ORIGINAL RESEARCH:
EMPIRICAL RESEARCH - QUALITATIVE

The experience of workplace gender discrimination for women registered nurses: A qualitative study

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Abstract

Aim: To explore the experiences of female registered nurses (RNs), who encounter workplace gender discrimination in nursing.

Design: This study used a qualitative exploratory design informed by feminist perspectives and was underpinned by social constructionism.

Methods: Women who were RNs (N = 10) and employed in New South Wales (NSW) were purposively selected to convey their experiences of workplace gender discrimination. Data were collected through semi-structured interviews, between April and July 2020. Analysis was guided by the work of Anderson and Jack (Women's words; 1991) who recommend three ways of listening. Interviews were transcribed verbatim and Braun and Clarke's (Qualitative Research in Psychology, 3, 77–101; 2006) six-step guide was used to develop themes.

Results: Thematic analysis revealed five overarching themes: It's a man's world; Gender stereotypes; Being a woman and nurse; Reluctance to call out gender discrimination and The status quo. Findings from this study highlighted that participants believed men's career progression in nursing were favoured over women.

Conclusion: Findings from this research highlight that socially constructed gendered norms continue to form the basis of inequality for women in the workplace. Fostering and sustaining workplace cultures that support family and work life balance, and that do not discriminate against women, is fundamental to ensuring equality for women.

Impact: There is limited qualitative research into women's experiences of workplace gender discrimination in nursing. This research highlights the need for workplace strategies to be implemented to ensure women are better supported and equally represented in leadership positions and advanced practice roles in nursing. All nurses should be given equal consideration based on experience and qualifications. Career development and progression opportunities should be fair, equitable and transparent with clearly documented criteria.

KEYWORDS
career progression, discrimination, female, gender, gender equality, midwives, nurses, nursing, women, workplace
1 | INTRODUCTION

Despite extensive legislation, policies and international commitments, workplace discrimination against women is widespread, both in Australia and across the globe. Across all continents, in nearly all occupations and at every educational level, women experience gender gaps in pay and are denied equal access to promotion (World Economic Forum, 2021). Within the global health workforce, it is estimated that 70% of health and social care workers are women and approximately 90% of nurses are women. However, this gender ratio is not reflected in levels of leadership (Global Health50/50, 2018). A World Health Organization (2019) report titled ‘Delivered by women, led by men’, reported that globally, in health, less than 25% of policy decision making and governance roles are held by women. In a review of the gender-related policies and practices of 198 global health organisations, it was reported only three out of 10 organisations have parity in senior management and in four out of 10 organisations, less than one-third of senior managers were women. The greatest inequalities were found to be at top-level management, where decision making remained largely with men. Statistically, men are 50% more likely to reach senior management in health organisations in comparison to women (Global Health50/50, 2018).

While there has been a major emphasis on reducing gender imbalances in leadership in the global health workforce in recent years, many organisations are not equipped to foster the leadership potential of women. Failure to take gender equality seriously has been identified, with only 49% of organisations globally having specific policies in place to improve gender equality and 29% of organisations completely silent on gender equality (Global Health50/50, 2018). Gender discrimination is both a social justice and an economic issue, with workplace gaps in leadership and remuneration resulting in life-long economic impacts for women (World Economic Forum, 2021). Unequal leadership opportunities for women in nursing reduce job satisfaction and thus retention within the profession. The retention of experienced nurses should be a priority, given the global nursing shortage (Royal College of Nursing, 2020). It is projected that Australia will experience a shortfall of 85,000 nurses by 2025, increasing to 123,000 by 2030 (Health Workforce Australia, 2014). Currently in the United Kingdom (UK), the National Health Service (NHS) has 40,000 vacancies for registered nurses (RNs) in England alone (Royal College of Nursing, 2020). This shortage is expected to worsen even further because of the current COVID 19 global pandemic, with many nurses burnt out and under enormous pressure leaving the profession (Tural & Nantsupawat, 2021). Therefore it is timely to explore the inequities in the nursing profession. This study aimed to explore women’s experiences of workplace discrimination in nursing. Understanding these experiences will enable the nursing profession to develop organisational practices and cultures that do not discriminate against women.

2 | BACKGROUND

Within the worldwide nursing workforce, there is a significantly higher proportion of women compared with men. In 2020, women made up 88.6% of all employed nurses and midwives in Australia (Nursing & Midwifery Board of Australia, 2020). Similarly, between 88%–95% of the nursing workforce in the UK, United States of America (USA), Canada and elsewhere are women (Royal College of Nursing, 2020). There have been a number of attempts to address this disproportion, both in Australia and globally; the main driver being to increase diversity in the nursing workforce to better reflect the population. For example, the Australian College of Nursing “Its Ok to care” campaign was started to encourage more men into the profession (Australian College of Nursing, 2019). Similarly, in the USA the Oregon Centre for Nursing launched the ‘Are you man enough to be a nurse’ campaign. Although the number of men in nursing has remained static over the last decade largely because of the association of nursing with femininity, the drive to recruit more men to a career in nursing continues (Whitford et al., 2020). Previous research on gender and the workplace showed that men take their gender privilege with them into female-dominated occupations (Cousins, 2019; Williams, 1992). Williams (1992) coined the term ‘the glass escalator’, a metaphor for the advantages men are the beneficiaries of in female-dominated professions.

