The impact of gender and gender perceptions upon career progressions in registered nursing in Scotland

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Dedication

In dedication and in part reparation to my mother, grandmother and wife

The greatness comes not when things go always good for you, but the greatness comes when you are really tested, when you take some knocks, some disappointments, when sadness comes; because only if you've been in the deepest valley can you ever know how magnificent it is to be on the highest mountain.

Abstract

The academic research into the relationship between gender, gender perceptions and career progression with registered nursing in the National Health Sector in Scotland remains under-conceptualised. While the effects of gender, working hours and school aged children upon career progression have been widely discussed, their short and long-term impacts have not been quantified. An exegesis of the extant literature also reveals limited investigation of the engagement between gender perceptions. Gender perceptions are defined for the purposes of this study as a simplified and standardised conception concerning the vocational and social roles of women (Diekman & Eagle, 2000) and their impact on women's career progression.

This thesis considers the impacts of these factors through a longitudinal analysis of a unique national database (NHS Scotland) of 65,781 nurses which includes 46,565 nurses who were registered over the period 2000-2008. It examines gender patterns within nursing careers in Scotland and explores the importance of various factors in explaining the influence of gender on the career progression of registered nurses. It explores the interactions between gender perceptions and professional values and how they reinforce each other to the relative detriment of women, particularly when the values and perceptions are in competition.

The research was conducted in three phases. The first phase involved a quantitative analysis of the gender patterns within the entire nursing workforce in Scotland comprising 65,781 employees. The second phase consisted of a longitudinal examination which explored the composition of the workforce, working hours, dependent children, career breaks and qualifications of registered nurses. This quantitative analysis sought to discern the factors and variables that influence women's career outcomes. This third phase of the research draws upon in-depth interviews with 32 female registered nurses in hospital 'acute' nursing from grades 'D' to senior nurse manager aged between 25-65 who have been employed in a variety of contractual working conditions, areas and grades.

Both phases of the research yielded a number of important findings. The quantitative study found that the influence of career breaks on career outcomes differed between female and male nurses. Career breaks had a significant detrimental impact on

women's career outcomes, while in the case of men the findings revealed that they did not in general work on reduced hours and career breaks positively impacted upon their career outcomes. The findings also revealed that women with children of a school age gained less post-registration nursing qualifications and this had a negative impact on their career outcomes. The qualitative study found that perceptions concerning parenthood actively informed women's access to and receipt of training and that gender stereotypes played a significant part in women's career outcomes. Professional values appeared to compound the agency and importance of the gender perceptions with their weighting of full-time working and professional flexibility and commitment at the expense of individual requirements. The active fusion of these factors combined to reduce the career outcomes of women with children of a school age in comparison to women without childcare responsibilities and men regardless of their circumstances.

The findings are relevant to the wider areas of equality of opportunity, employability as well as gender scholarship and add to the understanding of the impact of gender and gender perceptions upon career progression. They confirm that gender has a positive effect on the career progression of men and a negative effect on the career progression of women. Secondly, women's career progression in general is incrementally reduced by the presence relative to the age of the dependent children, the younger the child the greater the negative impact. For women there is a 'family penalty' in terms of career progression. It establishes that degree of impact children have upon women's career progression and outcomes. It confirms that gender perceptions and professional values work create a tension which works against women's individual requirements and career outcomes and creates unequal patterns of inclusion, particularly in relation to the access and receipt of training which is a key mechanism of the transfer of gender disadvantage. The complex relationship between dependent children, working hours, training and gender perceptions are part of a mechanism by which women's relative career disadvantages are transmitted.

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GLOSSARY

Accountability:	Nurses who are self governing, who are responsible for their actions and to those to whom care is delegated
Agenda for Change:	*'Agenda for Change'* is the single pay system in operation in the NHS. It applies to all directly employed NHS staff with the exception of doctors, dentists and some very senior managers. The three core elements that constituted the 'Agenda for Change' were job evaluation, harmonised terms and conditions and the Knowledge and Skills Framework (KSF). The objective was to simplify the process of designing new ways of working and the establishment of extended roles while providing the NHS organisations with the necessary tools to enable them to deliver workforce changes. In 2004, the Agenda for Change collective agreement was reached with the NHS unions. National roll out began in December, with pay and most terms and conditions backdated to 1 October 2004.
Career progression	Movement from a lower grade to the immediately higher grade
Competence:	Properly qualified, legitimate, skilful, suitable
Continuing education:	Upgrading of skills, attitudes and knowledge beyond basic training – is ongoing.
Gender Stereotypes	Gender stereotyping is defined for this purpose as a conventionally simplified and standardised conception or image concerning the typical social roles of male and female, both vocationally and socially. To simplify this definition, gender stereotyping are beliefs held about character, traits and activity-domains that are "deemed appropriate" for men and women (Diekman, A B & Eagle, A H "Stereotyping as dynamic constructs: Women and Men of the past, present and future" *Personality and Social Psychology Bulletin* (No 26, October 2000) P1174).
Non registered nurses:	Unqualified practitioners involved in the delivery of health care.
Nursing Practice:	Professionally recognised care of the sick, injured and frail.

Profession:	Profession refers to a set of characteristics that can vary from one occupation to another, that is, high involvement, feeling of identity, autonomy and high adherence to objectives and professional values.
Professional:	Describe the mastering or establish a set of knowledge and abilities related to the delivery of services Employed in a practice which is guided by standards and a code of ethics.
Professional development:	Improving one's professional status in the fields of knowledge, skills and attitudes
Senior Manager:	A manager placed above Grade 'I' on the Whitley Council pay scale.
Significant:	In statistics, a result which is statistically significant it is unlikely to have occurred by chance. Statistical significance is different from the standard use of the term "significance" which suggests that something is important or meaningful.
Standards:	Approved quality of care against which others can be judged bench-marks for practice.
Responsibilities:	Obligation, duties, outcomes for which a professional is responsible.
Registered nurse:	Nurses who are registered with the Nursing and Midwifery Council (NMC) formerly the UKCC (United Kingdom central Council for nursing, midwifery and Health visiting). Prior to 'Agenda for Change' graded between grade 'D' and senior nurse manager grade.
Role:	Specific function performed as part of the job.
Whitley Council:	Labour relations bodies also called Joint Industrial Council, any of the bodies made up of representatives of labour and management for the promotion of better industrial relations. An original series of councils, named for J.H. Whitley, chairman of the investigatory committee (1916–19) who recommended their formation, were first instituted as a means of remedying industrial unrest, many of them later developed into wage negotiating bodies.

Chapter One Introduction

1.1 Introduction

This chapter commences this thesis with an introduction to the research and a discussion of the rationale and a description of its aim and objectives. This is followed by an articulation of the research question and a summary of the research methods employed. The chapter then concludes with an outline of the structure of the thesis.

In nursing, women have in general less successful careers in comparison to their male colleagues (Riach & Rich, 1995, 2002). In Scotland, national statistics reveal that although there are high levels of female representation in nursing with females comprising 89.90% of the whole workforce and 97.49% of part-time employees, this representation is not translated into senior positions (ISD, 2009). Indeed, the figure, as at the 30th September 2008, showed that 27.59% of senior nurse manager positions were held by men who represented only 10.10% of the nursing workforce (ISD, 2009). It is against this background that this thesis seeks to examine male and female career progression in nursing and the factors which influence them in employment.

Sex segregation in employment has been a predominant feature of labour market research and is well-documented (Oaxaca & Ransom, 1994; O'Brien & Shemilt, 2003). Evidence of different career patterns and unequal opportunities for men in comparison to women, is widespread in studies of women's role and participation in employment (Witz, 1992; Walby, 2005, 2007). Mannion *et al.* (2010a) argued that the health system has been established by men and from a male perspective. This was achieved by meeting the career needs of men, but not those of women in the health professions, this encouraged gender career inequality. Similarly, Bolton & Muzio's (2007) analysis of men and women in the legal profession illustrates how promotion structures, legal careers, and patterns of practice have been organised to suit men. This form of organisation has resulted in slower promotion, different career patterns, and greater conflict between family and work commitments for many women. These works argue that gender influences careers within employment by facilitating the employment needs of men, while not meeting the requirements of women. As concepts like gender are socially constructed they are contingent on the significance attached to the social conventions between men and women.

However, Cohn (1985) argued sex segregation in employment stems from different processes in a variety of occupations and industries. He noted that in certain employments, notably clerical work the role played by employer preferences, ideology and economic concerns in sex-typing employment male or female. Further, Rose's (1986) studies of sex segregation in Britain highlight the impact of occupational history, men and women's traditional patterns of work, and accommodations between male and female workers in establishing patterns of sex segregation. Gender ideology and traditional gender roles have also been seen to impact how work comes to be performed by women or men (Rose, 1987). Armstrong and Armstrong (1992) observed that the prestige and power produced by financial remuneration is the generator of male workers attempts to exclude women from their occupations in order to gain greater job security, remuneration, and status for themselves. Ginn and Sandell (1997) and Crompton and Harris (1998), notably examined structural and cultural constraints on women's career progression. They argued that women are constrained in terms of career progression by the gendered concept of career which results in a 'male' model of full-time continuous working. Women's employment in professions still predominates in specialities and practice settings resulting in reduced careers, remuneration and prestige in comparison to men (Dex *et al.* 1995; Dex & Joshi, 1999; Alexander & Davies, 2001).

The gender debate related to parenthood and the family is extensive (Crompton 1996; Evetts, 1997; Halford *et al.* 1997; Dex & Sheibl, 2002; Walby, 2005). McQuaid and Lindsey (2005) consider that the organisation of work and the practicalities of combining career and family responsibilities are significant contributory factors to women's relative poor performance. They were unable to establish the degree of impact, however, they did note that women's responsibility for the home and child-care directly affected the type of roles women, particularly mothers, can take, prefer or are offered. Waldfogel (2007) described that as being detrimental and as a *"family penalty"* in terms of their career progression. She noted the difference in men's careers which suffer no disadvantage because marriage and family produce limited or no career interruptions for them. She observed that it is *"a well-established fact that women with children earn less than other women while no such difference exists for men"* (Waldfogel, 2007: 15). She argued this penalty may last after the woman has ceased to have childcare responsibility, indeed for their entire career, due to the

negative career effects of career breaks forming a 'negative shadow' on their future careers. She considered that this 'family gap' was more important than the gender gap.

There is a counter argument that locates preference as an agent of gender career differential. Hakim (1996) argues that some women wish to spend more time with their young child (or children) and feel that their presence at home is particularly important for the child's development in the early years. She argued that "*differentials in employment experience are due to personal choice as much as to gender discrimination*" (1996: 97-120). She argued that different groups of women do not all share the same preferences and priorities about work and family life, and that women's lifestyle choices have become a more important constraint than wider structures, such as social class or other macro-level influences (Hakim, 2006; 2008). However, Ginn *et al.* (1996) disagreed with this position and suggested that gender roles were dependent upon decisions which restricted women's careers. They contended that the *"majority of women were trapped in the vicious circle of low pay, leading to inability to afford full-day childcare and part-time employment."* (1996: 169). Caines and Hammond (1996) and Wise (2003), observed that women who choose the latter had a slower progress in their career: the greater emphasis on the family by women created a situation in which they just had less social and geographical mobility. They argued that with the birth of children, career breaks resulted frequently in women working on a part-time basis in order to provide childcare. The pressure on women to perform these roles resulted in their careers becoming secondary to the family unit - women required occupations with flexible hours in order to allow time for child-care. They considered that careers were significantly impacted by maternity, childcare and family considerations. Wajcman (1996, 1998) argued that children were perceived to be incompatible with work-time regimes and the daily practices and responsibilities prevalent in management cultures. She argued that many female managers had *"clearly decided that childlessness is a precondition for a successful managerial career."* (1996: 620).

