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Gender and nursing in Ghana: An explorative study of the reasons male nurses leave the bedside

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Abstract

Male nurses are reported to be stereotyped and discriminated against, lowering their interest in the profession and leading to higher attrition rate amongst them. The few that remain have also been reported to gravitate towards the islands of masculinity within the profession. However, in Africa, there is a paucity of literature with respect to the experiences of male nurses and their impacts on career decisions. This paper examined how gender influences male nurses' decision to leave the bedside in Ghana. It employed phenomenological qualitative design involving six key informant interviews and 24 semi-structured in-depth interviews with nurses. Transcribed qualitative data were analysed thematically. The findings showed that performance of 'feminine' tasks, expectations of patients and the general public, male-female nurse interaction and the need for autonomy compel male nurses were the key factors that influences male nurse to leave the bedside. The findings of this study underscore the need for heads of health institutions to adopt leadership styles that support male nurses and involve them in decision making at the wards and professional socialization to include helping nurses to discard internalised gender norms that prescribe certain tasks as masculine and others as feminine.

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Introduction

Social categories form the basis of people's expectations of the competence of others; and gender socialization leads people to expect certain kinds of behaviours from others based on their gender (Wharton, 2012). In any given setting, individuals are guided by the gender norms into which they have been socialized. The interactionist perspective, which guided this study posits that gender is something to be accomplished during social interaction since it is something that we are socialized into, and we are supposed to act according to our gender precepts in our interactions with others (Lindsey, 2015).

In recent years, however, due to social and economic changes, males are entering female occupations and *vice versa*. What has been of interest to many researchers of gender and sociology of work is the influence of gender on the occupational experiences of males and females in non-traditional occupations. Specifically, there has been significant attention on the career mobility of male and female tokens. While some have argued that males ride on a *glass escalator* (Punshon et al., 2019), others have suggested that this phenomenon does not apply to males from minority groups (Dill & Hodges, 2020; Wingfield, 2009). Although a body of knowledge exists on males and females in non-traditional occupations, in most African societies including Ghana, there is a paucity of research on the subject. In contemporary Ghanaian society, nursing is still considered a feminine occupation and dominated by females (Boafo, 2016a)..However, unlike other female-dominated occupations reputed to be low in status, it is a middle class occupation. In many African countries, including Ghana where unemployment rates are high, nursing offers job security and stable income in the public sector. Generally, the nursing profession in sub-Saharan Africa offers an opportunity for workers to travel abroad and practice their profession (Hollup, 2014). As a result, , the number of persons applying to public nursing training institutions in Ghana far outstrips the availability of training facilities (Addae, 2022) . However, the image of nursing as a feminine occupation has over the years discouraged many men from enrolling in nursing schools, and for that matter, male nurses remain a small minority in the profession (Feng et al., 2016; Williams, 1992).

Due to the linkage of nursing with socio-cultural constructions of womanhood, male nurses were considered as 'the others', anomalies and 'a matter out of place' (Douglass, 1966 cited in Hollup, 2014). Stereotypical views of male nurses as effeminate, homosexuals and suspicious abound in the literature (Ashkenazi et al., 2017; Williams, 1992). These stereotypes have functioned to deter men from entering the profession or have aided the movement of males into leadership positions and specialized sub-fields within the profession (Ashkenazi et al., 2017; Punshon et al., 2019; Williams, 1992) thus leaving fewer men at the bedside. However, there is a lack of empirical evidence of this phenomenon in Ghana and it may be erroneous to extrapolate the findings of these foreign studies to the Ghanaian context because the cultural, economic and other contextual environment within which the nursing profession exist in Ghana differ from other societies. For instance, in Ghana nursing provides job security and cannot be considered

a low status occupation as it is in some other countries. Moreso, gender constructions and its concomitant social expectations differ from one society. It is also known that in Ghana, some patients prefer male nurses to female ones (Budu et al., 2019). These make it imperative to examine the impact of conventional gender role expectations on career decisions of male nurses. This study thus investigates how gender affects male nurses' career decisions. Specifically, it examines how their experiences as male nurses compel them to leave bedside nursing. The significance of this study also lies in the fact that the existence of both male and female nurses at the bedside is necessary for the delivery of quality, patient-centered care. It is envisaged that the findings of this study will inform the practice of nurse managers, educators and other stakeholders to adopt pragmatic measures aimed at tearing down stereotypical gender norms that dissuade male nurses from remaining at the bedside.