Recent studies have reported that a gender pay gap exists between male and female nurses in the USA, Germany and the UK (Greene et al., 2017; Muench & Dietrich, 2019; Wilson et al., 2018). After adjusting for differences in work and demographic characteristics, the gender pay gap has been reported to be as high as 10% (Wilson et al., 2018).

Over two decades ago, Porter (1992) raised the issue of a predominately male managerial elite in nursing and warned of nursing becoming an occupation divided between male managers and female nurses working on the ward. Since then, a report by the Randstad Care Group in 2016 identified a significant gender imbalance in senior roles for women in nursing in the UK. While women make up 90% of the nursing workforce, men occupy two-thirds of the health sector’s executive and leadership positions (Randstad Care, 2016). Several studies, including one Australian study, have reported that men are significantly more likely to be in senior positions in nursing than women (Brown & Jones, 2004; McIntosh et al., 2012; Punshon et al., 2019). In addition, men achieve promotion more quickly than women in nursing. In a survey of 1500 nurse leaders from New Zealand, Canada, China and Saudi Arabia, Hader (2010) found that men who were RNs moved into more senior positions at a younger age and faster than their female colleagues. More recently, Wilson et al. (2018), reported that male RNs in the UK reached the two highest levels of seniority in 6 and 15 years, compared with 10 and 22 years respectively for women.

Most of the research examining gender and workplace discrimination for women in nursing is quantitative with a focus on human capital models. Human capital refers to variables such as education, qualifications, years of experience, skills and competencies of an individual. Proponents of this theory claim there are fewer women in senior positions, and they earn less, as they are less qualified and have less experience than men (Muench & Dietrich, 2019). However, recent studies in nursing have shown...
that education and years of experience were not effective against the gender pay gap. For example, Greene et al. (2017) reported a gender pay gap of $7405 per annum, for recently graduated nurse practitioners when qualifications and years of experience were similar. Punshon et al. (2019) reported that male RNs were in more senior positions in the UK despite having less years of experience than their female counterparts.

World Health Organization (2019) acknowledges that the narrative must shift away from approaches that examine 'where are women lacking' towards one that considers the root causes of gender inequality. To date, there is minimal qualitative research examining workplace gender discrimination from the perspectives of women in nursing. Furthermore, there are no contemporary studies examining workplace discrimination in the Australian nursing workforce. This current research explored women's experiences of gender discrimination in nursing to provide a better understanding and raise consciousness of the formal and informal ways in which workplace inequality is generated. This study has the potential to impact policy development that focuses on gender equity and equal career opportunities for women nurses.

2.1 | Theoretical framework

Social constructionism and feminist perspectives comprised the theoretical lens for this study. At its core, social constructionism is based on the premise that reality is socially, culturally and historically constructed (Burr, 2015). Social constructionism was considered appropriate for this study as ideas concerning gender develop from social and historical settings; the meaning of gender is constructed by society, and we are all socialized into that construction. Feminist perspectives were considered appropriate, as women and women's experiences were central to this research with the aim being to make a difference for women. With a focus on social justice, feminist research is emancipatory in nature (Harding, 2016). The feminist role is not simply to observe and substantiate what women tell us but rather to challenge the way in which women's experience is constructed under patriarchy (Chrisler & Johnston-Robledo, 2018). Feminist research and social constructionism both recognize that personal experiences are influenced by social context and shared cultural expectations (Burr, 2015). In this study, feminist perspectives underpinned by social constructionism capture the complexity of, not only individual concerns related to workplace gender discrimination, but also social, structural and political issues.

3 | THE STUDY

3.1 | Aims

The aim of this study was to explore the experiences of women who have encountered workplace gender discrimination in nursing.

3.2 | Design

A qualitative exploratory research design guided this study. Qualitative research is concerned with understanding human experiences and making sense of the social world (Bearman, 2019).

3.3 | Sample/participants

Participants were recruited through social media platforms such as Facebook™ and Twitter™. Purposive sampling was used, and the inclusion criteria were women who were RNs, employed in New South Wales (NSW) and available to participate in an interview to convey their experiences of workplace gender discrimination. Snowball sampling was also used in this study; the recruitment email included a request to consider forwarding the email to other colleagues/clinicians who may have been interested. See Table 1 for demographic characteristics of participants.

3.4 | Data collection

Data were collected through semi-structured interviews, either via videoconferencing or over the telephone, between April and July 2020, by the first named author. A semi-structured interview guide was developed by the authors, all of whom were women, RNs and academics. The interview schedule (Table 2) was underpinned by the literature and contained open-ended and prompt questions. The purpose of the prompt questions was to ensure the research aims were addressed; the use of open-ended questions allowed flexibility for the interviewee to discuss issues important to them (Bearman, 2019). Data collection continued until data saturation was reached which occurred after 10 interviews.