There is literature that relates woman's relatively restricted careers to the presence and the ages of their children. Manning & Robinson (2004) note that the presence of young children may be taken as a signal for the probability of having another child as

in many countries, including the UK, the parent would be entitled to maternity leave which would result in various associated employer costs such as maternity pay, loss of work time, hiring, wage costs of replacement staff and additional staffing costs. Neugart (2008) considered that there may be reluctance to promote parents with small children or those who may potentially have children in the near future. Two particular reasons for this are, first, workers with young children may be perceived to have lower productivity. This may be due, for example, to perceptions of them: being less flexible (for example in terms of hours they can work, days or periods they are unavailable, geographical area they can work in and the ability to change hours at short notice); being more likely to take more time off due to sickness or childcare arrangements for their children; having lower levels of work commitment or willingness to take on added responsibility; and requiring greater management or supervisory time to deal with, for example in creating fixed work rotas for them. Ekin (2007) argued that this was linked to the cost and availability of childcare, especially before the child goes to Primary School at around 5 years old (after which the childcare costs should reduce significantly as they will be at school much of the day). Ekin found that lower childcare costs, or higher wages, increased overall employment, although the elasticities are small. After the child reaches Secondary school age, at around 12 years, mothers are more likely to go back to longer work hours or full-time work as the children are more independent, need less childcare and spend more time in school. If the parent returns to full-time work at this stage, they are still likely to suffer long-term career disadvantage, as they may have missed out on the early career development stages compared to contemporary men and women who did not have children (or men who did have children), and also their commitment, aspirations and confidence in their future career may be more limited So being a parent with young children may increase the probability of such future costs (other such signals may be age and gender). Using British Household Panel data, Booth and Van Ours (2008) argue that a woman's labour market position is mainly influenced by the presence of children and their ages. In particular women without children, or who have children over 12 years old, were less likely to be in part-time employment.

The literature in relation to the impact of children and hours worked by men and women is diverse (Whittock *et al.* 2002; O'Brien & Shemilt 2003; Lane, 2006). Notably, Paull (2008) found that a child's birth had little impact on the hours a man

worked. Although after the first birth there was considerable movement towards part-time work for women which continued for the next 10 years and to a degree for the rest of their lives. She noted that men may also be similarly disadvantaged in career terms if they take the major childcare role however; there was no substantive evidence to support this position. McQuaid *et al.* (2009) observed that flexible employment, in terms of hours or part-time work were appealing due to the relatively straightforward entry/exit/re-entry procedures as they enabled women to combine work and family responsibilities more easily, but at a cost to their long-term career. They argued that these constraints frequently force women to take less 'attractive' positions or posts which accommodate personal circumstances on reduced salaries and hours of work or both. However, Grimshaw and Rubery (2001), Wise (2003) and Mannion *et al.* (2005) noted that management grades rarely exist on a part-time basis, then part-time workers, who are predominantly female, are detrimentally affected in terms of career progression. Consequently, the time that women can invest in their work either through training in skills or "extra" hours to complete tasks is limited (Johnston-Anumonwo, 1992; Dex & Shiebl, 2002). This is considered as a major determinant of women's careers and appears to be indelibly linked to part-time working (Hakim, 2004; Manning & Robinson, 2004). For instance two-thirds of women in a longitudinal study by Stewart and Greenhalgh (1984) who worked on a part-time basis had restricted careers. Manning and Petrongolo (2008) argue that the part-time versus full-time pay penalty is almost entirely a product of occupational segregation and is unrestricted in its impact both in the public sector (Jaumotte, 2003; Gash, 2008) and the private sector (Olsen & Walby, 2004; Gregory and Connelly, 2008).

The research into gender and careers has been long-standing and covered many determining factors, notably differences in human capital (Jusenius, 1976, 1977; Hearn, 1982; Humphries & Rubery, 1984). There has also been a research emphasis towards organisational structures and policies (Walby & Bagguley, 1990; Macrae *et al.* 1993; Kessler & Purcell, 1996). These investigations were predominantly concerned with how organisational structures and policies created barriers to women's advancement. However, other research considered the relationship between skills and attributes and male and female careers (Edgeworth, 1992; Gillespie & Brown, 1993; Rubery & Fagan, 1993; King, 1992; Hartley & Martin, 2003). Alternative research examined professional expectations, beliefs and values in relation to gender roles,

stereotypes and perceptions (Masteron & Cameron, 2000; Powell & Graves, 2000; Legault & Chasserio, 2003). Cohen and Huffman (2003) and Wadsworth (2005) investigated women's disproportionate representation in sectors and occupations with restricted careers. The focus of more recent research is on understanding the effects of children and the family and exploring how they impact on women's career achievements (Paull, 2008; Connolly & Gregory, 2008) and the access and receipt of training (McQuaid *et al.* 2005, 2007, 2009). While some of the previously mentioned studies into barriers to women's career progression included the nursing profession (Dex, 1987; Mackay, 1989; Goss & Brown, 1991) they did not do so on a national scale. Further, the majority of these studies were descriptive and utilised either qualitative or quantitative research methods with relatively few seeking to combine both which is the core of this research.

This led to the objective of investigating the complex relationship between career progression and gender and gender perception. The key questions in relation to career progression are thus: is there a gender disadvantage; and if so is there a *"childcare penalty"*? If there is, does it negatively affect the career progression of men and women with dependent children equally? Or if there is, what is the degree of disadvantage or advantage experienced by men and women? Finally, how do gender perceptions impact upon women's short and long-term career progression?

1.2 Rationale for the Research

This thesis examines the impact of gender and gender associated factors on career progression within registered nursing. The broad setting for the research was set within the context of a university funded studentship on gender stereotyping in the NHS. After an initial literature search, the specific focus on registered nursing was identified. Nursing facilitated the opportunity to examine gender in a profession numerically dominated by women, in an area in which grading structures are directly comparable. An early objective was established to try to establish the scale and pattern of employment patters for men and women in nursing and this was facilitated by access to the national database for the whole of Scotland. Investigating career progression at a national level within a large scale employer was the means to understanding how career progressions are determined.

As the thesis is concerned with gender in employment the use of the national databases affords a comparison between the sexes and categories within the sexes. National databases in general are of the highest quality due to mandatory and statutory requirements. These afford the opportunity to examine the effect of issues related to gender on the career progressions of male and female registered nurses of different circumstances.

As the produce of social activity, gender perceptions are neither perpetual nor static nursing affords the opportunity to look at the issue objectively against a defined theoretical framework. The qualitative exploration affords a rigorous examination of the factors. In-depth interviews provide a meaningful understanding of the factors under consideration within context. It was decided that it was important to understand the perceptions of women nurses themselves. The rationale for exclusively selecting women for the qualitative part of the study is based on the need to identify and describe organisational, situational, and individual factors related to the group with greatest relative career disadvantage. As women had a relative statistical disadvantage in relation to their careers in comparison to men their experiences are central to understanding the factors which define career progression within the workforce.

1.3 Aim and Objectives

The overall aim is to investigate the impact of gender and gender perceptions on career progression in registered nursing in Scotland. The specific objectives of the research are:

1. To establish the scale and pattern of gender differences in registered nursing in Scotland.

2. To analyse the impact of key factors - dependent children, age of the children, career breaks, part-time working and the access and receipt of training on career progression in registered nursing.

3. To explore the relationship between nursing values and gender perceptions on career progression.

1.4 Research Method

In order to address the objectives, the research is divided into two parts. The first part is quantitative; it is split into two parts a descriptive review (Objective 1) and an examination of the variables (Objective 2). The second part uses a qualitative approach to look more deeply into the views and experiences of women nurses (Objective 3).

In the quantitative part of the research, the first part focuses on the national nursing workforce obtained from the Scottish Workforce Information System (SWIS) in order to determine gender anomalies. It maps patterns of employment and identifies key factors which influence career progression in relation to gender in registered grade nurses in Scotland. This statistical data was provided by the Information Services Division (ISD) the statistical unit of NHS National Services Scotland. This data is collated from NHS Scotland Unified Boards, hospitals, general practitioners, local authorities, voluntary associations, community health partnerships and other care and service providers. These are official national statistics and as such meet essential criteria - they are methodologically sound, politically independent and transparently produced. They are produced in accordance with the 'Framework for National Statistics' (ISD, 2009) and comply with the principles embodied in the NHS 'Code of Practice' (*ibid*).

The variables to be examined were established as: gender ratio in registered employment grades, employment status (full-time or part-time working) and the age of the dependent children. This was concerned with understanding differences in the career progression of male and female registered nurses relative to these variables. The statistical data covered nursing grade 'D' through to management grades (to grade 'I'). The period elected for examination was the period 1st October 2000 to 30th September 2008. This period was selected because it was the last year in which clearly definable information relating to grading was presented. As 'Agenda for Change' was on-going subsequent to this period, new grades had not been comprehensively allocated and accordingly definitive information in relation to grades was not available.

The qualitative research focus through the use of in-depth interviews concentrated on exploring female registered practitioners' self-reflections on their career. It explored issues from the participants' own accounts and understandings of their experiences and their identification of factors that facilitated or hindered their career advancement. It sought to establish what role, nursing values, gender and gender perceptions have had on career progressions and short and long-term careers. These interviews were conducted through semi-structured in-depth individual interviews with female registered nurses. By focussing on women experiences an understanding of women's relative disadvantage in their short and long-term careers and the barriers and issues within their career paths.

This mixed method approach represents a means of understanding occupational segregation in nursing by examining the associations and determinations within the wider workforce. The examination of the direct experiences of the group with the greatest relative disadvantage allowed for the identification of historical, internal and external factors and barriers within women's career progression and short and long-term careers. The comparison of the workforce and the experiences of female registered nurses allow this research to establish what role, if any, gender and gender perceptions have on short and long-term careers.

1.5 Structure of thesis

The next three chapters provide a critical review of the literature related to concepts of importance to this thesis. Chapter two examines the literature related to careers and gender including critical discussions on issues such as gender segregation, human capital and gender segmentation. Chapter three explores occupational gender stereotyping and perceptions and the construction of gender stereotypes and Chapter four is devoted to an exploration of the extensive literature related to nursing including the development of nursing, nursing identity and professional values. Chapter five details the research methodology and methods including the research design and techniques applied in this thesis. Chapter six examines the descriptive statistics it investigates if the percentage representation of women decreases the higher the grade in registered nursing and if part-time nurses have restricted careers in comparison to their whole-time colleagues. Chapter seven examines the composition of the registered nursing workforce. It analyses the career progression between men

and women with and without dependent children of a school age, the impact of the age of the children, working hours and career breaks on the careers of men and women. It provides a detailed analysis of the quantitative national data relative to differences in the career trajectories of male and female registered nurses. This is followed by chapters eight and nine which present the qualitative analysis concerning career breaks, access to and receipt of training, the impact of professional values upon women's short- and long-term careers and the impact upon women's careers of gender perceptions. Chapter ten concludes the thesis and includes a summary of key findings from the research, a discussion section, a review of the limitations of the research and a statement of significance. A policy recommendations section, a statement of significance, reflections and closing comments completes this thesis.

Chapter Two Gender and employment

2.1 Introduction

This chapter examines gender and careers given that this has been an area of academic interest for a considerable period. It is important, in reviewing the literature, to appreciate the complexity of this field and accordingly the following section will consider, in the first instance, occupational gender segregation. The subsequent four sections will then engage with the debates related to gender economics, human capital, parenthood and preference theories.

2.2 Occupational gender segregation

The critiques in relation to gender segregation attempt to determine the scale and extent of male and female segregation in employment and in relation to theory. Segregation concerns the tendency for men and women to be employed in different occupations from each other.

Levels of segregation and concentration have been considered to be a significant factor in the discrepancy and constraints imposed upon the careers of women and men (Groshen, 1991; Reskin & Hartmann, 1992). Segregation refers to the separation of the two sexes across or within occupations; concentration refers to the representation of one sex within occupations or set of occupations (Beechey & Perkins, 1987). Vertical occupational segregation is defined as "*when men and women both work in the same job categories but men generally do the more skilled, responsible or better paid work*" (Grimshaw *et al.* 2001: 25). Horizontal segregation refers to the extent in which women are located in lower paid occupations (Hersch & Viscusi, 1996).