Methods

Research design and setting

The study reported in this paper is part of a larger study aimed at investigating workplace experiences of nurses in Ghana. The original study involved a mixed methods research design. It included six key informant interviews, 24 semi-structured in-depth interviews and 592 cross-sectional questionnaire surveys. Participants were drawn from two teaching hospitals, five regional and five district hospitals in Ghana. In all, there were three teaching hospitals, nine regional hospitals and over a 100 district hospitals in Ghana. To ensure that the Northern and Southern divide of the country are represented, the Tamale and Korle Bu Teaching Hospitals were included in the design. Five out of the ten administrative regions of the country were randomly selected for the study - Greater Accra, Eastern, Volta, Ashanti and Northern Regions. From each of these regions, the regional hospital was chosen and a district hospital was randomly chosen from that region. This yielded five district hospitals and five regional hospitals. All of the 10 regions had a regional hospital with the exception of the Ashanti Region where no hospital is designated as such by the Ghana Health Service. In view of this, a government hospital located in Kumasi (the capital of the Ashanti Region) was chosen to represent a regional hospital for the purposes of this study. For the purposes of this paper, the qualitative procedures involving the 30 semi-structured in-depth interviews are reported.

Selection of participants

Permission letters were written to the various health facilities selected for the study. After permission had been obtained, initial meetings were arranged with the directors of nursing services in the various hospitals, where the study was explained to them. After each of these meetings, the researcher made contacts with nurses in the hospital and those who were deemed to be resourceful for the purposes of the study, were requested to take part in the qualitative interviews. These selections were made with the help of the

heads of nursing services and through the snowballing technique.

The data presented here involved 30 participants. Six of these participants were key informants. Of the six key informants, two were not nurses by profession. One was a hospital administrator and the other was a member of the board of the Ghana Nurses and Midwifery Council. Of the professional nurses, three were heads of nursing services in their respective hospitals and the other one was a national executive of the Ghana Registered Nurses and Midwives Association, In terms of gender composition, 13 were males and 17 were females. Of the 13 males, 11 were nurses by profession. The ranks of participants who were professional nurses ranged from Staff Nurse (SN = 6) Senor Staff Nurse (SSN = 4) Nursing Officer (NO = 5) Senior Nursing Officer (SNO = 3), Principal Nursing Officer (PNO = 4) to Deputy Director of Nursing Services (DDNS = 1). The majority (12) had Diploma qualifications, and about one-third (10) were within the age group of 21-30 years. Only one person was more than 60 years. It is important to note that this person was not a nurse. In Ghana, the retirement age for nurses is 60 years.

Data collection

Interviews were conducted at a time and place convenient for the participants, and safe for both the participant and the researcher. This ensured minimal disruption in the activities of the participants. Most of the interviews were conducted in empty offices or spaces in the hospital where the confidentiality of the participants could be ensured and had low noise levels. Two interviews were conducted in the office of the researcher and another two were conducted over the telephone. One of the interviews was conducted in the house of the interviewee. All interviews were conducted in English, were audio-recorded with the consent of the participants. Member checking was employed to ensure the accuracy and authenticity of the qualitative data. Authenticity here refers to presenting a fair, honest, and balanced account of social life from the point of view of the participants (Neuman, 2011). In this study, interview transcripts were taken to some of the interviewees for them to check for accuracy of the data. In all cases, no changes were suggested by participants. Other participants were too busy with work and other personal duties and could not go through their interview transcript. This setback was however offset by the fact that throughout the process of the interviews, the researcher summarized the information provided and questioned interviewees for confirmation and clarifications (Neuman, 2011).

Ethics approval and consent to participate

The Edith Cowan University Human Research Ethics Committee approved this research in July 2013 (project #9561). The Ghana Health Service Ethics Review Committee also provided ethical clearance in January 2014. Additionally, permission was sought from hospital administrations of all the hospitals included in the study. All participants provided oral consent prior to participation. Participants were assured of confidentiality

and anonymity, and all names used in the excerpts from the data are fictitious.