3.5 | Ethical considerations

Ethical approval from the Western Sydney University Human Research Ethics Committee (HREC) was obtained prior to recruitment: HREC Approval Number H13688. Informed consent was obtained from all participants following the dissemination of a participant information sheet containing the purpose of the study, potential risks and benefits of the study and right to withdraw from the study. Pseudonyms were used to de-identify participants.

3.6 | Data analysis

Audio-recordings were transcribed verbatim by the first author, which facilitated a thorough understanding of the data. Post transcription, a process of immersion in the data began, the first author read and re-read the interviews, and repeatedly listened to the audio recordings. The process of listening was guided by the work...
of Anderson and Jack (1991) who identify three ways of listening to assist with hearing participants’ voices: listening to moral language, attending to the meta statements and observing the logic of the narrative. After listening and re-listening to interviews, a process of thematic analysis was undertaken guided by Braun and Clarke (2006). Initial thoughts and codes were noted on a hardcopy of each transcript, and significant quotes highlighted. Once familiar with the data, the first author worked through each data set allocating codes manually on the text with coloured highlighters. Individual extracts from transcripts were matched with the codes. The codes were then sorted and resorted into potential themes. The four authors met regularly to discuss the development of themes which were defined and named and constantly reviewed until consensus was reached (Braun & Clarke, 2006).

### Rigour

Rigour for this study was guided by Lincoln and Guba (1985) who maintained there are four criteria in establishing rigour in qualitative research; these criteria are credibility, confirmability, dependability and transferability. Reflexivity was one of the key strategies used to indicate credibility in this research. The first author is a woman, mother, a RN and a feminist. The purpose of maintaining a reflexive approach was to be cognisant not to impose her own beliefs, experiences and views during the process of data collection, analysis and findings. The first author reflected on her own socially constructed viewpoints, and subjective perspectives by journaling throughout the study duration and regularly debriefing with the research team. During data analysis, all authors were actively involved, ensuring the credibility of theme development. In addition to reflexive practice throughout the conduct of the study, confirmability was also maintained by ensuring accuracy of participants’ meaning. It is important that researchers follow, rather than direct the research. The first author actively listened to participants during the interviews to ensure correct interpretation of participants’ meanings and sought clarification when required. Transferability ‘determines the extent to which the findings of a particular inquiry have applicability in other contexts or with other subjects/ participants’ (Lincoln & Guba, 1985, p. 290). Strategies to enhance transferability in this study included the provision of detailed participants’ demographic information and clear descriptions of the study methods. Dependability was established through a meticulous audit trail via documentation and regular meetings among the four authors.

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<tr>
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<th>Clinical area</th>
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<th>Job title</th>
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### Interview guide

1. Can you tell me about your experience of gender discrimination in nursing? How did this make you feel?

Prompts
- Can you tell me about incidences of workplace gender discrimination you have observed?
- Do you think workplace gender discrimination is common in nursing? Why or why not?

2. Tell me about your experiences of career interruption and returning to work.

Prompts
- Do you feel career breaks impacted your career progression?
- Was your seniority on the ward impacted after a career interruption?
- Was your access to training opportunities affected by career interruption?

3. Describe career opportunities for female registered nurses who take a period of leave.

Prompts
- What have been your observations during your career?

4. Can you tell me about your working hours? What hours have you worked in your career? Has it affected your career?

Prompts
- Do you think the number of hours worked impact on opportunities for training?
- Do you feel nurses who work part time are still a valued part of the team?

5. Describe your experiences of working with your male nurse counter-parts.

6. Is there anything else you would like to tell me about?
4 | FINDINGS

A total of 10 women participated in this study. Seven women were interviewed via videoconferencing and three via telephone. Duration of interviews was between 30 and 60 min. The women's ages ranged from 29 to 58 years, with an average age of 41.8 years. Six participants were born in Australia, two were born in Asia, one in Africa and one in the UK. Years of clinical experience ranged from 4 to 38 years, with an average of 15.4 years. Five participants were employed full-time, four permanent part-time and one participant was employed on a casual basis. Three participants were employed in senior management roles, and nine had post-graduate qualifications.

Thematic analysis of the data revealed five overarching themes and four sub-themes. See Table 3 for themes and sub-themes.

4.1 | Theme 1: It's a man's world

The theme It's a man's world, captures the many ways patriarchal culture oppresses female nurses in the workplace. Examples from participants highlighted how gendered power structures were reinforced and maintained in the workplace, and how women's lives were constrained by gendered role expectations. This theme consists of two sub-themes, Grooming men: 'They are tapped on the shoulder' which shows how men in nursing were supported and encouraged to seek leadership opportunities within and external to their departments. The second sub-theme, Treated differently: 'Why was it ok for him but not okay for me?' relates to participants' perceptions of being held to different standards to their male colleagues.

4.1.1 | Grooming men: 'They are tapped on the shoulder'

Male nurses in the clinical area were commonly thought to be on their way to 'greater things'. All participants commented on the apparent ease and rate men progressed in their nursing careers. They indicated that male RNs received promotions and opportunities based on their gender, rather than being earned by merit. Theresa commented: 'If you're a guy, you're definitely going to get a promotion' and according to Karen: 'Guys are pushed to go into those areas (management)'. Participants felt that the tracking of men into leadership positions was overt, transparent and common knowledge across organisations. Jackie stated: 'Management wants more male management in the system, and they (team leaders) have been encouraged to encourage them (male RNs) more'.