There were differences in interpretation of the meaning of horizontal and vertical segregation. Kerfoot (2000) argued that vertical segregation entailed inequality and horizontal segregation produced differences without inequality. Blackburn *et al.* (1999), whilst acknowledging aspects of this critique rejected this analysis as simplistic and inadequate. They stated that these positions tended to confuse overall segregation with its vertical component and that this theoretical position produced substantive contradictions. It assumed and implied that greater empowerment of women would reduce overall gender segregation. They argued the reverse occurred in practice and affected career opportunity, working conditions and remuneration

contending that there were multiple factors involved in these occupational processes which facilitated segregation. They argued that it was naive and simplistic to consider one as independent of the other. If men worked as doctors and women as nurses, for example, this would be horizontal segregation but the same phenomenon could also be vertical segregation. They noted that within aggregated occupational data the correlation between female-male employment ratio and occupational segregation were counter-intuitive and only when multiple factors were taken into consideration that a coherent explanation was found for both the level of female-male careers.

Williams (1992) and Gunderson (1994) argue that occupational gender segregation is reproduced by dialectic between structure and interaction, between gendered organisations and the ongoing performance of gender by individuals. Drawing on this, Williams and Gunderson go in different but complementary directions, in describing the performance of gender. Williams focuses on gendered worker interests, while Gunderson makes a distinction between gender behaviour and gender identity. Williams especially ties her analysis to Connell's (1987) idea of hegemonic masculinity, the socially dominant form of masculinity in a historical period. Male roles frequently depend on proving themselves in gender-appropriate work. When men occupy traditionally female occupations they set themselves apart from their female colleagues and reproduce the dominant forms of masculinity. In both formulations, gender shapes the organisational and occupational practices, while the practices reproduce the gender relations between organisational and occupational members.

Joseph (1983) and Rousseau (1995) observed that within organisations, structural network was situated in a larger web which consisted of the local gendered practices. These practices reflected the traditional gender relations of the local or national labour market in which these organisations operated. Guest and Conway (2001) argue that institutional behaviour tends by its very construction to discriminate against women in favour of men and in doing so gendered occupations and facilitated segregation. They noted that this is enabled in part by perceived differences in productivity, skills and experiences of men. Ferber (1992) and Marshall (1994) observed the self-propagating nature of environmental cultures as the agent which maintained institutional gender patterns of employment. These notwithstanding, Guest (2004) argued that

institutional/structural discrimination was demonstrated and perpetuated through promotion and recruitment systems which directly advantage men. He contended that this resulted in gendered substructures which undervalued the role and contributions of women and reinforced gender patterns whilst creating a psychology which systemically gendered employment and roles within it. Grant *et al.* (2006) argue that this locates segregation within the interaction of complex circumstances - cultural and psychological. Certain careers are built upon the position that employers recruit, dismiss, promote and remunerate through a gendered perspective. The central argument relative to structural frameworks is that men maintain their positions to the detriment of women because of the institutional structures in operation.

A large part of the literature discusses the metrics which measure gender segregation and concentrations. This material observes the existence of horizontal and vertical segregation. This material does not in itself provide an explanation for these phenomena. There is not an unequivocal conclusion provided in reference to gender. However, within the literature two key views emerge in relation to gender and employment: an organisational barrier encountered as a result of organisational practices and social barriers based on gender. This literature is not divorced from alternative explanations and debates, notably, economic theory and this will be explored in the subsequent section.

2.3 Gender Economics

The basis of occupational critiques lies within the proposition that employment was systemically gendered. Within the literature, there is an apparent relationship between gender, employment and economics.

Boserup (1970) stated that theoretically, in a competitive economy, the most suitable person would be employed in order to decrease costs and increase profits. This implied that with overlapping skills, individual preferences and the availability of labour supply, occupations would include equivalent percentages of each sex. Blinder (1973) noted diverse factors influenced and governed employers' preferences for male or female employees but in relation to gender female careers were affected by perceptions concerning higher cost in comparison to men. Sellgren, *et al.* (2006) contended that labour legislation and regulations actually increased the cost of female

workers as compared to males. They observed that paid maternity leave increased the cost of women workers relative to men and therefore became a factor in the employer's cost equation. They did acknowledge that this was a complicated situation. While maternity leave costs were borne by the state and not solely by employers, there was still a belief amongst many employers that maternity leave was a detrimental and needless additional cost.

This was exacerbated by beliefs concerning turnover costs, principally high staff turnover associated with women leaving employment in order to take care of their families and children (Gregory, 1992). Hersch and Stratton (2000) and Prasch (2000) noted similar labour turnover rates for women and men. Simpson (1997) noted that these perceptions resulted in women being considered less flexible than men due to women usually being the main carers of dependent children. He argued this propagated assumptions that the employment of women means higher direct and indirect labour costs and disruption to the delivery of services. He noted that crèche facilities in the workplace were frequently considered an additional needless cost for employers despite them being a tangible benefit for women. This was exacerbated by concerns concerning absenteeism. Doyle (2000) observed that while women were found to have higher absentee rates, mainly due to family responsibilities, the difference between male and female absenteeism rates was negligible. However, he observed that for employers, even a minuscule difference reinforced negative gender perceptions for women and increased the demand for men as employees.

Budig (2002) observed that flexible working within the labour market was the product of business and economic requirements. Organisations adopted part-time working arrangements as a means of responding to fluctuations in their output schedules for providing services on an all year basis and for competing within the local labour market. Women gravitated towards occupations with flexible conditions because of this characteristic and the ease of employment. Kersley *et al.* (2005) and Maxwell *et al.* (2007) observed that where certain employers had deliberately structured jobs flexibly to appeal directly to women with care responsibilities these were not designed for altruistic reasons but were based on financial and economic rationales.

It appears that employers make employment decisions based on assumptions about the economic cost of employing women. Career progressions are not linked to simple economics thought but wider gender issues. Economic theory is not divorced from external factors, notably human capital and it is this that will be examined in the following section.

2.4 Human Capital

Human capital, even in its very definition is a contested domain - there are different points of analysis and interpretation. While there is no consensus, there are various areas of consideration, educational and vocational qualifications are considered to be significant arbiters within human capital theory (Mincer, 1958; Becker, 1962, 1964). As these directly relate to this thesis, these will be specifically reviewed.

Human capital theory refers to the belief that, in the absence of more direct measures of productivity, employers use indicators such as qualifications and years of experience to gauge the potential and worth of an employee. Employees with higher qualifications are thought to have demonstrated their ability to acquire knowledge and to have gained potentially useful knowledge and skills. Similarly, an employee with a greater number of years experience is seen to have acquired an *in-situ* education which is of value to an employer (Bell & Klein, 1987; Howson, 1993). They argue that the careers of men and women are affected by this factor. However, Bakker (1988) observed that human capital was neither fair nor equitable. He opined that female human capital was considered as *"the lowest level of human capital despite advances in education and female labour force commitment"* (1988: 12). The power of perceptions it would appear, according to this argument, would have greater importance than other rationales. This it was argued was highly observable in relation to the access and receipt of training, Broadbridge *et al.* (2007) noted, cost implications associated with women, notably the possibility that they would take maternity breaks reduced their access to training.

Sutherland (1995) argued that female disadvantage in human capital terms arose because traditionally women had not received the same standard of education as men thus restricting their opportunity to gain enhanced qualifications. They observed that traditionally girls had received less relevant training and education in relation to the

skills required for the labour market than boys. This resulted in women being unequally represented in certain occupations with a greater concentration in lower level posts. Cooper (1996) acknowledged this historical relationship as evidence of the bi-directional relationship between education and employment but contended that reflected the greater importance of social agency as a greater factor than education. However Miller and Wheeler, (1992) argued as women's transferable commercial and industrial human capital were detrimentally affected by intermittent employment or truncated because of marriage and/or household/childcare responsibilities this positively advantaged men producing a situation which enhanced male careers. They considered that this factor led to women accumulating less labour market experience than men. Gaze (1987) and MacInnes (1998) considered that women's 'traditional' responsibilities for household work/child care resulted in women acquiring less labour market experience in comparison to men. The family ensured female withdrawal from the labour force on a temporary basis and at times on a permanent basis handicapping careers. Wise and Bond (2003) argued that aspects of the family, including the organisation of the household, early, temporary and/or permanent withdrawal from the labour force due to marriage and/or to care for dependent children limited female careers. In essence, these authors argued that as women were almost exclusively occupied with child-care and family responsibilities this resulted in these women having less paid work experience than their male counter-parts. This division of responsibilities determined that women accumulated less human capital in comparison to men and were less attractive to the labour market.

Davey *et al.* (2005) found an association between career break and interruptions and women's acquisition of human capital. They noted the negative impact of career breaks in caring for children with the ability of women to progress from one grade to another and their long-term careers while having no discernable upon men's careers. They argued that organisational practice recognised the scale and length of experience as the single most significant arbiter of human capital. The inability to accrue human capital was related to the career breaks an individual took. Continuous experience was privileged within paid work variations from this employment experience, handicapped and restricted both opportunities and careers. This observation was strongly supported by Newman (2001) and Morrison (2001) who observed that breaks in employment had a direct relationship to the accumulation of human capital. Leach (2002) noted

that as organisations tended to give preference and privilege to continuous employment, the handicapping of women who had taken a long-term career break became disproportionate. Thus women, who spend less time in the labour force than men, accordingly have less opportunity to invest in the accumulation of marketable human capital. Borjas, (2005) considered that there were other factors which in association exacerbated the detrimental impact of career breaks on female long-term careers - the traditional role of women in relation to the family and part-time working.

Human capital theories have multiple theoretical explanations in relation to the worth subscribed to individual factors. Human capital is the economic value that an employee provides to an employer. The assessment of this value is related to the body of skill, knowledge and experience that the employee possesses. Factors such as formal education and participation in ongoing training related to the workplace also help to enhance the human capital that the employee represents. As one of the basic factors of production, human capital is essential to the operation of all employments. Employing individuals who have the necessary expertise, judgment and ability to function within their assigned roles allows the organisation to operate at maximum efficiency. A failure to develop individuals with the necessary combination of skills, experience and education can undermine the efforts of even the most well organised institutions. Education, work experience and career breaks are central arbiters in the acquisition of human capital. Career breaks are located as significant inhibitors upon women's human capital and subsequent career progression. The literature notes that women who are intermittently attached to the labour market are found to work, on average, in occupations associated to significantly lower prestige levels. In particular, additional family-related interruptions have a negative impact that becomes persistent and cumulative. Moreover, the decreases in prestige levels are linked to the length of career breaks. It raises the question what is the impact of career breaks on career progression? This question will be addressed later in this thesis; prior to this the critiques related to parenthood will be examined in the following sections.

2.5 Parenthood

Within the literature parenthood, dependent children and the family are strongly related to short and long-term careers. This is also within the literature linked to working patterns. The extent and the impact of dependent children and the family

have occupied the literature for a considerable period. There were common themes and points of convergence - a focus on the domestic, parenthood and the family as "*the underlying agent of male domination and female subservience*" (Mills, 1970: 2). Murphy and Welch (1990) conjectured that the family was the focus of employment inequalities in relation to gender. They noted that, whilst female-male opportunity differentials were small for single persons, married or co-habiting, women accounted for the entire observable female-male differential suggesting a clear link to dependent children and the family. The needs of the family dominate women's working life. In particular, the requirements of dependants manifest themselves most clearly in the family/home environment in terms of the sexual division of labour and the allocation of responsibilities (Witz, 1990; Williams, 1992). Family structures and ideology has been constructed around the notion of women as mothers.

However, Phillips (1998) criticised this argument for placing too much emphasis on the biological underpinnings of sex and not enough on historical and socio-political factors. Walby (1986) added that there was "*a tendency to essentialism, to an implicit or explicit biological reductionism and to a false universalism which cannot understand historical change or take sufficient account of divisions between women based on ethnicity and class*" (1986: 132). She contended that the "*majority of women were trapped in the vicious circle of low pay, leading to inability to afford full-day childcare and part-time employment.*" (1996: 169). They argued that the birth of dependent children frequently resulted in women working on a part-time basis in order to provide childcare. The pressure on women to perform these roles resulted in their careers becoming secondary to the family unit - women required occupations with flexible hours in order to allow time for child-care.

