e., there are gaps and, therefore, other questions require asking in subsequent research), the analysis of the male nurse responses is based on these previous results. The interview script included a set of topics focused on the following seven major aspects: (i) the participant's entrance into the nursing profession and their career trajectories; (ii) their experiences in nursing (i.e., the dynamics of tokenism as they experienced them); (iii) the competencies that the participants consider necessary for effective nursing practices; (iv) the family–work balance; (v) the origins of gender inequality in nursing, their opinions about the situation and suggestions for promoting equality; (vi) whether or not they experience gender discrimination or advantages; and (vii) their level of mobilization around the gender equality issue.

Procedure

This convenience sample was selected according to the snowball technique that began with the personal contact of an employee at the Portuguese Directorate-General for Health, who then provided us with the contacts of some male nurses, thus facilitating our access to interviewees and avoiding formal bureaucratic procedures. Following a request either by e-mail or by telephone, participants received details about the goals of the study along with guarantees of confidentiality and anonymity. The interviews took place during the same period as those of the other two studies, specifically between the beginning of March and the end of April 2013, in a quiet place somewhere in the hospital they work at and lasting between 25mn and 112mn apiece. With participant consent, we recorded the interviews before fully transcribing.

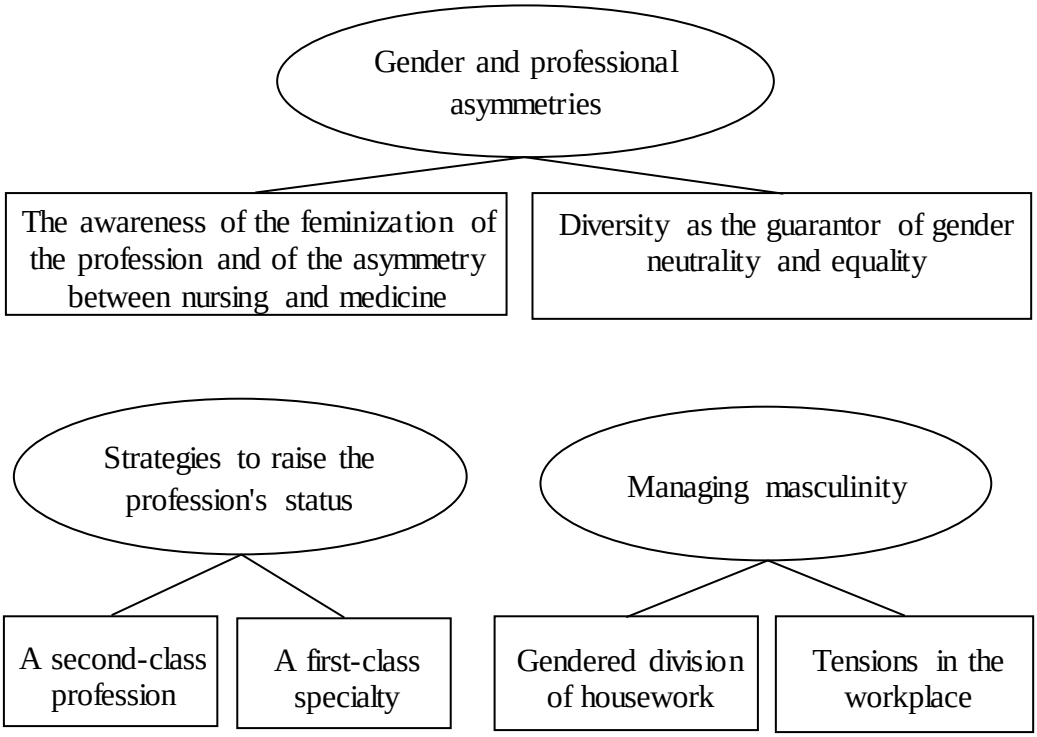
Data analysis assumptions

After carrying out exploratory screening of the data (i.e., integrating all of the participant discourses around the interview topics described above) by recourse to Alceste 2012 software (Reinert 1986), we conducted thematic analysis on the outputs obtained with the aim of 'identifying, analysing and reporting patterns (themes) within data' as proposed by Braun and Clarke (2006: 79). This thematic analysis, driven by our analytic questions and the social constructionist perspective in gender studies (Burr 1995; Nogueira 2001), enabled us to interpret and problematize the classes obtained via the Alceste software according to the rationale of identifying the diversity prevailing within each major theme (identifying subthemes), while maintaining the distinction between themes. We considered two sociodemographic variables: fatherhood (with children vs without children) and age group, constructed from the median age (from 40 to 45 vs from 46 to 58 years old).