Consistently across the interviews, women discussed the idea of an informal network of men supporting men'. These networks which maintained traditional gender hierarchies were widespread in the nursing profession. Participants reported being excluded from male social cliques in and outside the workplace. With Karen explaining that male RNs, 'socialised outside of work and supported each other to team leader positions'. Jackie was angry as she described a situation where a male colleague applied for a nurse unit manager (NUM) position. Initially, he was reluctant to apply for the position: 'Because having no real experience, he had no expertise in his field and was umming and erring about working or applying for this position'. Jackie explained that she was told 'he had a mate who was quite high up at this particular hospital, and he had been told to apply for it because you know you will get it'.

In this study, women reported feeling mostly invisible in the workplace and were routinely denied opportunities offered to men. Participants believed male RNs were given increased opportunities to attend conferences, workshops and seminars. Grace explained that recently 23 new RNs (20 women and three men) were employed to work in a busy acute care department. She described how within 2 months of commencing employment, all three male RNs were asked by the male NUM to join workplace committees while none of the women were invited: 'The three guys tapped to go onto committees, the women (20) do your work on the floor'. Working on committees in the clinical environment was seen as a catalyst to career progression including promotions to roles such as clinical nurse specialist (CNS), clinical nurse educator (CNE) or NUM. One of the new male employees was invited to participate on the committee which Grace led. He had less than two years’ clinical experience and no experience in an acute care area. This committee was in the

<table>
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<th>TABLE 3 Themes and sub-themes</th>
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<td><strong>Themes</strong></td>
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<tr>
<td>It’s a man’s world</td>
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<td>Gender stereotypes &quot;Just a nurse on the floor&quot;</td>
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<td>Being a nurse and woman</td>
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<td>Reluctance to call out gender discrimination: “I’m not sure if it relates to gender”</td>
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<td>The status quo: “We’re just kind of used to it, aren’t we?”</td>
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process of initiating a major change for employees, Grace was frank in her response:

I mean, who is going to listen to someone that’s been there a week trying to roll out a new program. You have to grow some roots before you can start to make change, people are just going to go, ‘who are you? I have never seen you before’.

4.1.2 | Being treated differently: ‘Why was it okay for him but not okay for me?’

The women in this study discussed how male RNs were held to different standards and subject to fewer rules and regulations. Of particular concern to participants were inconsistencies in requirements for career progression between men and women. They perceived they were judged by higher criteria than male RNs. For the women in this study their career progression followed a sequential process, in that they were required to have a certain level of experience and qualifications prior to gaining advanced practice positions. Throughout the interviews there were many examples of female RNs with extensive postgraduate experience and qualifications being ‘pushed aside’ for male RNs no post-graduate qualifications and/or less experience. Participants recognised a patriarchal culture in nursing which valued the success and achievement of men over women. Heidi conveyed an example of a male RN with less than two years’ clinical experience and no post-graduate qualifications who was offered an acting CNE role by his male NUM in an acute speciality ward. The role of a CNE is to provide clinical education and support for staff at the bedside, and as such they are required to have substantial expertise. According to Heidi:

Eighty percent of the other staff on the ward are probably better qualified and have better experience. How can you guide other people in that area, if you do not have the right experience? How can you expect someone who has just walked into the ward who has only just got himself orientated maybe a year back to whatever happens on the floor, to actually be a leader for everybody else, as an educational leader?

Participants also identified a double standard in terms of expectations of male and female RNs in the ward environment. Much of the discussion focused on the socially constructed view that women tidy up and men do not. Participants believed male RNs were not reprimanded for being untidy and not discarding rubbish or linen. However, according to participants, female RNs were scrutinised closely on these everyday tasks. While subtle, these gendered role expectations increased men’s authority in the workplace. According to Sapphire ‘boys are terrible, they leave a mess’, yet they are excused as:

Oh, that’s just them you know what men are like. Just seems to be excuses, they get excuses. Yeah, they are excused on a lot of their behaviour, and the females aren’t. Guys are definitely treated differently to the girls.

In this study, patriarchal oppression towards women was perpetuated by other women. Participants agreed that female team leaders were friendlier with male RNs and gave them respect which they perceived was unearned. Male RNs used these relationships to their advantage, to be allocated to team leader positions or more favourable workloads. Participants discussed being disadvantaged in the workplace as their female leaders supported and protected the careers of their male colleagues. Charlie described an example of a male RN who was excused for drawing up an incorrect intravenous medication in a paediatric ward. The female CNE ‘nudged him in a, like in a friendly banter kind of way, she liked him, and they just fixed it and it was no biggie [big deal]’. Shortly after Charlie witnessed her male colleague’s error, she was involved in a medication incident with the same CNE. The response from the CNE however was very different. Charlie was required to meet with her NUM, and to attend remediation:

Why was it okay for him but not okay for me? Because he is popular, and everyone liked him, and you know she liked him. She just kind of made things worse for me, instead of supporting me and educating me, she didn’t do that. But with him she has allowed that. You are male, you’re tall. You’re a male and you’re good looking. Um, you could get away with it. Yeah, so I said that to him, you can get away with murder here.