Caines and Hammond (1996) considered that the relative under-representation of women from senior level employment in general was evidence of difficulties in combining career and family. They argued that woman's traditional responsibilities for housework and child-care affected the type of jobs women preferred, since flexible employment in terms of hours or part-time work was appealing to their relatively straightforward entry/exit/re-entry procedures which enabled women to combine work and family responsibilities more easily. They observed that work tasks, both within and outside the home, tended to follow the gender-specific pattern. Datta

Gupta *et al.* (2006) stated that historically women tended to be involved primarily in the domestic spheres of housework and childcare while men were more closely associated with the public sphere of full time employment. They noted that the tasks and roles associated with senior positions were frequently considered too important to be performed on a part-time basis and this restricted many women with dependent children of school age and family commitments from occupying these positions. As part-time jobs are mostly found in low-level occupations, many women therefore accept a convenient job with reduced hours or lower status, in order to be able to combine paid work and family responsibilities.

Akerlof and Kranton (2000, 2005) argued that it resulted in a cultural expectation where post-holders were expected to work 'whatever hours it takes' but in doing so denied many women with childcare issues access to enhanced careers. It created a situation where careers were located in the spectrum full-time working. Grimshaw and Rubery (2001) stated that the 'elevation' of paid work over other forms of labour contributed to the normalisation of 'full-time' hours and conditioned both employers and employees to see this as the accepted form of working. In effect, this meant a complete, day-time commitment, to paid employment. *"Part-time, as its name implied, was only part of a whole: to work part-time was to renege on an agreement to do a whole, complete job"* (2001: 93). Organisational systems and processes which included reward systems, promotion criteria, training opportunities and pay scales appear to uphold and reinforce the 'privileged' status of full-time work as the normal working-time regime. Wise (2004) advanced this position noting that senior management positions had been virtually unaffected by the increased use of flexible working arrangements and this ensured that gender positions remained relatively unchanged.

Yeandle *et al.* (2006) stated that the effects of dependent children were particularly acute in Britain, where full-time working predominated. Worrall and Cooper (2000) contended that an increase in hours worked, resulted in deterioration of conditions which resulted in employment insecurity allowed gender demarcation to flourish. Wajcman (1996, 1998) argued that dependent children were perceived to be incompatible with work-time regimes and the daily practices and responsibilities prevalent in management cultures. She argued that many female managers, for

example, had chosen the former role and had *"clearly decided that childlessness is a precondition for a successful managerial career."* (1996: 620). She emphasised that concepts like gender were socially constructed, they are contingent on the social significance attached to the differences between men and women rather than any other determinant and this has powerful connotations within power structures. The rising trend in the rate of return to work after childbirth was taken as an indicator of women's attachment to work (Datta Gupta & Smith, 2002). However, Wise (2003) observed that women who placed a greater emphasis on the family created a situation in which they had a lesser degree of social and geographical mobility.

Datta Gupta *et al.* (2006) found that the income penalty associated with career interruptions for women, and those in highly skilled work, was small relative to those who worked continuously - this is important. Consequently, the wage gap between mothers and other women could represent a considerable cost of childbearing. Marriage and family are associated with interrupted careers for working women and employers regard career breaks as periods during which a person's human capital stagnates. Guest and Peccei (2001) suggest the careers of women with dependent children are the result of interrupted work histories. They noted that certain employers discriminate against women who interrupt their careers for the sake of their dependent children. Certain employers expect the first child-related career break to be followed by other interruptions, believing that women who return after a career break are more likely to take time off work to look after sick dependent children or deal with other domestic emergencies. Because the dominant model of careers includes requirements for linearity and gender asymmetry continues to disadvantage women with child care commitments.

However, Walby (1986) while recognising the contribution of this analysis argued that this did not fully recognise the impact of the family on women's career. She argued that the there were economic vested interest in the continuation of the division of labour and the maintenance of the family. It resulted in a biased allocation of careers and status to the advantage of men: women occupying the majority of lower status paid jobs, and men occupying the majority of more highly paid status posts. Waldfogel (1999) observed that *"it is a well-established fact that women with*

dependent children earn less than other women in the United States" (1999:141) noting that:

> *Even after controlling for differences in characteristics such as education and work experience, researchers typically found a family penalty of 10-15 percent (of their income) for women with dependent children, as compared to women without dependent children* (1999: 143).

She noted no such family penalty exists for US men and observed a gender dividend for men ranging from 10 to 15 percent in terms of additional income. Waldfogel (2007) observed that major pay differential existed in Britain between women with and without dependent children. However, her research does not differentiate how the age of the child impacts upon the career progression of women. There is a literature stating it is not only family children which affects women's careers but gender inequality. This is reproduced in general employment which argues women without children still face worse careers than their male colleagues (Coulshed & Mullender, 2001).

Regardless of this, the consensus of the theories concerned acknowledges the family and parenthood as the principal agent of women's position in relation to career progression. If differences in careers are a consequence of issues and perceptions related to dependent children this *"family penalty"* is significant as is its degree of impact in terms of career progression and working patterns will be investigated, particularly in relation to the age of the child. However, prior to this the following section will examine a divergent critique – preference.

2.6 Preference

Preference theory emphasises the role of choice, in terms of women's employment as the key factors in determining both career and career progression. This theory classified women in three groups: home-centred women, for whom dependent children and family life are the main priorities throughout life; adaptive, non-career oriented women who wish to combine work and family or who have unplanned careers; and work-centred women, for whom employment (or the equivalent) is the main priority of life (Hakim, 1996; Hakim, 1998).

Hakim (1996), argues that the majority of mothers do not have a strong personal commitment to paid work or to a career and that after having dependent children *"female employment continuity is driven by personal motivations, social and economic factors"* (1996: 129). According to Hakim, part-time workers are secondary earners and their primary identity and commitment is to the homemaker role. She claims that the majority of women who enter occupations are adaptive - they choose these occupations so they can *"fit paid work around their domestic role, rather than vice versa"* (Hakim, 2000: 167). She suggests that in the main, adaptive women who work part-time are closer to home-centred women in terms of attitudes and behaviour to work and family than women working full time. They form the largest and most diverse category of women who want to combine work and family and who *"want to work but are not totally committed to a work career"* (Hakim, 1998: 138). This category includes women whose preferences change over the lifecycle. Many women may appear to be work-centred and work full-time until they have dependent children. Once they have dependent children, however, their priorities change - a change which is reflected in a reduction in working. According to preference theory then, women returning to work after career breaks are not motivated by career and work reasons, especially if they return on a part-time basis. This "*differentials in employment experience are due to personal choice as much as to gender discrimination*" (Hakim 2000: 97). This view considers that it is women's choices about employment and lifestyles which is the key source of their under-achievement in the labour market and which accounts for most of the differences between female and male careers.

However, Ginn *et al.* (1996) disagreed with this position and suggested that women's careers were affected by other more important economic circumstances than preference. Cousins and Tang (2004) argued that preference theory ignored the effect of structural constraints and differences. They argued that the fluidity of domestic circumstances and the stages of their life course produce temporary changes in women's commitment to paid employment. They argued that 'preference' theory overlooks the ways in which women's 'choices' are shaped by perceptions and options which are structured by factors such as the local labour market. While the costs and the availability of necessary services such as childcare and the impact of government policies (relating to tax and benefits, for example) are not considered in relation to female choice. They noted that the practical support and pressures which

social institutions, such as family background, cultural and societal membership are not factored into the concept of preference. Women's choices and preferences in relation to paid work are an outcome of the interplay between many of these factors. The argued the greatest career inhibitor for women was the preference of employers for certain types of employees in certain economic circumstances as opposed to women preference for any other working arrangements. Fundamentally for many women there was no choice they were subject personally and professionally to economic circumstances.

Preference theory suggests that different groups of women do not all share the same preferences and priorities about work and family life, and that female lifestyle choices have become a more important constraint than wider structures, such as social class or other macro-level influences. Its basis is that women can make lifestyle choices generally free from any major limiting constraints. Given this freedom to choose, Hakim argues that most women are not committed to work as a central life goal or to career progression. However, her threefold ideal-type classification of women in relation to market work: 'home-centred' women who always prioritize their family, 'work-centred' women who always prioritize work and their career, and 'adaptive' women who try to combine work and family does not convince or engage with the economic circumstances in which many women are faced.

2.7 Summary

A review of this literature highlights a number of key questions and theories for this research. Davey *et al.* (2005) position that women who take a career break have reduced promotion possibilities and reduced careers this is linked within the literature to the acquisition of 'human capital'. Dependent children and the family were located as significant factors within careers with the impact of career breaks being a constant theme within the literature (Waldfogel 1999; 2004; 2007). These raise several markers for consideration:

- Are there differences between male and female career progression?
- How significant is the access and receipt of training and career breaks to women's career progression (Human capital)?

- What is the impact of having children on male and female nurse's career progression and is the age of the child significant? Is there a short and long-term gender disadvantage and if so is there a "childcare penalty"?

- To what extent is their real or meaningful choice in terms of employment for women?

Prior to addressing this, the literature related to gender stereotyping needs to be examined. This will be executed in the following chapter.

Chapter Three Gender perceptions and stereotyping

3.1 Introduction

The previous chapter examined the debates related to gender and career progression while this chapter will examine the literature associated with gender perceptions and stereotyping. It will focus on several key issues: firstly, it will consider the literature on explanatory theories related to the construction of gender stereotyping. Secondly, it reviews gender perceptions and employment for women and men. Finally, it will examine gender expectations and behaviours in employment.

3.2 The construction of gender stereotypes

The literature related to gender stereotypes is complex and varied and were developed from sociological, psychological and patriarchal positions. This section examines these perspectives and other explanatory paradigms.

Berger (1966) indicated that gender stereotyping occurs when gender identities are defined as the product of social construction rather than biological determinations. He considered that these identities were *"deep-rooted, often an unconscious system of beliefs, attitudes and institutions in which distinction between peoples intrinsic worth are made on the grounds of their sex"* (1966: 271). Atkinson *et al.* (1993) acknowledged the significance of biological differences but positioned socialisation as the key agent within the process of gender stereotyping. Hall (1996) argued that gender stereotyping is a highly simplified and reductive mechanism of separation, *"a strategy of splitting.....part of the maintenance of social and symbolic order"* (1996: 257). She noted *"It sets up a symbolic frontier between the 'normal' and the 'deviant', the 'normal' and the 'pathological', the 'acceptable' and the 'unacceptable' and what 'belongs' and what does not or is 'Other', between 'insiders' and 'outsiders', Us and Them"* (Hall, 1996: 258).

Bem (1985) suggested that gender stereotyping is the product and manifestation of a larger psychological process, gender polarisation. She considered that polarisation is intrinsic to the definition of gender in terms of identity and the reinforcement of gender perceptions where the *"sex of the body matches the gender of the psyche"* (Bem, 1993: 115). Cann (1993) argued that this gender polarisation constructed 'masculine' and 'feminine' perceptions, predisposing men to construct identities

around dominance and women around deference. However, Bernd *et al.* (1995) in developing this position contended that individuals need not be directly conditioned, as continued exposure to others in these roles was sufficient reinforcement. He observed that normally individuals conform to socio-cultural 'norms' and were socialised by means which constantly reinforced the beliefs and behaviours which were prescribed and presupposed by that social environment. This, he contended made it, *"impossible to understand the personal or social world without a gendered perspective"* (Bernd *et al.* 1998: 91). Gender perceptions were conditioned by notion of 'normal'. This normality reinforced stereotypical expectations of men and women and their 'roles'.

Within the critiques related to 'normalcy' the sphere of the family and parenthood had great importance. Hardy (1986) Carlen and Worrall (1987) and Bell and Klein (1987) recognised the impact of the family in ensuring that gender stereotypes were 'normalised'. Lentell (1988) argued that the family was the ideological site in which gender stereotypes were constructed, they legitimised gender stereotypes within a defined framework of social relations, *"Family ideology in our society asserts that the co-resident nuclear family is a universal and desirable way to live"* (1988: 45). She added that parenthood roles were generated from this narrative, *"the woman is housewife and mother and primarily located within the private world of the family and the man is the wage-earner and breadwinner located in the public world of work* (1988: 46). This position was widely supported, Hearn (1982) and Coote and Campbell (1987) argued that concepts related to 'the family' promoted the model of the male as provider, head of the household and the wife as mother and nurturer as this then socialised them into gender roles. They argued the pervasiveness and acceptance of this model combined with a general belief in its importance and worth facilitated the continued reinforcement of gender stereotypical beliefs, values and structures. Stiles *et al.* (1997) did caveat this by noting that its existence and promulgation could only occur if these assumptions were considered both desirable and positive to social cohesion.