Analyses

Thematic analysis was employed in analysing the data. The analyses were guided by the steps suggested by (Braun & Clarke, 2013). The analysis began with transcription of the audio recorded interviews. All interviews were transcribed verbatim. This was followed by reading and re-reading of the transcripts to deepen familiarity with the data. The data was then organised by way of developing codes. A number of similar codes were put together to form themes. The themes were refined - where necessary themes were modified or changed to reflect the codes they contain and to ensure there is not too much overlap between themes. At the end of the day the themes that remained are those that tell a story about the data in relation to the research question. The last stage of the analysis involved the writing up of the research report based on the themes. In sum, the analyses mainly involved searching through the entire data set to identify repeated patterns of meaning. Prior to analysis, the transcribed data was sent to interviewees to confirm whether their views were correctly captured or if they wanted to any modifications to the information provided (i.e. member checking). This was to ensure the reliability and authenticity of the data. In all cases, no changes were suggested. The methods used in this study have also been published elsewhere (Boafo, 2016b, 2018; Boafo et al., 2016).

Findings

Two main themes identified: occupational trajectory of male nurses and the push factors for male nurses to leave the bedside. These factors are discussed further below.

Occupational trajectory of male nurses

Occupational trajectory here relates to the career paths and progression that male nurses intentionally choose. Most of the participants were of the view that the number of male nurses found at the bedside is not commensurate with the number of males who train as general nurses from colleges and universities across the country. Participants believed that many male nurses leave the profession entirely or divert into other sub-specialties such as anaesthesia, ophthalmic nursing, ear, nose and throat nursing (ENT), just to mention a few, after practicing for a few years. Akua, a female SSN in one of the regional hospitals indicated that:

> …you come to wards and you see about ten nurses and there may be no male. And some wards you may find one male nurse but they are training more [male nurses] too, so where are the male nurses? I think they divert (Akua, female Senior Staff Nurse).

This view was corroborated by Akweley when she said

> ...most of them [male nurses] work for a while and venture into these physician assistant and anesthesia. So they just take the opportunity to be in nursing and work for a while and venture into other areas. They don't stay for long; it's a platform for them to go into anesthesia, to be physician assistants, to be lecturers… (Akweley, female Senior Staff Nurse).

It is worth stating here that in Ghana, the specialized areas in nursing such as ear, nose and throat (ENT) nursing, ophthalmic nursing, anaesthetics and the like are mostly post-basic courses. This means that one should have qualified as a professional nurse before pursuing these areas. Although most male nurses had the intention of working in one specialized area or another, they had to first qualify and work as general nurses. As per the regulations of the Ghana Health Service (2010), nurses qualify for study leave for the first time after working continuously for three years.

The belief that male nurses do not stay at the bedside for long was also shared by male nurses as well. For instance, Omari a male NO suggested that male nurses usually leave the profession entirely because they feel they do not belong there when he remarked:

> "... by the time you go through the mill, let's say from the training schools or university, by the time you reach your SNO you will find that you don't belong to an institution like this. So people [male nurses] divert, others still remain in the profession but go to teach in the nursing training schools or heading someone's private clinic. But in all public institutions… for over four (4) years, I have not seen any male PNO let alone to talk about DDNS which is a top position. It is not coincidence that for several decades now, we just had a male CNO [Chief Nursing Officer] for the country".

Push factors for male nurses to leave the bedside

This theme describes the key factors that influences male nurses to leave the bed side. Here four sub-themes were identified, namely, performance of feminine task, deviation from social expectations, subordinate-superior interactions and the need for autonomy. These reasons were embedded in social constructions of masculinity and femininity. The narratives of participants show that these issues act individually and in combination with others to motivate male nurses to leave the bed side. For analytical purposes, these issues are discussed individually in the sections that follow.

Performance of feminine tasks

Gender socialization within the Ghanaian society still define certain tasks such as serving bed pans, assisting the sick to bath, etc. as feminine (Kyei-Arthur, 2017). This sub-theme looks at how the performance of tasks which are defined as feminine and for

that matter expected to be performed by females compel nurses to leave the bedside. The data revealed that male nurses' own awareness of these gender expectations, and the pressures from within and outside the healthcare facilities compelled them to find avenues which are more compatible with the social construction of masculinity within Ghanaian society. Responses from nurses revealed that because general (bedside) nursing involves the performance of several tasks which are associated with feminine roles, males usually divert into areas which do not require them to be at the bedside or working in areas which are seen as more masculine.