4.2 | Theme 2: Gender stereotypes: ‘Just a nurse on the floor’

The theme Gender stereotypes: ‘Just a nurse on the floor’ refers to participants use of socially constructed gender norms and stereotypes of jobs culturally characterised ‘men’s’ or ‘women’s work’. All participants were aware of the stereotyping of the nursing profession as women’s work. Additionally, they were aware that nursing was devalued as both a feminised profession and a care profession. According to Karen ‘Men don’t want to see themselves as just a nurse on the floor, and you know being caring. They want to do all the business strategic side rather than the caring side’. Women in this study described male nurses as ‘more superior’, ‘more assertive’, ‘more authoritarian’, ‘more confident’ and ‘more dedicated to the job’. Some participants believed that men were better suited to higher level roles in nursing, as stated by Raquel ‘In the roles of managers and executive positions I think they (male RNs) have a stronger personality to do that position’. Many of the participants implied that men were more focused in the pursuit of career progression while female
nurses were too submissive. The implication being that women were in fact culpable for their own lack of career progression. According to Sapphire, ‘Men seek further opportunity rather than women who just sit back and wait their turn’. In contrast to the characteristics ascribed to men, participants described female nurses in terms of their emotional and maternal qualities. These ingrained stereotypes that position women as carers, reinforce female subordination in the workplace. Women were described as ‘more empathetic’, ‘more caring’, ‘more compassionate’, ‘more family orientated’ and ‘the child bearers’. Participants also used socially constructed stereotypes to legitimise women’s subordination in the workplace. Patriarchy conditions women to support these stereotypes. Heidi explained: ‘Women are more family orientated, and they probably don’t want, I don’t know it could be that they don’t want to take the extra burden of management’. Similar comments were made by Sapphire, ‘women need to be with their families’ and Karen, ‘pregnancy and family commitments stop women from progressing’.

4.3 | Theme 3: Being a nurse and woman

The theme Being a nurse and woman, highlighted the systematic subordination of women in and in particular, women who were mothers in the workplace. This theme consists of two sub-themes, the first being, Being judged incapable: ‘Don’t deny me an opportunity to use my skill’. This sub-theme refers to participants’ experiences of being judged as incapable and less worthy for undertaking certain roles, responsibilities, and positions in their clinical settings. The second sub-theme is titled, Being a nurse and mother: ‘You are no good to us anymore’ and includes participants’ descriptions of the impacts of pregnancy and family commitments to their professional lives.

4.3.1 | Being judged incapable: ‘Don’t deny an opportunity for me to use my skill’

Participants frequently talked about their abilities being devalued, and their skills and knowledge being unnoticed in the workplace, leaving them feeling marginalised and disempowered. Karen had more than 20 years’ experience in the clinical setting; she was confident in supporting patients who presented with challenging behaviours and is skilled in de-escalation techniques. While Karen did not doubt her knowledge or skills, it was usual practice in her ward for male RNs to designate themselves in the management of aggressive patient behaviour which required de-escalation. She had to prove herself because she felt that gender was used to minimise her individual competence. Karen stated: ‘They didn’t feel that I had the capability as a woman to de-escalate a volatile patient’. She had to fight for the opportunity to use her skills: ‘Don’t deny an opportunity for me to use my skill, my negotiation skills. Do not deny me that opportunity. I’m going to go with you to de-escalate’.

Participants talked about their experiences of ‘becoming invisible’ and feeling marginalised and diminished in the workplace as they aged. Most participants agreed this was evident once they entered their forties. Sapphire who was 43 years of age stated: ‘The older you get in nursing, especially for a female, the chances of growth become less’. Participants emphasised that this did not apply to male RNs: ‘With male RNs whether you’re old or young, you can still progress’. Participants described how women in their ward aged over 40 were delegated to the less acute areas and offered less opportunities for training and progression. There was a perception that older female RNs were not competent for what were perceived as the more ‘challenging roles’. Heidi stated she felt “less worthy, even though you know that this is something that you can easily do”.

Amelia was ambitious and determined, and at the time of the interview she was completing post-graduate study. Amelia worked in an acute care area; career progression was a gradual process through several areas of increasing patient acuity. However, Amelia conveyed her career progression was suspended by nurse educators because of her pregnancy: ‘The reason they are giving me is that oh you know that this is something that you can easily do’.

Amelia was angry, that she was not permitted to continue her progression through the department despite her protests, ‘It’s not a sickness it’s just pregnancy’. Amelia vehemently argued her case to continue working through areas of high acuity to progress her career:

I’m like, well, I’m pretty sure what I’m capable of, and also, I’m in the middle of, you know like, at the moment I’m pregnant, I work full time and I’m doing my post-graduate study. I’m in the middle of building a house so I’m coping, you know, really nicely. I mean very nicely. I don’t have any issues.