However, Daly (1978) considered that the most significant reason for construction and maintenance of gender stereotypes was the patriarchal system. She defines patriarchy is a social system in which the role of the male as the primary authority

figure is central to social organization, and where fathers hold authority over women, children, and property. It implies the institution of male rule and privilege, and is dependent on female subordination. He considered as a social construction, which can be overcome, by revealing and critically analysing its manifestations. Patriarchy is considered as the result of sociological constructions that are passed down from generationally. These constructions are most pronounced in societies with traditional cultures and less economic development. Patriarchal structures dictate the behaviour of men and women and reinforce stereotypes in which women perform specific and subservient roles that are assigned to them, *"femininity is characterized by passivity and submission"* (Adeline, 2007: 169). She notes:

> *In patriarchal societies, masculine values become the ideological structure of the society as a whole. Masculinity thus becomes 'innately' valuable and femininity serves a contrapuntal function to delineate and magnify the hierarchical dominance of masculinity* (2007: 173).

She noted that within patriarchy, stereotypical masculinity is portrayed as natural, universal and desirable. Equally women subordination is considered normal while deviation from this is undesirable. Nicholson (1986) considered that patriarchal oppression is not objective and is not simply the result of the phenomenological understanding of those who are actually experiencing it, *"The ethnographic studies of every society that has ever been observed explicitly state that these feelings (feelings of both men and women that the males will dominates the females) were present, there is literally no variation at all"* (1986, 25). He believed that even the beneficiaries of patriarchy can come to see its oppressiveness.

There was a view that patriarchy was the product of evolutionary factors as opposed to social factors. Festau (1987) acknowledged that there are relatively few physical differences between men and women beyond the reproductive, but the physical distinctions that there are, are significant. They argued that men's greater physical strength allowed for the demarcation and defining of primary social roles and that the reproductive process defined gender roles and perceptions. This was seen as the basis of patriarchal structures. Parens (2004) and Dar-Nimrod and Heine (2006) believed that gender differences in cognitive developmental processes was the commencement point of this process. They argued that as male and female brains have different levels

of testosterone and hormone processes, social differences emerge from these variations. 'Grey' matter development in the brain's parietal and cerebral cortices leads to greater performance in spatial tasks in men whilst women's 'white' matter activity enhances women's abilities in relation to organisational abilities. Through these biological differences social differences emerge. Thus patriarchy was a product of sexual biology a 'biological imperative'.

The biological explanation of patriarchy was heavily contested. Burgess and Borgida (2000) contend that social and cultural conditioning is primarily responsible for establishing male and female gender roles. Haaken, (2002) argued that the biological view was too generic and could not account for global variations of gender roles and perceptions. The assumption that gender roles were biological and therefore unchanging could be refuted by the observation that gender roles have changed and were in the process of changing. They contended that if gender roles were biologically transmitted as opposed to culturally transmitted, then patriarchal structures would be universal wherein gender roles, perceptions and stereotypes are culturally adaptive. For example, there are a number of societies that have been shown to be matrilineal or matrilocal and gynocentric, especially among indigenous tribal groups. McMillan *et al.* (2006) argued this view of the development of patriarchy was naive because it only superficial engaged with relatively minor aspects of the gender debate rather than engaging with its wider social substance. While there is an undoubtedly worth to scientific evidence, the biologic determinist view failed to place within context the wider structural and social aspects of patriarchy and this appears to diminishes its worth.

This placement of gender stereotypes within the realms of patriarchy was heavily supported but not universally accepted. Regardless of this, the extent to which the family and perceptions concerning parenthood is pervasive within the literature. As the critiques emphasise that perceptions, assumptions and expectations concerning women's role with the family, it is not unreasonable to consider that they have a direct impact on female life and career by defining both self-expectations and those of 'others'. It raises the question - do gender assumptions and expectations surrounding parenthood impact upon career progression. The next section will commence with a discussion about gender perceptions and its influence on employment.

3.3 Gender perceptions and employment

As suggested in the previous section, gender stereotyping has a role in defining socially acceptable employment roles for men and women. This section will consider the critiques; debates and paradigms related to gender perceptions and in relation to general employment and management both national and international perspectives within this area.

Cockburn (1991) and Anker (1995) observed that employers freely admitted that a persons gender was an important consideration affecting recruitment and promotion decisions. They concluded that when responses acknowledged a gender bias, this indicated gender stereotyping. This opinion is not an isolated conclusion. Paukert (1994) noted that approximately 89.1% of the employers in engineering industries in central and Eastern Europe indicated that they preferred men for repair and maintenance occupations whereas only 2% preferred women. He argued this gender-biased preference was connected to the prevalent culture in these countries and the gender perceptions produced therein. Sziraczki and Windell (1992) noted in their Hungary and Bulgaria survey that 65% of the employers questioned preferred men for production occupations compared to 15% who preferred women.

It could be argued that this was circumstantial evidence concerning the impact of gender perceptions in employment. However, more compelling and substantial evidence is provided by House (1986) who noted that in Cyprus the traditional 'male' employment, 85% of employers indicated that they preferred male candidates due to their 'natural' disposition for that type of work. Conversely for a given list of traditional 'female' jobs, 89% of employers preferred female candidates due to their 'natural' disposition to that type of work. While Papola (1986) found that in Lucknow, India, of the employers interviewed 60.2% reported that women were unsuitable or less suitable than men for sales, production, service and executive/supervisory positions. Anker (1994) and Scoble and Russel (2003) in their qualitative research indicated that the employers frequently declined to hire women because they did not have the suitable 'character' for the job. These quantitative and qualitative analyses strongly infer that typical 'male' and 'female' occupations are consistent with, and by implication possibly determined by, the stereotypical

characteristics of men and women. Employment appeared to be a major site were perceptions were adhered and subscribed too.

However, Rosener (1990) and Savage (2000) observed that many of these perceptions overlapped in their effects, with perceptions reinforcing gender segregation in particular occupations. They argued that these environment restrictions defined acceptable roles for men and women. In this regard, Mernissi, (1987) noted the scale of this when observing that in many Islamic states 'purdah' effectively forbade women from interacting with men in public. In occupational terms, this resulted in many Muslim women being strongly discouraged from employment except in establishments where customers were all women. Jamal al-Lail (1996) instanced an example where women were only allowed to work in a factory comprising women alone. This example was not isolated in terms of geography or history. Itzin and Newman (1995), Bruley (1999) and Ramsden (2002) stated that in the United Kingdom up to the 1950s it was the accepted culture that women upon marriage would cease to work. These restrictions on women were enforced through strong social sanctions and underpinned by the gender perceptions that they were both produced and reproduced. They did note that these sanctions were strongly enforced by certain groups of women, particularly older women.

This literature indicates that gender perceptions and stereotypes have considerable agency in general employment not merely in Britain, but internationally. Gender stereotypes clearly influence which jobs are appropriate for men and women. Certain employments were considered socially acceptable and some unacceptable employment for men and women. These comparative studies concerning gender belief systems put these research findings in a broader perspective; gender perceptions have a subjective power. They were maintained and propagated by powerful groups both male and female. The literature indicates that such differentiation is international. However, what is also evident is that perceptions of 'appropriateness' vary by location and over time. This dynamic process in relation to general employment was considerable and it was equally extensive in relation to gender perceptions and it is this that will be discussed in the following sub-section.

3.3.1 Gender perceptions associated with women and work

There is a debate concerning what are discerned to be feminine attributes and their relationship with employment. For the purposes of this sub-section those perceptions and attributes which have been historically linked to the female character are considered in relation to work. This debate is summarised in a tabular format in Table 3.1 and presents a grid of gender perceptions and their relationship to employment. This grid denotes inherent presumptions and the differences associated with gender perceptions and their impact on employment.

Agar (2004) argues the key perceptions which are considered to be female attributes are empathy, beauty and selflessness. She argues that the most significant 'feminine' characteristics are related to selflessness and empathy as these are strongly linked with motherhood and the family, *"coping, caring, nurturing and sacrificing self-interest to the needs of others....being intuitively sensitive to those needs without them being actively spelt out"* (2000: 3). Empathy was valued for its emotional capital in employment. She contended that it facilitated a situation where the perception of women as carer was a significant agent in determining career paths. She noted that it was the acceptance of this perception, particularly by women, that propagated its impact on life and career. It resulted in the effective 'disqualification' of women from many employments and working patterns within certain types of employments. She did note that in certain circumstances, these prescriptive perceptions were positively valued. For example, empathy was considered an essential characteristic for nursing creating a situation where it became an acceptable and an exclusive employment for women.

Weisel (1991) argued that gender perceptions concerning 'feminine beauty' traditionally qualified women for certain professional roles i.e. shop assistant and beautician but curtailed them in others, manager and executive. She argued that when women were depicted in a sexualised manner they were commodified and their worth as human beings was diminished and this continued in employment. Women who do not conform to this perception were often stigmatised. Marshall (1992) stated that by accepting and conforming to these perceptions, women were seen as extending their femaleness, however in doing so they were limiting the scale and extent of their employability. Boydell and Hammond (1985) and Bartram (1992) suggested that

organisations required traditional 'feminine' approaches e.g. the ability to facilitate and support their colleagues, intuition, a communal style of communication and these were indelibly linked to the residual image of the woman. Amsden (1994) and Wahl (1998) supported this position and argued that 'beauty' incorporated all these traditionally 'feminine' characteristics.

Thomson (1998) observed that there was an emphasis among many women towards a 'traditionalist' approach towards the family built upon perceptions related to duty and obligation. This manifested itself in relation to concepts as selflessness, *"Being a helper is central to female gender stereotype prescriptions, which dictate that women be nurturing and socially oriented (communal)"* (1998: 431). It was identified by a women's greater emphasis in combining the family and employment by participation, motivation by inclusion and compromising. Linstead (1995) argued that the image of a caring woman allows *"the colonisation of certain attractive parts of 'feminine' attributes in order to re-centre than de-centre 'feminine' attributes and further marginalise the feminine by creating an incomplete version of 'feminine' attributes"* (1995: 200). Through this transaction power by position for rewards and favours is exchanged. Women's wider goals and desire to succeed within the remit of the family framework facilitate a situation that result in women limiting their career opportunities to accommodate these perceptions. For women, perceptions directly linked to the family frequently led in employment to *"the perverted devaluation of women both as women and as employees"* (Fiske & Stevens, 1993: 157). They did note that while this appears to limit many women's career, it facilitates other but to which degree these are 'positive' events remains ambiguous.

Table 3.1 Perceptions of femininity and work

Stereotyped perceptions.	Career access	Consequence	Comments.
1. Empathy Occupation: Nurse, Doctor, Social – worker, Teacher and Midwife.	Considered to qualify women for occupations where others are cared for, such as children, the ill, older people. A considerable range of occupations and sectors which are critically dependent on team work, for example, nursing.	Occupations which require care but which also require greater authority, such as medicine still remain male-dominated this attribute is still not considered important.	As women give birth this is a biological difference. However this cannot be confused with the social convention that women are generally responsible for childcare in most societies. Though empathy is a highly valued 'soft' skill in the roles women occupy, it does not translate into employment.
2. Beauty (Sexually attractive) Occupation: Shop Assistant, Salesperson, Receptionist and Airline stewardesses.	Part of wider aesthetic labour literature. In this case it is argued it helps qualify women for occupations where physical appearance would help attract and/or please customers. E.g. Airline stewardesses who were originally sought for their physical appearance. It can result in a greater acceptance to do monotonous or repetitive work.	This advantage is often thought to be combined with the perception that female personalities are more pleasant and accommodating. This perception within employment can infer greater docility and servility. However, this perception arguably facilitates the commoditisation of women.	In certain cultures and countries where public interaction between men and women is frowned upon, this perception disqualifies/excludes women from certain occupations. The value ascribed to this perception is not universal.
3. Selflessness/ Family centred Occupation: Some part-time employments. Vocation role: Mother and wife.	Great willingness to accept lower wages or employment which does not fit intellect or abilities. Often driven by the need to balance income with the needs of the family and the need of many families for multiple incomes but which generally negatively inhibit women's career s.	Facilitates women into occupations and sectors of the economy where work is organised around the needs of the family. Home-based work is easy to combine with household/child care. However, it restricts many individual women's professional development.	This perception implies a key 'soft' skill as a team player. Results in women prioritising the family and home at the expense of their career. This unpaid home and family work is instrumental to the financial well-being of the family. Despite the increased incidences of female-headed house-holds.