Results

Within the broader theme of individual and professional dynamics, we identified three major patterns/themes that were labelled as follows: (i) gender and professional asymmetries, (ii) strategies to raise the profession's status and (iii) managing masculinity (see Figure 1).

Figure 1: Main themes and subthemes.



Gender and professional asymmetries

Although each theme contains contributions from most participants, some display greater levels of representation. All the male nurses interviewed contributed to the first major theme. We identified two major subthemes structuring the positions of interviewees and thereby highlighting gender dynamics within nursing and the relationship between medicine and nursing. They are as follows: (i) awareness of the feminization of the profession and of the asymmetry between nursing and medicine, and (ii) diversity as the guarantor of gender neutrality and equality.

The first subtheme reveals that, in line with that reported in the two previous studies on medicine (Santos et al. 2015) and politics (Santos et al. 2016), there is an awareness among these interviewees that nursing constitutes a ‘traditionally feminine profession’. Indeed, as shown by the following testimony of a male nurse, ‘the situation of the

profession being mostly female? This is a phenomenon. It's not a phenomenon, it's the reality, not just a Portuguese reality but a worldwide one' (41 years old, married, 3 children, maternal and obstetric health[2]. They also acknowledge that female-dominated professions are undervalued as this extract illustrates: 'I do not think nursing has a high status. I do not think so, but I think that it was worse in the past, of course' (45 years old, divorced, two children, community).

In addition, there is a similar awareness among male nurse interviewees that there is an imbalanced relationship between doctors and nurses. Indeed, they identify a clear power asymmetry, with medicine holding a higher social status than nursing. However, the interviewees also perceive this reality as changing, considering that with the advances in nursing, there already exists interdependence between nurses and doctors in practice and with less emphasis on hierarchy:

> I don't know. But there may be people who think that being a male nurse is undignified, even today, I guess. I suppose so. '*Why not become a doctor*?' We hear this question a lot. And: '*You're almost doctors*'. They have nothing to do with each other. They're completely different professions. *[Do you think there is a different status between nursing and medicine*?*]* There is. Completely. In terms of weight, in terms of strength. Yes, in negotiating terms. When we have to negotiate with the board of directors. (44 years old, 2 children, paediatrics and child health)[3]

> The doctor is the Mr. doctor, the one in the prescriptive phase. The nurse is the provider of the care prescribed by the doctor and therefore has more direct contact

> […]. This has to do with society, with what society understands nursing to be; that the nurse is the servant of the doctor. (55 years old, married, 4 children, community)

A second subtheme conveys how there is a consensus that mixed teams work better (e.g., they are healthier, there are fewer conflicts) and that this happens because men and women have different sensitivities and are different due to several factors (e.g., women are more conflictual, men manage conflicts better). Male nurses state that the presence of both sexes in teams is important to improving team dynamics even while arguing that caring is gender-neutral. In fact, as two male nurses said 'I think that teams gain by being more mixed, no doubt, but I don't think the profession is affected' (45 years old, divorced, 2 children, community) or 'care is neutral so can be performed by both men and women' (58 years old, 1 child, medical–surgical). However, when evoking stereotypes associated with caring, they do this by accentuating 'women's specificities', as verified in the study on medicine (Santos et al. 2015), where we also identified gender-stereotyped discourses between females and males about what it means to be a 'man' or a 'woman' in the profession.

This subtheme also demonstrates how, and again in keeping with what we found with male medical specialists, but not with female medical specialists and female politicians (Santos et al. 2015, 2016), the male nurses interviewed did not report experiencing any difference in treatment between themselves and female nurses, except in specific situations linked to physical strength and the issue of touch in intimate caring. In these cases, they do not view different treatment as discrimination but rather as a legitimate patient preference. As the dynamics of tokenism in medicine generate more negative consequences for female medical specialists than for male medical specialists, with the former being more

disadvantaged and the latter more stimulated, some male nurses did also perceive that phenomenon, realizing that sometimes they do obtain benefits in terms of their careers:

> No, I don't feel big differences. No. Of course, there are occasional situations. Of course, if we imagine a situation where you need to lift a very heavy patient, perhaps they ask [for help] much more easily from a man in the team than from a woman in the team. (43 years old, 2 children, rehabilitation)

> We have mainly women and the boss is a man, isn't it? We have an Order with men. I've no idea [why this happens]. It can be some bias. I don't know. Maybe some protection for men, I've got no idea, this is pure conjecture. (40 years old, married, 2 children, paediatrics and child health)

Strategies to raise the profession's status

Although all participants contributed to this major theme, male nurses aged between 46 and 58 years contributed to a greater extent. We identified two subthemes regarding the entry of males into nursing and their career trajectories: (i) a second-class profession, but (ii) a first-class specialty.