However, she was told that she ‘may forget everything on her maternity leave’. Amelia was angry, that she was not permitted to continue her progression through the department despite her protests, ‘It’s not a sickness it’s just pregnancy’.

4.3.2 | Being a nurse and mother: ‘You are no good to us anymore’

This theme highlights how gendered stereotypes associated with motherhood disadvantaged women and further oppressed them in the workplace. Women in this study identified that motherhood resulted in the devaluing of their abilities and directly impacted their career progression. They perceived that their skills and expertise were not given the same recognition once they became mothers. After announcing her pregnancy, Therese was confronted with the stigma of motherhood, she was told by the male NUM ‘You are no good to us anymore’. After returning from maternity leave, she was no longer allocated to team leader positions and excluded from leadership and decision-making roles. Therese explained:

You weren’t offered, anything at all it was like, now you’re a mum. I wasn’t given any in charges (in charge of shift). I’ve never had a sick record. I’ve never had any disciplinary issues or anything, it was purely because
he thought that I was a mother, that I wouldn’t live up to the job.

Another major challenge for participants who were also mothers, was the presumption from employees and colleagues that they were no longer interested in progressing their careers. While participants argued that motherhood had not altered their career commitment, they described the socially constructed expectation that motherhood should be the centre of a woman’s life and she should no longer have career ambitions. As stated by Sapphire: ‘Everyone presumed that now I have a baby, my priorities should be looking after the child’. Consequences of this perceived disinterest in career progression were decreased opportunities for professional development. Participants spoke of feeling disregarded and disempowered as RNs with consider-ably less experience and qualifications were offered opportunities for career progression. They maintained that once they became mothers there was no support from their NUMs for their professional development. Heidi recounted her experience of returning to work post ma-ternity leave:

I didn’t feel that there was any support from anyone in my ward, from my NUM or my educator. In a sense, they did not try to motivate me to do anything better, because they decided she is not going to be interested in anything.

Similarly, working part-time because of caring responsibilities resulted in women being marginalised in the workplace. While participants maintained there were benefits in relation to work-life balance, full-time work was often considered a criterion for leadership and advanced nurse practice positions. Jackie explained:

But then my hours, decreased, and then I wasn’t put in that position (team leader) for ages. So then one day I did ask a clinical NUM, why I wasn’t getting rostered on into those positions; and it was basically, you’re not here long enough, or you don’t do as many shifts as we would like.

4.4  |  Reluctance to call out gender discrimination: ‘I’m not sure if it relates to gender’

The theme Reluctance to call out gender discrimination: “I’m not sure if it relates to gender”, highlights how deeply ingrained patriarchal culture is in society. The women in this study deflected and mini-mised the gendered issues they faced in the work environment. They were reluctant to depict themselves as disempowered, and were ‘unsure’, ‘uncertain’ and ‘unclear’ if they had experienced gender discrimination. Participants legitimised and rationalised their own oppression, unwittingly conditioned to the beliefs of a patriarchal system. For example, Katie stated: ‘It could be women don’t want these jobs’ and for Charlie it was because: ‘He was tall and good looking’. Raquel and Amelia preferred the term favouritism: ‘I’m not sure if it’s a male thing or is it favouritism. I don’t know, I’ve had a few experiences’ and ‘I don’t know if it’s the gender or if it’s favouritism’. In addition to a reluctance from participants to acknowledge they had experienced workplace gender discrimination, participants frequently looked for ways to justify their colleagues’ actions. Grace’s comment highlights this point, she did not want to believe her male NUM was unfair. She stated early in the interview ‘not ever thinking that my boss would be one of those people’ (who discriminated against women). Grace said:

Not that the women were discriminated against, I think it was, it’s more that the men are highlighted to go up the ladder quicker.

4.5  |  The status quo: ‘We’re just kind of used to it, aren’t we?’

The final theme The status quo: ‘We’re just kind of used to it aren’t we?’ highlights how participants demonstrated a passive acceptance of the patriarchal status quo. While participants were initially reluctant to use gender as an explanation for their workplace experiences, later in their interviews they spoke more candidly. Participants were in-fact cognisant of the widespread gender bias in their organisa-tions. They viewed gender discrimination as pervasive, systemic and culturally ingrained. As such, it was regarded as a normal part of working life. According to Grace: ‘We don’t put it down to gender discrimination because we’re just kind of used to it aren’t we?’. Participants expressed disappointment that women still had to fight for equality, even in a female dominated profession such as nurs-ing. Heidi was despondent: ‘Every opportunity, it’s an extra fight for women, all through life. Well, now it looks like even a nursing career is no different. It’s not easy for a woman’. Participants conveyed that at one stage they had ambitious career plans and were keen to pursue opportunities of team leader and education roles. However, participants who perceived they have experienced workplace discrimination became less confident. Raquel was emphatic: ‘I wanted to be a team leader, or an educator, I didn’t want to stay just an RN’. However, despite obtaining post-graduate qualifications, she was denied job opportunities from her female NUM in favour of male RNs with less experience and no ad-ditional qualifications: ‘I wanted to leave the department because I felt I was not achieving what I could achieve with the qualifications I had, the expertise that I had’. Raquel did not leave her department, she decreased her hours to explore alternative career options, how-ever, she lost her confidence; she retained part-time employment and stopped applying for other positions. The following quote from Raquel highlights her cynicism when she asks: ‘Would it be different anywhere else?’.