(Agar, 2004; Amsden, 1994; Bartram, 1992; Boydell & Hammond, 1985; Fiske and Stevens, 1993; Linstead, 1995; Marshall, 1992; Thomson, 1998; Wahl, 1998; Weisel 1991)

The perceptions which are considered to be the significant female stereotype are far from universally agreed. Women are considered to be emotionally intelligent and socially oriented. There were divergent views as to the significance ascribed to them. However, the power of these is a constant within the literature while their impact may well not universally be subscribed to the view that these perceptions are personally and professionally restrictive does have a high degree of acceptance. The cumulative impact affects lives and employment, and the degree to which this is the case will be

examined in chapters eight and nine. Prior to this debate concerning gender perceptions associated with men exists in tandem with the aforementioned discussion and these will be addressed in the following section.

3.3.2 Gender perceptions associated with men and work

As with the previous section, the perceptions reviewed are those that within the literature that have been historically viewed as being 'masculine' traits. The characteristics which are generally considered to be 'male' are: leader, physical strength and provider. It should be acknowledged that this list is not exhaustive and is refined in this sub-section for reasons related to clarity and focus. The stereotypical male characteristics outlined in Table 3.2 are not universally agreed but these are the major perceptions generally cited:

The most significant perception within the literature is man as financial provider (Cartledge & Ryan, 1983). They noted that men benefited from the power of these perceptions and that due to its cultural influence, male hegemony in certain areas and types of employment was maintained. This directly led to the monopolisation of power by men in these employments and the institutionalisation of systems which favour men. This 'provider' role was linked to male assertiveness and independence which cascades into employment roles and behaviours (Grimwood & Popplestone, 1993). Rudman (1998) considered that this facilitated a psychological contract built on power and control. This perception stressed difference and sought to defend privilege but was concerned with power and authority. There was little disagreement concerning the impact of this perception in employment. Cockburn (1986) and Powell (1988) argued that organisations were structured to protect male 'financial' power and rewarded 'masculine' attributes accordingly. The preserved 'masculine' attributes of a job were considered important even when the status of the job had been downgraded (Collinson & Knights, 1986). Men's ability to retain management roles as a male domain was due to men's 'ability' to portray the skills that make up management as being rooted in 'masculine' attributes and roles. Phillips and Taylor (1980) noted: *"Far from being an objective economic fact, skill is often an ideological category imposed on certain types of work by virtue of the sex and power of the workers who perform it"* (1980: 84).

Williams (1993) noted that men in organisations create and maintain masculine identities through the expression of gendered power and status in the workplace. She observed there are many types of 'masculine' attributes to be found in organisations but men's dominance in positions of power was the recurring theme in all of them. 'Masculine' attributes and management were not two separate concepts but those notions of 'masculine' attributes infused employment and men and women who enter it. Physical strength legitimised male hegemony both at home and at work. Physical strength had a positive benefit employment (Dominelli & McLeod, 1989). Thompson (1995) argued gender perceptions/values negatively affected and inhibited some men's life and work opportunities though arguably not to the same extent or depth as those experienced by women. There was pressure and difficulty for men in failing to conform to this model and this frequently caused emotional stress and anxiety and was a barrier which prevented many men from developing careers and lives that they found acceptable. They stated that this entire situation was dependent on both sexes accepting their own role and that of the opposite sex (Kunda *et al.* 1997).

Hearn, (1994) considered that leadership was perceived as 'masculine'. He observed that men and women generally agreed about the characteristics of a successful leader, particularly a successful manager. Leadership was indelibly linked to the 'masculine', *"think manager – think male"* (Schein, 1976: 5). However, Abercrombie *et al.* (2000) observed that of the 16 items considered by both men and women to be very characteristic of managers, 8 items were gender-neutral, 6 items were not considered characteristic of men or women, and 2 items were considered very characteristic of both men and women. However, Johnson *et al.* (2001) stated that positive 'masculine' traits were considered more applicable to leadership posts in these studies with the image of the successful leader appearing to be far from 'feminine'. They noted that there was a relationship between the stereotypes of men and the 'masculine' image of the successful leader and the delay of organisations in recruiting women for leadership posts. They observed that this perception sub-consciously influenced the expectations of both the applicants and the employer. The degree of similarity between the desired characteristics of the jobholder and the perceived/stereotypical characteristics of the applicant influences the decisions regarding recruitment and promotion. These perceptions gave men a distinct advantage over women regardless of the background and capabilities of the female applicants; women with equal

qualifications were handicapped by the 'masculine' stereotypes associated with the successful leader. Women, who attained leadership positions, achieved this despite having to operate within an environment which was frequently 'masculine' in psyche. Grint (1995) noted that the 'masculine' leadership approaches were not an obstacle to men's progress in employment but a positive.

Table 3.2 Masculine stereotypes and work

Stereotyped perceptions.	Career access	Consequences	Comments.
1. Leader. Occupations: Sales, Strategic management, Supervisors with in industry.	Helps qualify men for all types of supervisory and managerial occupations.	This is arguably a stereotype where the positive career consequences for men are clear. This perception is a major cause of career success for individual men. It enhances men's career paths and avenues.	This perception affects employment with lower level jobs for women and higher for men. Men due to the relationship between professional advancement and this perception have unbridled access to career mobility.
2. Physical, muscular strength Occupations: Miner, Fire-fighter, Police officer, Construction worker and Security guard.	This perception assists men in qualifying for occupations where these attributes are required. Helps qualify men for occupations where physical danger is relatively great.	This is considerable overlap in the physical strength of the individual women and men, which means that many women are physically capable of doing this work but stereotypes do not facilitate this. It is becoming less and less important in the contemporary economy.	This is a gender perception which restricts career opportunity and personal development. Its maintenance bears no relevance to the individual or individual circumstance but whilst being a biological difference is highly dependent on social and environmental conditions. This perception is becoming less significant in the Western World.
3. Provider – financial Occupation: All full-time employments. Vocational role: Father and husband.	Enhances and qualifies men for occupations.	This can produce individual stress within the family. This is arguably more an economic circumstance and social construction. Traps men into a masculine image – can result in psychological entrapment.	This is a learned gender difference. Many women are willing to do these occupations. This perception affects life and employment with direct consequences for men and women.

(Abercrombie *et al.* 2000; Cartledge & Ryan, 1983; Cockburn, 1986; Collinson & Knights, 1986; Dominelli & McLeod, 1989; Grimwood & Popplestone, 1993; Grint, 1995; Hearn, 1994; Johnson *et al.* 2001; Kunda *et al.* 1997; Phillips & Taylor, 1980; Powell, 1988; Rudman, 1998; Schein, 1976;Thompson, 1995; Williams, 1993)

Masculinity within the employment framework is dominant. This results in the perception becoming a positive demarcation for men. The perceptions are indelibly linked to men as financial provider and leader within and out with the family. The

power of these perceptions appeared to be pervasive and resistant to change. These conceptions appear to have considerable power amongst both men and women as fundamental social conventions. Within this thesis, the acceptance and adherence of perceptions related to men and women is significant and will be examined in chapters eight and nine. Prior to this the following section will discuss gender expectations and behaviours in employment.

3.4 Gender expectations and behaviours in employment

The previous examination of the literature observed a relationship between gender and employment. This section will consider the debates, paradigms and positions related to gender behaviours and expectations of women by women. There was disagreement on the importance of traits and values associated in relation to employment.

Heilman (2001) investigated gender stereotypes and bias evaluations of women in work settings. She noted the way in which the perceived lack of fit between stereotypes of women and perceptions of the requirements for jobs considered to be male in gender type leads to negative performance expectations, and resulted gender bias in judgments. Women were considered in comparison to men and were less likely to be selected for male gender-typed positions and are more likely to have their performance in such positions devalued. Consequently they are given fewer opportunities for career advancement. She considered that the tenacity of stereotype-based expectations and their resistance to disconfirming information was built upon a *"attributional rationalization"* process, in which a woman member of a successful team are unlikely to get as much credit for a team's success as her male counterpart. She is then seen as having been less influential in bringing about the successful outcome. Positive performance information about women is distorted so as to maintain gender stereotypes, and perceptions of femininity, such as being a mother or being attractive, can exacerbate stereotyped-based bias.

Legault and Chasserio (2003) built upon this in *"Family obligations or cultural constraints"* they sought to examine the extent to which 'commitment' is seen as important to career advancement. While the subtext of the article's titles indicated that the focus was on professional women, the research involved an analysis of data from

both men and women. There was no meaningful justification of the companies selected. Even though this was a quantitative piece it was objectivist in nature and no indication of the role of the researcher. There was limited indication of job contents and job requirements. The male sample was homogenised and there was no indication of any difference in terms in terms of for example, dependent children.

It is indicated that women's reasons for working part-time had to do within the context of family commitment and this was not the same for men. Commitment was fixed and an unchanging function of gender while perceiving to be strongly prescriptive, it was unequally perceived. Legault and Chasserio advanced the position that culture propagates perceptions concerning work and life commitments, a criterion eminently tied to employment. The operational perception from the outset opposes the demand for private time. It has the same effect as the need to balance work and private life in restricting women's careers. There was an examination on male and female behaviour, both towards each other and in relation to values. In relation to 'commitment' while women considered that they possessed these characteristics, they devalued women with children in relation to employment. They considered that when these perceptions were in conflict, it resulted in career opportunities becoming more restrictive and inhibited for women. Paradoxically this rigidity of thought was not in general imposed upon women by men but frequently by women upon women. The extent of this was not restricted to women in general or women with children but the contractual condition of employment themselves.

Heilman *et al.* (2004) supported this position and noted the powerful impact when gender stereotypes were calculated on women by women. They found there were observable differences in behaviours between women with other women. There were differences in approaches in specific behaviours, notably, if a woman was under performing, women were more likely to adapt their response to a perceived cause: if the problem was inability, they may use training; if the problem was lack of effort they will punish. In contrast, women who were heavily influenced by gender perceptions were more likely to adopt a conciliatory approach to men by either using training or punishing in every case. Women influenced by gender perceptions created and reinforced barriers between themselves. She rejected the proposition that self-interest was the underlying intention of the women exhibiting these behaviours.

Heilman and Chen (2005) argued this was closely related to gender stereotypic norms, which dictate the ways in which women should behave, and the disapproval and approbation women experience for violating these "shoulds". Heilman and Haynes (2006) noted the reactions to actual violations of prescribed behaviours, demonstrating that women who choose not to help others are reacted to far more negatively than males who behave similarly, and are given less credit when they do help. They noted that inferred violations of gender norms resulted in women being penalised in employment domains that are considered to be female and the underlying dynamics of this process penalised women, while men were not subjected to employment penalties. These gender inconsistencies exacerbated domains in which a woman's perceived femininity will intensify and ameliorate these effects ultimately leading to self-censorship behaviours in an effort to stave off negative reactions (Heilman, & Welle 2006; Heilman & Okimoto, 2007).

A significant aspect of the literature considered the debate concerning management and the association of 'male' and 'female' perceptions within management but the paradigm here was acceptance and adherence. It was argued within the literature that women were the stronger adherents to 'traditional' perceptions however men were the direct beneficiaries of their maintenance. It raises questions as to how do these perceptions and values unfold in relation to careers and specifically in regards to nursing.