> …it's a female job honestly, because what we do here basically… a female can do something better than a male, so I feel their interest is not on the ward sometimes the kind of things we do I don't think a male will do… Oh! serving bed pan to a patient on the female ward, that is male nurse in a female ward changing the pampers of a female patient for instance…There is no problem with a female doing these things for a male patient. So, I think these are some of the things they don't stay on the ward (Akua, female Nursing Officer)

The comment above reflects the perceptions of nurses themselves regarding the unsuitability of males for certain nursing tasks. They were of the opinion that males must not perform some tasks. Males were not only seen as being unsuitable for these tasks, but they were also demeaning to them. Male nurses thus felt uncomfortable when they had to perform such tasks. The data suggested that, where female nurses were available, males usually relied on them for the performance of these tasks. The discomfort that males go through in performing specific nursing tasks (such as cleaning patients, serving bed pans, and performing other personal care and other intimate tasks especially on female patients motivate them to leave general (bedside) nursing. The feminization of certain jobs was not only evident in the narratives of participants, but they were also institutionalized. For instance, at the time of data collection, regulations of the Ghana Nurses and Midwifery Council barred males from studying midwifery. Such discriminatory policies thus reinforce already entrenched gender role expectations. It was therefore encouraging that towards the end of 2013, this policy was scrapped to allow the training of male midwives to begin (Peacefmonline.com, 2013).

Deviation from societal expectation

This sub-theme relates to the fact that male nurses are seen to have departed from what is expected of them as males by becoming nurses. Within the healthcare sector, males taking care of patients are expected to be medical doctors. Male nurses were thus seen to have deviated from social expectation since nursing is considered a female occupation. The data revealed that males taking care of patients were mistaken for medical doctors by patients and their relatives. According to participants, some patients even prefer being taken care of by males as they perceive them to be medical doctors. The expectation that male caregivers at the hospitals must be medical doctors puts pressure on male nurses to

leave the bedside. The nurses stated that male nurses are often called 'doctors' by patients and their relatives. Male nurses thus feel that they have deviated from societal expectations by being in a female occupation. They are expected to be in a male occupation, which is medicine. This situation, according to participants is uncomfortable for many male nurses for which reason they aspire to more specialized areas. This view was captured by Afia, a female SSN when she stated

> … they leave because when they come to the field, they don't feel much comfortable. And they are not called nurses, they are called doctors by the patients… but you are not a doctor, and they are calling you a doctor I don't think they should be happy (Afia, female Senior Staff Nurse).

Males working on patients in the wards were expected to be doctors and not nurses. As noted by Böhmig (2010) in her study at the Korle Bu Teaching Hospital in Ghana, the image of a nurse is a woman and not a man. This deviation from societal expectation thus compelled male nurses in the current study to 'migrate' onto the 'Islands of masculinity' (Hollup, 2014) within the profession. In other words, female and nurse are completely compatible under the social gaze. But male and nurse are incongruent (Tollison, 2013; White & White, 2006), thereby encouraging men to be more hands-off with patients. This was succinctly captured in the comments of Kofi, a male Staff Nurse when he remarked "how many times have you heard of papa nurse? It's always been auntie (aunty) nurse".
Kwadjo, a male SN also shared this view when he stated:

> …so when they see you, they will say "eii mmarima so ye nursing, nurse deɛ se aye mmaa dea" (are men also doing nursing, nursing is meant for women). So, if you are the emotional type, you will feel bad and you may find your way out.

Male subordinate vs. female superior

The relationship between male and female nurses, particularly female superiors was also found among the reasons why male nurses move away from bedside nursing to specialties dominated by men. Although male nurses reported that they have cordial relationships with their female colleagues, the same was not said about female superiors. The interaction between male nurses and their female superiors made them feel alienated. Their opinions were not taken seriously in matters related to patients' care. They felt incompetent on the wards when their superiors were around, and they were often made to feel unwelcomed in the wards by their female superiors. Several of the male nurses felt their female superiors did not want them in the wards. In simple terms they felt they did not belong in the ward.