Theresa was employed as an after-hours manager, a posi-tion that did not come easily. Despite her own experiences with workplace gender discrimination, she did not challenge gender
discrimination against other women in her workplace. Theresa explained that while she was sympathetic to other women and had advocated for equality in the nursing workplace over the years ‘What is the point?’.

This was the job that I wanted. I had to fight for it, I got it. I don't have the fight in me anymore, I fought and fought for the right thing for nurses for females, for maternity leave, for FACs leave for their kids. So now I just shut up and try and fly under the radar, as much as I can. I don't get involved in anything. It might sound a bit of a cop out but what can I do?

5 | DISCUSSION

5.1 | Male privilege

A significant finding in this study was that participants believed male RNs were groomed for opportunities that would fast track their career pathways. In the sociological literature on gender and the workplace, considerable attention is given to the advantages men are granted in female dominated professions (Cousins, 2019; Williams, 1992), which is also evident within the profession of nursing (Punshon et al., 2019) and reinforced by the findings of this study. Williams (1992) suggested that men progress more quickly because ‘men and qualities associated with masculinity are more highly valued than qualities associated with women and femininity’ (p. 601). The notion of men experiencing a more rapid career progression than women was echoed by most participants in this study. The women in this study recognised a culture in nursing where the success and achievement of male RNs was prioritised. However, Williams (1992) made a more profound point regarding the division of individuals into gender appropriate roles within organisations. One of her most significant findings was that men were promoted in female occupations because it was considered unsuitable for them to be engaging in care work, and it was more appropriate for them to be managing the women who should be doing the caring. This resonates with the historical general perception that nursing is ‘women’s work’ (World Health Organization, 2019). The notion of nursing being more suited to ‘women’ was also highlighted by participants in this study who conveyed ‘Men don’t want to see themselves as just a nurse on the floor and being caring’.

5.2 | Gender stereotypes

Gender stereotypes are cultivated through years of socialisation and are deeply embedded in society. They are a powerful part of a larger conceptual process on how we view men and women. Gender stereotypes permeate every aspect of our lives, including our professional lives and are a fundamental component of the maintenance of patriarchal culture (Nicholson, 2015). Congruent with this study’s findings, men are usually rated more highly on agentic qualities, such as instrumental competence, assertiveness, self-confidence, autonomy, rationality and competitiveness. Women are rated more highly on communal attributes such as kindness, sensitivity, helpfulness, nurturance and emotional expression (Vial & Napier, 2018). In this study, male RNs were described by participants as ‘superior’, ‘assertive’ and ‘confident’; in contrast female RNs were described as ‘caring’, ‘empathetic’ and ‘compassionate’. While the stereotypes used to describe both men and women superficially appear to be positive and unproblematic, they drive expectations for men and women at work. Ingrained stereotypes that position women as carers, reinforce female subordination in the workplace (Nicholson, 2015).

Discriminatory practices against women in the workplace stem from incompatibilities between the attributes associated with women and the demands of higher-level positions; the ‘lack of fit model’. This model is based on the premise that gender stereotypes are prominent in the workplace, and significantly influence the way men and women are perceived (Heilman & Caleo, 2018). Despite the model being introduced 37 years ago, recent research shows its ongoing relevancy (Ling et al., 2020). The perception that male RNs were a better fit with leadership positions was widespread amongst the women in this study. Interestingly, in the leadership literature, leader role expectations are becoming increasingly more compatible with communal traits such as empathy and compassion (Vial & Napier, 2018). Nevertheless, the idea that successful leadership requires agentic traits largely persists, both within the literature and within this study (Heilman & Caleo, 2018). Stereotype-based expectations can result in the presumption that women lack competence, resulting in lower performance expectations for women in the workplace and decreased opportunities for skill development for women (Heilman & Caleo, 2018; Ling et al., 2020). This was evident in the current study with many of the participants highlighting that their gender diminished their perceived individual competence.

5.3 | Motherhood in nursing

Women with children experience disadvantages in the workplace, additional to those related to gender. It has been identified that many of the disadvantages mothers experience in the workplace stem from the devalued social status associated with being a mother. Mothers are thought to have decreased job performance and decreased commitment to their jobs (Yu & Kuo, 2017). However, this current study’s findings highlighted that women who were mothers were invested in their work as nurses. Nonetheless, many of the women described being professionally marginalised and excluded from decision making and leadership roles when they became mothers. Findings from this study are consistent with those reported in previous research by women in nursing (McIntosh et al., 2015) and, also within other professions (Halley et al., 2018). Interestingly a recent study reported that men who requested flexible work arrangements to care for their children were seen as more committed to
their jobs than women who request flexibility to care for children (Munsch, 2016).