3.5 Summary

The debates taking place within the literature generally centred on explanations in relation to gender stereotypical attributes and cognitive generalisations. They were concerned with the genesis, consequence and importance of these perceptions. There were significant debates within the literature, notably patriarchy; however the pivotal area of importance for this thesis is gender perceptions and values related to the women's role within the family - motherhood and childrearing is a major issue. Two key authors emerge from this, Legault and Chasserio and Madeline Heilman as being significant to this thesis.

Legault and Chasserio's (2003) research in that gendered perceptions and values, in particular those directly associated with parenthood and work-life balance negatively

impact on women's careers is of major significance to this thesis. As is Heilman's (2004, 2007) position that gender perceptions are biased against women and this produce gender inequalities in employment. This set an interesting question for this research:

- How do stereotypical assumptions of women in careers in employment (nursing) interact with stereotypical assumption of women as mothers?

This situation is made more complex when nurse management is considered, where managerial work is stereotypical as 'male'. It is to these issues that the next chapter will turn with a more detailed consideration of the nursing chapter. Accordingly, the next chapter will examine registered nursing in its history, culture and if its culture is required. It will also provide a review of the literature related to the operational values in registered nursing.

Chapter Four Nursing

4.1 Introduction

The previous chapters discussed gender stereotypes and perceptions. In the first instance, this chapter will review the literature related to nursing and as the material related to this area is extensive, only specific aspects related to this thesis will be reviewed here. This will include an examination of nursing, nursing grades and nursing specialties. It will then review professional values in nursing: considering commitment, flexibility in relation to work and professional knowledge. Finally it will review careers in nursing and in nursing management.

4.2 Nursing

The literature related to nursing and its development is extensive - in particular its evolution in the nineteenth century through the Nightingale reforms. A particular emphasis will be within the literature of organisational relationship, professional responsibilities and hierarchical relationships which will be the focus of this section.

Griffiths (2008) considered that the development of nursing was primarily based upon its relationship to the provision and control of care. Nursing subordination to the provision of care produced its authoritative and powerful position and created within the profession a sense of duty along with a value system focussed on the patient. Nursing professional integrity is maintained through the development of a defined role and the elimination of professional ambiguity. The means by which this was achieved was by establishing rigid lines of authority and control within the remit of hierarchical structure of which led to a progressively systematised form of qualified nursing which prioritised technical skills at the expense of care skills. He noted Organisational change was viewed as a significant arbiter of professional development *(see appendix 1 for more details)* which increased nursing's authority and professional status. These organisational changes enshrined nursing authority and the values intrinsic to it. The ambition and desire to give qualified nursing an autonomous professional identity defined its aspirations whilst not altering its core values. This 'policing' of professional boundaries was pivotal in creating the professions disciplinary approach and values. Nursing became the custodian of its own professional practice and this 'ownership' was intrinsically linked to creating the

underlying norms and values within the profession (Hartley & Martin, 2003). Ten Haven (2000) argued this shaped its hierarchical structure, its professional identity and its influence in defining professional values. Consequently a hierarchy within the profession was created whose entry required were exclusively defined by adherence to professional values and customs.

Mannion *et al.* (2010b) argued the consequence of this process is the accentuation of the predominant values ensured that adherents' nurses would enhance their careers. Within this hierarchy, adherents were judged positively and the non-adherents are judged negatively (Bolton, 2003). He argued as nursing is organised within a highly structured and constrained hierarchy that power, prestige, status and careers are developed through these relationships. As this hierarchical structure precedes individual nurse's entry into the profession, practitioners are faced by a dilemma: do they derive their professional identity from the values and beliefs at the core of this structure or reject them and negatively affect both their professional acceptance and their own careers within the discipline. Nurses who interact with the values and beliefs despite personal reservations enhance their own careers and by doing so accept the prototypical view of the profession.

Bennett and Maben (2007) considered organisational structure as the *"established pattern of relationships among the parts of the nursing profession"* (1993: 348) which leads to differentiation, the development of the hierarchical structures and relationships, formalised policies/ procedures and controls that guides the organisation. This structure prioritisation is to *"take actions which protect and improve the welfare of registered nursing"* (2007: 206). It could be argued that with such an emphasis within the profession, personal needs and desire are secondary. Thus meanings and expectations associated with registered nursing are reinforced by the professions hierarchy perceptions and values become entrenched and dominant, *"while values need to be maintained, the profession also needs to be maintained through the former although the latter will be achieved. A nurse cannot simply be guided by the profession; it must be guided by its values"* (Maben, 2007: 24).

Nursing is a patient focused profession; nurses professionally are subservient to the patient and the discipline. While organisational changes were fluid, professional development is subservient to this negotiated relationship. Regardless of this, the

profession remained the exclusive territory of registered nursing and they remain the sole arbiters of professional practice. These professional values are the demarcation agents of registered nursing. They are defined by professional principles concerning the provision of care, autonomy and accountability. This notwithstanding the profession operates within the parameters of nursing grades and this will be discussed in the following section.

4.2.1 Nursing grades

As this thesis is concerned with career progression, an understanding of nursing grades is required. *'Agenda for Change'* is the single pay system in operation within the NHS. It applies to all directly employed NHS staff with the exception of doctors, dentists and certain senior managers. Until the introduction of *'Agenda for change'* in 2006, nurses were graded within the Whitley Council grading system. The *'Agenda for change'* process has an appeal process and this process had not, at 2009, been exhausted; therefore the Whitley Council grading structure was the basis of review. This structure places nurses on "grades" between 'A' and 'I' with 'A' being the most junior and 'I' the most senior. Professional nursing is divided by registration. Registered nurses are individuals who have met the educational and technical standards of proficiency for registration and who are held on the register as a person who is capable of safe and effective practice. Those who have not completed this level of training and are employed on Whitley Council grades 'A' to 'C', while registered nurses, are employed on various grades between 'D' to 'I' (NHS- NES, 2005). The following table outlines these:

Table 4.1 Nursing Grades

Grade	Training	General comments.
Unregistered	Level of training commensurate with non-registered staff performed a number of roles, clinical support and healthcare support.	They are engaged in direct patient care normally under direct or indirect supervision of a fully qualified registered nurse.
Registered Grade 'D'	Entry level with promotion to a higher graded post dependent upon skill development or training.	Access to post-registration training is only available to within the same disciplinary
Registered Grade 'E'	This grade is attained through experience and post-registration qualifications.	Post –registration qualifications are specific not transferable.
Registered Grade 'F'	Appointment by interview, post-holders are required to hold post-graduate qualifications. Midwives were normally appointed on the scale before rising to the following grade.	Within this role they have specific responsibilities in relation to the administration of the ward in accordance with instructions from senior management.
Registered Grade 'G	Appointment by interview, post-holders are required to hold post-graduate qualifications. The substantive grade for a midwife.	Junior/deputy ward managers and charge nurses assist in the day-to-day management of the ward or unit. These posts have additional responsibilities - budgetary control or greater numbers of staff under supervision or resources to be managed can be placed on a higher grade
Registered Grade 'H'	Appointment by interview, post-holders are required to hold post-graduate qualifications.	A ward manager is responsible for an entire ward and these posts are employed at 'H' grade.
Registered Grade 'I'	Appointment by interview, post-holders are required to hold post-graduate qualifications.	Grades are linked to defined responsibilities but certain posts can occupy grades at variance with the general grading for that level of post.
Senior nurse manager	Appointment by interview, post-holders are required to hold post-graduate qualifications.	These grades are responsible for overseeing all nursing within a department or directorate.

(DOH, 2004c; SEHD, 2007; SGHD, 2007)

Nurses can only work in grades commensurate with qualification and experience. However there are some exceptional circumstances which are directly related to remuneration detriment, preserved salaries, additional responsibilities based on acting to a higher post or remunerated variations of levels of responsibility (*ibid*). Qualifications and experience are central to attainment in grades. These grades are linked to nursing specialties and these will be reviewed in the following section.

4.2.2 Nursing Specialties

The central nursing disciplines are 'adult'; 'child'; 'mental health' and 'learning difficulties'. These are further sub-divided into hospital specialties; acute, midwifery, paediatric, care of the elderly, infection control and 'community' equivalents. There

are several types of specialist nurses, the foremost are nurse practitioners who are nurses performing care at an advanced practice level. They frequently perform medical roles in primary care, general practice surgeries or in accident emergency departments in a hospital. They are complimented by specialist community public health nurses who are traditionally district nurses and health visitors: this group of practitioners included school nurses and occupational health nurses. Clinical nurse specialists are nurses who provide clinical leadership and training for staff nurses working in their department. They work in tandem with nurse consultants who are nurses with advanced clinical specialisation. The grades available in these areas cover the full range of grades available in registered nursing.

Table 4.2 Nursing Specialties

Area and responsibilities	Training
Acute nurses are responsible for the treatment, safety and recovery of acutely or chronically ill or injured people, health maintenance for the healthy and treatment of life-threatening emergencies in a wide range of health care settings.	The duties are in general performed in a clinical setting where the nurse is required to develop their skills to maintain and enhance service delivery.
Midwives are the lead health care professionals attending the birth of a child. Midwifery is a discipline with a high degree of operational flexibility and autonomy, due to this; these posts are graded at a higher level. They were normally appointed at grade 'F' before progressing to the substantive post held at grade 'G'.	These posts require an advanced level of training. This qualification is gained either through direct entry study which requires the completion of a university level qualification or by gaining a post-registration qualification. Access to post-registration training is only available to adult nurses. All other entrants need to complete the full period of study to qualify as a midwife.
Mental health nurses care for patients with psychosis, depression or dementia. To practice in this area a nurse must be specifically trained in the discipline.	There is a wide spectrum of specialties within this area which afford accelerated career development but they are dependent upon access to and the completion of post-registration training.
Learning disabilities was historically a sub-discipline of mental health.	Nurses can enhance their careers in these specialist areas through access to and the receipt of post registration training.
Care of the elderly nursing has traditionally employed a greater percentage of its staff on a part-time basis.	This work has a reputation for being an un-glamorous backwater of nursing. There is limited access to training beyond generic in-house or training.
Paediatric nursing is an area of nursing practice with a focus on providing care to infants, children and adolescents.	Paediatric nursing is a niche discipline: the nurses are specifically trained for this function. This area has no provision for training out with its disciplinary remit.
Infection control nursing is the discipline concerned with preventing the spread of infections and is a sub-discipline of epidemiology.	These practitioners in general work either individually or in small teams and due to the specific nature of this work there is a training plateau.

(DoH, 2005; SEHD, 2006; RCN, 2010)

'Community' nursing personnel provide nursing service to patients and clients in the community. There are many disciplines in this area with many career trajectories. These disciplines include 'health visitors', 'district nurses', 'midwifery', 'psychiatric', 'learning disabilities' 'school' and 'clinic' nursing which have the same career and training avenues as their hospital colleagues. However, there are only slight variations. Health visitors are qualified registered nurses or midwives who have undertaken further post-registration training in order to work as members of a primary healthcare team. These posts have considerable responsibilities and autonomy and this is reflected in its grade, the entry level is usually at grade 'F'. District nurses provide care for patients and support family members in the home environment. District nurse training programmes are known as specialist practitioner programmes and are at degree level. They are normally no less than one academic year (32 weeks) with full-time or part-time equivalent. District nurses, like health visitors, are in positions which require the application of independent judgement and initiative. The posts have a very high degree of autonomy and responsibility and again this is reflected in the salary grade. The entry level is usually grade 'F' then 'G' after the satisfactory completion of their probationary period (NMC, 2005; SGHD, 2007).

Within the literature it is apparent that nursing careers are intrinsically linked to the access, scale and extent of training and development. Certain specialties have greater access to training, particularly 'acute' nursing and midwifery and accordingly have relatively accelerated careers. However, there are areas, such as care of the elderly, where restricted access to training restricts careers. The receipt of training is a significant career arbiter in nursing; however, there are other factors which affect careers including professional values and these will be examined in the following section.

4.3 Professional values

The literature in relation to the nursing professional is twofold; one considers the nature of the values while the other discusses the inter-group dynamics, which are a consequence of them. The former will be discussed in the following sub-sections: commitment, professional knowledge and flexibility in working. But first it is necessary to discuss the impact of these values.