> ...the pressure from outside [public] doesn't really affect me. For example when they call me doctor I try to tell them I am not a doctor. But within the profession

> itself, there is this kind of unseen conflict, but you will feel it when you are working with a female boss. She feels you don't belong here and your concerns or anything you bring on board doesn't matter, so these things make you feel that you don't belong here, this is not your right position and sometimes if you don't have the heart you will wish to find yourself out and that's how come you will hardly find male staff who is holding a PNO position even though it's a tertiary institution [teaching hospital] (Omari, male Nursing Officer).

A key informant, Mokporkpor, also shared this view. He was the administrator of one of the hospitals. Mokporkpor was of the view that males are less respected at the bedside, and this accounts for why most male nurses move away from bedside nursing after a few years of practice.

> It seems that the male nurses are not respected at the bedside of nursing, so they quickly move on to higher profession in nursing like anesthesia, physician assistant as well as medical assistant… The stigmatization and discrimination from the general public and among the nurses leads to the diversion of male nurses to higher profession within the health sector or even divert completely into something else like administration or management.

Need for autonomy

Closely related to the previous issue is the need for autonomy. The need to avoid being under the authority of female nurses, and the quest for autonomy came up as reasons why males divert into other areas defined as masculine. Like some African countries such as Rwanda (where, for example, more than 50% of parliamentarians are women) (Goetz, 2003), in contemporary Ghanaian society, females now occupy leadership positions in various sectors. For instance, the position of Chief Justice, the Chairperson of the Ghana Electoral Commission and several other high political and non-political offices are held by women. In spite of this, traditional gender norms still influence most people to believe that men are superior to women (Wrigley-Asante, 2012). This situation also accounts for the existence of the glass ceiling in several institutions in Ghana and other countries globally (Ohemeng & Adusah-Karikari, 2015; Purcell et al., 2010; Sharma & Kaur, 2019). The data showed that as a result of not wanting to be under the authority of female superiors, male nurses move into other sub-fields that are usually dominated by males; where they are more likely to be supervised by other males or become autonomous to a greater extent. Participants revealed that working in a 'female profession' and under the direct authority of a female boss at the hospital ward was an uncomfortable situation for most male nurses.

> …you know males don't want to be ruled by women, and most of these senior nurses are women. so they [male nurses] they think when they come to our side, that is general nursing they will be supervised by women but the psychiatric

> nursing most are men. I think that is why they prefer psychiatric nursing; they don't want to be under women (Adwoa, female Principal Nursing Officer).

> This is a profession that looks like, the only time you are going to be a boss or someone who is very in charge is when you are old. And male too … personally, I wouldn't want to be old and still be taking orders from somebody. Personally, I have not seen a male nurse who stays in to the last stop when he is called the DDNS or something. Even if they do, they take it through the academic level (Kwame, male Staff Nurse).

The comments above capture the desire of males to be autonomous, and their unwillingness to be under the supervision of female superiors. The immediate escape route for this is to divert into other areas which are considered masculine within the profession or leave the profession entirely.

Discussion

This paper explored how the experiences of male nurses in Ghana influence their decision to leave bedside nursing. It was found that the performance of "feminine tasks", interactions between female superiors and male subordinates, and deviation from societal expectations were among some of the challenges which compel male nurses to leave the bedside.

The performance of feminine tasks as a reason for leaving the bedside gives credence to other studies which have reported that when occupational roles do not conform to the gender-appropriate roles prescribed by the society, it puts the self-esteem and prestige of male nurses at risk (Ajith, 2020; Ashkenazi et al., 2017). They are neither recognized as true nurses nor as real men (Ajith, 2020). General (bedside) nursing is often considered incompatible with masculinity (Kalemba, 2020; Williams, 1992) and linked to the notion that nursing is an occupation for virtuous women. Thus, to be a 'good nurse', one had to be a 'good woman' (Gamarnikow, 1978). Nursing was associated with traits like compassion, submission, nurturance and tenderness, which were considered intrinsic to females (David, 2018). Nightingale stated that the "horny hands" of males were harmful to caring (David, 2018). It is, therefore, not surprising that males in nursing were often considered anomalies (Douglass, 1966 cited in Hollup, 2014), and stereotyped as effeminate, suspicious and homosexuals. It has been argued that these gender stereotypes have acted to perpetuate nursing as a predominantly female occupation (Feng et al., 2016). In Ghana, male nurses are often prevented from working in certain areas of the hospital such as obstetrics and gynaecology as a matter of policy (Budu et al., 2019) meanwhile, no such restrictions exist for medical doctors, thus reinforcing that entrenched notion that males are unsuitable for nursing. This finding supports the interactionist view that gender is often used as a social 'short hand' in judging people's suitability and competence on particular jobs (Wharton, 2012).