Correll et al. (2007) maintain that discrimination occurs against mothers, partially because cultural understandings of motherhood "exist in tension with the cultural understandings of the ideal worker role" (p. 1298). The ideal worker is an individual who works full-time hours and does not require time off for family commitments. Implicit within this concept is gender, with the ideal worker being a man. Those who meet the requirements of the ideal worker, are most likely to climb the career ladder (Halley et al., 2018). However, a considerable number of female RNs work part-time and take career breaks for family reasons. In 2015, almost half (149,867 or 48.8%) of RNs worked less than 35 h per week in Australia (Australian Institute of Health and Welfare, 2015). It is a paradox that in a profession so numerically dominated by women, that expectations are so incompatible with the needs of working women (McIntosh et al., 2015).

5.4 | Oppression of women in nursing

Participants believed female leaders scrutinised the daily tasks of female RNs more than their male counterparts and were friendlier to male RNs. Although subtle, these actions increase men’s authority in the workplace and perpetrate the devaluing of women in the workplace (Nicholson, 2015). In addition, participants perceived that female team leaders facilitated the careers of their male colleagues over more experienced and qualified female RNs. Women nurses’ collusion in supporting and nurturing the career trajectory of men in nursing can be understood within the context of oppressed group behaviours. Nurses as women are an oppressed group owing to their subordinate status in a patriarchal society (Ferguson & Anderson, 2021). Patriarchy is a system which creates privileges and oppression, it values men over women and propagates oppressive gender roles (Nicholson, 2015). Oppressed groups take on the norms and values of their oppressors, believing that the traits of the powerful group are superior. Consequently, female nurses unwittingly value the success and careers of male RNs over their own, which they perceive to be of less value (Ferguson & Anderson, 2021).

The women in this study deflected and minimised the gendered issues they faced in the work environment. According to feminist authors Anderson and Jack (1991), when women are discussing their lives, they often mute their experiences, particularly in circumstances where women’s ‘interests and experiences are at variance with those of men’ (p. 11). The notion of women being muted does not mean they are silent, women speak; however, they communicate in ways which are restrained and influenced by the greater social power of men (Anderson & Jack, 1991). For example, as stated by one participant in the study, ‘Not that the women were discriminated against, it’s more that the men are highlighted to go up the ladder quicker’. Women are socialised to be self-silencing and subordinate, they are conditioned to the beliefs of men in a patriarchal society. Consequently, women accept the patriarchal/male version of their lives as their reality. Patriarchy according to the feminist literature is so entrenched in society that it has been normalised (Nicholson, 2015). Simpson and Lewis (2016) maintain that women consent to the status quo with their silence and thus inadvertently perpetuate their own oppression. However, women do not have a voice to articulate what they know is true, they speak with the language they have been conditioned to speak with (Anderson & Jack, 1991). Listening to women is not simple; we must learn to listen carefully, and we must learn to understand the language women speak.

5.5 | Limitations/Strengths

One strength of this study was the diversity of participants in relation to ethnicity, age, and years of experience. However, participants represented only a small geographical area in Sydney, NSW. Most worked in acute care areas which may not be an accurate reflection of the diverse clinical settings nurses work within. Another additional limitation was the small sample size. Interviewing greater numbers of female RNs from a larger geographical region and more diverse workplaces may provide greater insights.

6 | CONCLUSION

This paper illustrates the multiple and complex issues related to workplace gender discrimination for women in the nursing workforce. It highlights that socially constructed gendered norms continue to form the basis of inequity for women in the workplace. Expectations of gendered behaviour enforced and reinforced through socialisation processes resulted in participants’ rationalising women’s inequality based on her own choices and capabilities, particularly in relation to motherhood. Compliance to the socialisation of traditional gender roles makes it difficult for women to challenge their own oppression. Of particular note in this study was the deflection from attributing the label of gender as the root cause of participants’ workplace experiences. While this is consistent with literature on women and oppression, it is new to nursing research, and thus requires further exploration.

Given the global nursing shortage, maximising the skills and recognising the experience of all nurses should be a priority. In this study, women who were mothers and worked part-time believed they were discriminated against in relation to career prospects. All nurses need to be valued and provided the opportunity to return to their substantive roles and positions after a career break. Fostering and sustaining workplace cultures that support family and work life balance and that do not discriminate against women is fundamental to ensure equality. Notwithstanding there are challenges for organisations in successfully establishing practices to support more flexible work environments for women; retaining experienced nurses will enhance quality of care, prevent the deskilling of a significant proportion of the workforce and prevent the loss of professional knowledge. In addition, this is a more efficient use of resources, decreasing healthcare costs associated with training new staff. Career development and progression
opportunities should be fair and transparent, with clearly documented criteria. All nurses should be given equal consideration based on experience and qualifications. As such, these processes could be managed by external departments and recruitment of positions managed by Human Relations: this could assist with managing bias in decision making processes related to nursing roles and positions. Further qualitative research is required to understand the role of sexism and how it contributes to workplace gender discrimination and why it continues to exist for female nurses. We must stop rationalising workplace gender discrimination and start addressing this real and pervasive issue for women in nursing.

CONFLICT OF INTEREST
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