The first subtheme reveals how, as had occurred in the previous studies with female and male medical specialists and female politicians, there are several reasons leading these interviewees to choose nursing, including interest in or personal preference for health, the influence of certain people, especially family or relatives who were already in nursing; chance; and good career opportunities at that time. However, this also reports how nursing was clearly a second choice for many male nurses, a phenomenon that we did not observe

in the other two studies (Santos et al. 2015, 2016) centred on higher status professions. In fact, these interviewees revealed that they or their families preferred medicine especially due to the fact that nursing lacked social recognition:

> I graduated in 1978. The course was the General Nursing Course, a three-year course. At that time, the market was facilitated in terms of possible places of work […]. So, [medicine] was a concern of my parents. For me, taking medicine wasn't the main goal. I took nursing because I identified myself very much with my uncle who was a male nurse. Honestly, at that time, that was very important. (56 years old, married, 3 children, rehabilitation)

> As it was obvious to me that I wouldn't manage to get onto a medicine degree, I thought that maybe nursing would be something that I would like to do […]. Moreover, the professional status, at that time, was non-existent. Nurses were basically people in the service of doctors. (47 years old, 1 child, psychiatric and mental health)

A second subtheme focuses on the reasons for choosing specialist fields and reveals that, in line with the existing literature (e.g., Williams 1995a), the medical–surgical field (deemed more 'masculine') was one of the most sought-after specialist fields due to its versatility. Interviewees furthermore did not always follow their first-choice option both because of 'natural' evolutions in their professional activities and the opportunities emerging throughout their careers. These male nurse discourses also demonstrate how, within the nursing paradigm then prevailing, getting a specialty was a way of advancing in their

careers as illustrated by this extract: ‘I just had to make it to be chief, because it [specialty] was a sine qua non condition to rise to leadership’ (58 years old, cohabiting, 1 child, medical–surgical) or the next one:

> The specialty in rehabilitation wasn’t my first choice. First, I tried to take the medical-surgical specialty because I was working in medical-surgical services in several aspects: cardiothoracic, cardiology, medicine, surgery, etc. […]. First of all, I applied twice to medical-surgical. It’s not easy, it’s harder to do but it’s easier to get into. Because medical-surgical gives that opportunity to choose. Nowadays, that’s no longer the case. It was the one that everyone wanted. At that time, everyone wanted to do medical-surgical because it was a versatile field. (56 years old, married, 3 children, rehabilitation)

Managing masculinity

This theme proves the least important of the three, resulting mainly from the discourses of male nurse aged between 40 and 45 years, but also structured around two major subthemes: i) gendered division of housework and ii) tensions in the workplace.

The first subtheme details evidence of how the reconciliation of family and professional lives does not seem to be a problem for male nurses thanks to the help of relatives (mostly parents) and housemaids, except when both members of the couple are nurses, have children and work rotating shifts. When this did occur, the couple solved the problem by one member, usually the woman, changing to a fixed schedule and thus continuing to suffer the burden of the double workday, as also previously observed with female doctors (but not with male doctors, Santos et al. 2015) and female politicians (Santos et al. 2016). Such contexts demonstrate that the balance between careers and family

life clearly remains a problem for women, for whom reconciliation is difficult (Amâncio 2007; Rosa 2018), but does not seem to really be a problem for male nurses:

> It's difficult! It's complicated! For example, my wife also worked rotating shifts. She did shifts, just like me. And when our second daughter was born, she had to leave the hospital and go to the health centre, to get a normal schedule like normal people. (40 years old, married, 2 children, paediatrics and child health)

> And with both of us working [him and his wife] at night, we didn't have anyone to stay with the kids, did we? We swapped nights for a while. But it wasn't for too long, fortunately. Then, there are maternal rights as well and the mother then asked to stay off the roster [in terms of schedule]. Therefore, it was her that got out of shifts. (44 years old, married, 2 children, paediatrics and child health)

However, a second subtheme conveys evidence pointing to certain workplace tensions associated with the profession and their relationships with colleagues. In fact, again in line with the results of the two previous studies (Santos et al. 2015, 2016), male nurses feel good, like their activity and feel satisfied and supported by colleagues. However, in line with the findings of a study focused on elementary school teaching (see Santos et al. 2018), they also mentioned certain issues linked to physical strength and the sexualization of male nurse touching, especially in the intimate care of female patients, and the perception that there is a greater likelihood of male nurses being attacked by patients than female nurses, especially in the mental health and psychiatric field:

> Every time that it was time to take a bath, there was always a female nurse and a male nurse. It was me. And I was helping, and, at the same time, I was touching. She was already a lady of a certain age and my colleague served to support my presence. (55 years old, married, 4 children, community)

> Imagine that I was with four 15-year-old girls who are menstruating, and it was necessary to make a baby gel, I would not do it, it's a matter of common sense, my colleague would do so. (40 years old, married, 2 children, paediatrics and child health)

> I was hit several times because I was a man. It was not for any reason. Because there I apparently represented repression, and before the patient realized that I was a support, he decided to assault me. (47 years old, cohabiting, 1 child, psychiatric and mental health)

Discussion

This article presents a research study that sought to identify the gender dynamics unfolding in a context of tokenism in which males are proportionally scarce – nursing. Specifically, this research aimed both to ascertain the experience of men in a feminized profession (as tokens and as men) and whether there are the same dynamics for men in nursing as for men in medicine as nursing occupies a lower position in the medical hierarchy (Carapinheiro 1993; Carpenter 1993; Porter 1992).

The results convey how the dynamics of this tokenism context clearly interweave a double-power asymmetry: the asymmetry between both professions, with medicine holding

a higher status than nursing, especially given that our sample entered the profession at a time in Portugal when nursing studies were considered only a technical qualification and not equivalent to a higher education degree (Nunes 2003), leading to low social recognition that seems to have remained constant ever since; and the symbolic asymmetry (Amâncio and Oliveira 2006) of gender relations, with men considered the symbolic universal reference of a 'person', associated with the public sphere, authority and leadership, and with women as a gendered category, more closely linked to family care and the domestic sphere. This double asymmetry underlies the entire health care system context in which gender inequalities still remain both within and between medicine (a 'men's world') and nursing (a 'women's world'), which seems to protect male nurses from the tokenism dynamics and processes identified by Kanter (1977, 1993). Indeed, in accordance with our study on the medical field (Santos et al. 2015) and international research findings (e.g., Evans 1997; Porter 1992; Williams 1992, 1995a, 1995b), male nurses hold advantages compared to female tokens. Even while they hold token status in nursing, except in specific physical strength-related situations and the sexualization of male nurse touching in the intimate care of some female patients (Evans 2002; Harding et al. 2008), the male nurses interviewed do not experience the marginalization otherwise associated to tokenism, that is, they do not suffer either greater pressure over performance, social isolation or role encapsulation, particularly younger nurses.

Nevertheless, it is also clear that male nurses attempt to distance themselves (as men and as tokens) from their female colleagues and the feminine image of nursing vertically and horizontally, vertically, for instance, by striving to choose more 'masculine' specialties, those generally more valued, stressing the importance of the role of men in improving the dynamics of nursing teams in terms of conflict management, and horizontally, for instance,

by adopting strategies to raise their status in the profession by ascending the career structure. We must underline that six of the twelve male nurses interviewed hold leadership positions at the time of the study. All of these processes, which involve personal and organizational strategies, lead to positive consequences for male nurses, who are correspondingly overrepresented in leadership and positions of power. This remains true even in the most 'feminine' specialist fields, such as maternal health and obstetrics, and paediatrics and child health. For instance, among the four male nurses interviewed from these specialties, three held positions of leadership. Gender stereotypes may contribute to this result (Simões and Amâncio 2004; Laranjeira et al. 2008). In fact, the feminine stereotype continues to be more closely linked to care and hence to nursing and the private sphere and the masculine stereotype remains most closely associated with management and leadership. We must also note that, contrary to the case of female doctors (Santos et al. 2015) and of female politicians (Santos et al. 2016), 'reconciliation' does not appear to represent a barrier to male nurse career advancement as also stressed by Evans (1997). These facts may thus still help push male nurses up the glass escalator, as suggested by Williams (1995a).

Therefore, although the advantages to male nurses are often hidden, the asymmetry of the male and female trajectories has been so evident that Porter (1992) has already stressed how 'nursing will increasingly become an occupation divided between male managers and female ward workers' (p. 524). According to Evans (1997), this is due to gender dynamics that continue to distinguish the masculine over the lesser valued feminine in a 'women's world', thus maintaining male status and power.

In conclusion, despite some limitations associated with the qualitative approach (e.g., the inability to generalize the results to the entire Portuguese nursing population), the

analysis carried out demonstrates how the gender dynamics prevailing in this specific tokenism context – where men take on a double status of dominant and dominated – seem to reproduce and maintain the gender order more broadly prevailing in Portuguese society. Hence, this study contributes to overcoming one gap in the research on gender and nursing in Portugal although future studies are still needed to deepen and update our knowledge on the gender dynamics operating in nursing and other gendered professional contexts.

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Notes

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