Consequently, all male nurses in the current study who indicated they would remain in the nursing profession also expressed their intentions of going into sub-fields like anaesthesia, ear nose and throat and ophthalmic nursing. This finding is compatible with other studies (Snyder & Green, 2008; Williams, 1992), which have reported horizontal segregation within the nursing profession. These areas, or sub-fields, are considered more compatible with masculinity, and are thought to be more prestigious (Kalemba, 2020).

Accounts of participants in the current study suggest that most of patients and the general public expected males caring for patients to be medical doctors and not nurses. This created discomfort for male nurses because they feel they have deviated from societal expectations. Most patients and their relatives called male nurses "doctors", and this suggests that they have fallen short of social expectations. Males taking care of patients at the hospital are expected to be physicians and not nurses. Being a male nurse is regarded as more or less a step down the social ladder – nursing is to femininity as medicine is to masculinity. This situation may also explain why Budu et al. (2019) reported that many patients in the hospital they studied preferred male nurses to female nurses. Indeed, in the Ghanaian setting, female nurses are easily recognizable by their uniform but same cannot be said about their male counterparts. Male nurses usually dress in khaki trouser and a white shirt with a lab coat which make them resemble medical doctors.

The need for autonomy was also found to be one for the driving forces for males leaving the bedside. Being under the direct authority of females was found to be a major reason why male nurses divert into other sub-fields that are considered masculine and dominated by males. The masculine identity of male nurses is bruised by the fact that they were mostly under the authority of female superiors. This finding supports the observation by other investigators that some men are challenged by submitting to the authority of females, and some females also have problems managing men (Ofori, 2007). Although in contemporary Ghanaian society women hold high ranking positions, the general gender expectation is for a man to be in a leadership position (Abotchie, 2008). In view of this, women in Ghana still encounter the *glass ceiling* in various institutions including the civil service (Ohemeng & Adusah-Karikari, 2015). Male nurses thus suffer a double blow of being in a feminine occupation and being under the authority of females. They therefore try to redeem the situation by pursuing post-basic training in the so-called masculine fields which will either make them autonomous or put them under other males. For this reason, male nurses in the current study were desirous of pursuing specialties that will make them autonomous.

Limitations of the study

The qualitative nature of the study and the sample size involved makes it impossible to generalize the findings of the study to all male nurses in Ghana. However, the study provides useful insights into the experiences of male nurses at various hospitals in Ghana. Another limitation of the study was that it did not explore how gender intersects with other social and personal factors to produce particular experiences for male nurses.

Implications for nursing practice and training

This study has implications for nursing leadership at the facility level. It suggests the need for supervisors (particularly female supervisors) to make conscious efforts towards inclusivity. Male nurses should not be made to feel like a 'matter out of place' and be involved in decision-making on the wards. The training of nurses should also be devoid of practices that reinforce conventional gender roles and division of labour based on sex so that they will not feel uncomfortable when they have to perform certain tasks on the wards. Nursing tutors and receptors must endeavour to help male trainees to uproot internalised gender norms that prescribes certain tasks as masculine and others as feminine.

Conclusion

The current paper presented qualitative findings regarding the ways in which gender impacts the experiences and career aspirations of males within the nursing profession in Ghana. It was found that male nurses faced many challenges and difficulties as a result of gender constructions. These included performing 'feminine' tasks, having to cope with alienation and stigmatization from female superiors, and the embarrassment of having to correct patients and their relatives that they are not medical doctors. In sum, internalized gender norms and societal expectations based on gender stereotypes compelled male nurses to take steps towards migrating to the 'islands of masculinity' within the profession or to leave the profession entirely. It is recommended that superiors adopt leadership styles that support male nurses and involve them in decision making at the wards. It is further recommended that nursing education should also aim at re-socializing nurses to do away with internalised stereotypical gender norms which prescribes certain tasks as feminine and others as masculine.

Disclosure statement

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

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