Mannion et al. (2009b) stated the professional values produced in nursing practice were built upon clinical self-verification and personal detachment. Through this the nurse is supported by the profession and has mechanism to cope with the stress and strain which is associated with this type of employment. This facilitates cohesiveness, cooperation, emotional containment and collective action integral to the execution of the nursing task. Wade (2001) argued that this has resulted in nursing values becoming indelibly linked to the task as opposed to the individual needs of the practitioners. The nature of these tasks confirms and reaffirms structural arrangements and relationships. Nurses adhere to the profession structure and behave according to the expectations and values, acting in the context of and referring to them.

Maben *et al.* (2007) argued this was a factor which underpinned nursing motivationally. They considered that when this occurred, nurses behaved to enhance their own practice and careers. By maintaining meanings and expectations associated with the role and tasks, nurses maintain the complex interrelatedness of social structures and professional standards, "*Nurses are tied to the values, tied to their role and tied to the discipline*" (Maben *et al.* 2007: 61) Meanings and expectations are tethered to values regarding performance and these influence perceptions and cascades throughout the profession. These values are fostered to enhance knowledge, professional standards, self-efficiency and to reduce malpractice and uncertainty. Nurses act to match their behaviour to the values relevant to the profession's social identity, so as to confirm and enhance themselves and the profession (Murrells *et al.* 2009).

Values control and validate both the discipline and the practitioner they are generated from a desire to produce and maintain professional standards of competency and efficiency in relation to the task. This is built upon conformity, confirmation and perceptions. It is important to note that there is a difference between personal and professional values but they are at times symmetrical and symbiotic. At this juncture the professional values need to be discussed. These include commitment, professional knowledge and flexibility in working. Nursing values are not limited to these, but for the purposes of this thesis these will be the ones discussed.

4.3.1 Commitment

Commitment is a primary value factor within registered nursing with an extensive variety of definition, all of which have some form of legitimacy. Regarding definitions on commitment in nursing, only those aspects related to the organisational and professional environments will be discussed.

Aarons and Sawitsky (2006) noted commitment is equated with prioritisations and difference in prioritisation, both personally and professionally. They considered that the predominant benchmark in relation to commitment was the commitment to the patient demonstrated by total patient care – nursing as a vocation. This form of nursing 'commitment' was clearly defined by the prioritisation of the patient as opposed to the nurse's individual needs. While this form of commitment engages with fellow practitioners, the degree of commitment varies as it is this variation which is a significant arbiter within any profession or organisation. This form of commitment was perceived as a devotion to the profession and intrinsically linked to professions values of altruism, devotion to duty; dedication to the profession, empathy towards the patient, physical presence, championing the patient, trust and loyalty both to the patient and the profession. Griffiths *et al.* (2009) considered that this model of commitment was placed within a historical frame of reference. The profession as opposed to the organisation, whose prioritisations were a more mechanical form of nursing dependent upon technical skills and knowledge. This professional 'commitment' fundamentally lay in *"resolving clinical issues and to ensure the functioning of the care program"* (Griffiths, 2009: 6).

Within the competitive framework that nursing operated, the degree by which commitment identified the most able and ambitious was noticeable. Beesley (2002) observed that in uni or multi-disciplinary environments, practitioners developed their knowledge and experience through practice and she contended that it was essential that 'good' practitioners be committed to maintain a comprehensive knowledge of nursing practice. This form of commitment was considered essential for day to day practice as it was measured in relation to the ability to implement clinical protocols and guidelines, *"Mobilising to the best of one's ability the knowledge of the nursing requires personal commitment and a willingness to take on the tasks assigned"* (2002: 56). This implies a differentiation between commitments, one a 'total' commitment

with the individual consumed by the profession as a vocation and a commitment qualified by technical knowledge and skills. The totality of this converges on organisational interests, *"the sum of normative pressures applied upon a nurse to act towards operational objectives and interests"* (Griffiths, 2008: 329).

Carney (2006) went further and considered that career motivation was tied to levels of commitment - the greater the commitment to values the greater the career outcome. He suggested that this marked the evolution of the profession and coincided with the rise of professionalism within the discipline. Though, Bondas (2006) argued that boundaries exist in terms of the nurse's commitment within the remit of multiple obligations and deterrents in the work place. These include staffing shortages, reduced autonomy and low remuneration and external commitments. Nurses that prioritised their personal needs above the profession had experienced reduced career progression and outcomes. Griffiths *et al.* (2009) supported this position noting that commitment was defined primarily by an individual practitioner's relationship with the profession as opposed to any other determinant. They observed that at the highest levels of nursing, professional commitment was the essential criteria yet it was not a significant arbiter in lower graded posts where suitability for promotion was mediated by other factors. Regardless of this, while it is not rigid or universally prescribed it appeared that 'professional' was a significant arbiter by which a nurse was defined in terms of their career.

However, Robinson *et al.* (2006) presented a more sophisticated model of 'commitment' one which was an exchange, given by the nurse to the profession and received by the nurse from the profession. This presented itself in support and affirmation and allowed for the construction of patterns of commitment: the doubly committed, those individuals committed with both career and organisation. This presented itself within the context of a *"positive motivation and attitude of a nurse in relation to their profession"* (2006: 90). This resulted in nurses becoming embedded in the role and tied to the profession. Robinson and Bennett (2007) suggested the existence of the doubly non-committed, those committed neither to the organisation or the profession, which manifested itself within nurses, *"who were disconnected to the profession"* (2007: 43). The unilaterally committed, those who were restrictively committed to the profession within personal caveats and restrictions. These nurses had

a *"relative engagement and involvement in nursing, relative to their restrictions they imposed"* (Pirie, 2004: 54). This would support Maben and Griffith's (2007) position, that nursing 'commitment' for many nurses was a multi-layered split between the personal, the patient, the colleague, the corporate and the 'profession'. This produced a conflict between the desire to adhere to organisational values and personal attachment and loyalties. Adherence to the agency of organisation's values and objectives resulted in a willingness of practitioners to propagate these values.

It is evident that within the literature, professional commitment is a multi-dimensional variable. There were in general three types of commitment - the affective, the instrumental and the normative. An affectively committed nurse was emotionally engaged with the profession's aims and objectives, regardless of personal circumstances. The normatively committed feel obliged to adhere to the aims and objectives of the profession despite personal reservations. The instrumentally committed, is the nurse whose involvement is conditional upon internal and external factors. Professional 'commitment' it appears, influences the probability that a nurse will have enhanced career progression and outcomes. These latter points are particularly interesting. It presents a direct link between commitment not just to the patient but directly to and with the nursing profession. It would suggest that with this form of 'commitment' nurses are linked to a professional subservience. Within this, logic external activities or interests could not be allowed to interfere or be curtailed by external obligations. This would appear to be incompatible with the pursuit of individual self-interest or needs. The adherence to a definition of 'commitment' based upon professional needs, regardless of individual need is paramount to significant factors and agents within the profession. Nevertheless, 'commitment' is a perceptual and a relative concept and highly disputed but regardless of this, perceptions concerning commitment and its impact as a 'professional' value indicator require scrutiny. It does not exist in isolation but exists relative to professional knowledge and this will be discussed in the following section.

4.3.2 Working time flexibility

Within the literature, professional commitment within registered nursing appears to have a strong relationship with flexible working. There is a debate as to which is most valued but regardless of this, the ability to work flexibly was considered significant in

terms of career progression and outcomes. There appeared to be a great deal of controversy in the literature in terms of meanings, applications and associations. There seemed to be a general view that the ability and availability to work flexibly was driven by the needs of the service as opposed to the needs of the nurse.

Simms *et al.* (2000) argued that a nurse was defined by their ability to work flexibility, particularly in relation to the needs of the service being considered fundamental to registered nursing. Hyde *et al.* (2005) and Weiner *et al.* (2006) observed that there was a strong belief that qualified nurses were required to be flexible in respect to their own working patterns to ensure the success of the nursing processes and to the satisfaction of the patient, the NHS and other stakeholders. They argued that the ability to work flexibly maintained the nursing system and enhanced an individual's professional practice. The quality of practice and care was inversely proportional to the exercise of flexibility, as the essential aim and objective of nursing was to ensure the completion of all duties. The ability to work flexibly was critical to receiving enhanced training and experience (Tierney-Moore, 2007).

Collins *et al.* (2001) and Mullallay (2001) contended that the discipline was myopic in its understanding of the nature of flexibility. Traditional perceptions of flexibility were centred on the requirements of the service as opposed to the needs of the individual nurse. This was counter-productive and denied the profession access to a wider range of able practitioners. They noted that flexibility was the key to developing skills in the long-term and preventing the loss of skills. However, they disregarded a prescriptive concept of 'flexibility' in favour of systems that confronted the difficulties that faced the nursing profession – an aging workforce and a skills shortage. Beesley (2003) argued that concepts concerning working flexibility were more influenced by traditional roles and conservative values rather than the development of nursing, in particular that part-time working in nursing was not considered desirable and full-time working was essential. They argued that flexibility was superficially concerned with standards of care and treatments but did not relate to the private sphere of individual need. However, there was a view that the ability to work flexibly was socially and economically desirable for many nurses (Garcia-Vivar, 2006), particularly in light of family needs represented by dependent children.

Regardless of this, all working patterns in nursing are legally subject to legislation and internal NHS policies. Nursing shift patterns function by virtue of professional needs and employment legislation. The working times directive (Statutory Instrument 1998, number - 1833) defines the working patterns in operation for nursing. Prior to its introduction, nurses performed three fundamental shift pattern variations or combinations of them: day shift, back shift and night shift. These shift patterns included un-social hours and weekend working and were highly attractive on a part-time basis due to the financial enhancements paid to nurses and the perceived flexibility for the employee (Trofino, 2003). In 2001, the NHS in Scotland introduced shift patterns which differed from the previous shift patterns in one fundamental area - the length of a shift. Previously a shift was generally 8 hours in length: the new shift pattern for some staff was 12 hours in length. The advantage of this shift pattern was that it prevented a back shift being followed by a day shift. The disadvantage was that for part-time workers it was relatively inflexible for many members of staff who had to accommodate alterations (Unison, 2006). Unison argued that this did not inform or affect the function of nursing, as nursing could be performed on any working basis but these patterns do impact on ease of access to training. Working patterns had a significant impact on the type and range of work available to nurses. They are legally regulated but do not provide provisions in relation to the access and availability of training for all members of staff equally.

Flexible working operates in the framework of equal opportunities legislation and policies but it operates in a social framework in which the ability to work was considered as a core value within the profession. This at times worked hand in glove with personal needs, where working flexible was essential if family needs were to be reconciled with financial and career needs. This complex relationship had a relationship in defining the development and understanding of the final value under consideration which is professional knowledge.

4.3.3 Professional Knowledge

As indicated in the previous sub-section, commitment is perceived within the literature to be a central nursing value. This value of commitment is possibly equalled by that of professional knowledge. Nursing has an extensive range of theoretical and

practical knowledge in their work. There is a consonance between nursing knowledge and practical experience and qualifications.

Kerfoot (2000) and Gough (2001) argue that nursing's unique body of knowledge defines nursing as a profession. It has a distinct knowledge base which stems from the lived experiences of nurses involved in caring relationships with their clients. This is a central and unifying domain for nursing knowledge. Polletta and Jasper (2001) considered that nursing knowledge is a particular kind of knowledge, one which concentrates on understanding its application within the remit of practice. They assert that nurses constitute an *"epistemic community"*, whose professional knowledge is linked to its knowledge of care, clinical effectiveness and by professional enquiry built upon *"knowledge of practice"* (2001: 2). Though, the emotional intuitive aspect of nursing knowledge, in comparison to within some circles (Scoble & Russel, 2003) equally weighted. This distinction between knowledge is often referred to as the *"know-how and the 'know that conundrum"* (Pollock, 2004: 12). He argued that 'Know-how' knowledge is gained through personal experience and is not usually articulated but is a learnt practice – the art of nursing. 'Know that' is knowledge that's gained, usually comes wither theory or research - the science of nursing. The competition between the pillars of the two fundamental types of knowledge is well documented and is referred to as the art-science debate. The gap between these two knowledge sources is sometimes known as the theory-practice gap. However, it would not be unreasonable to state that nursing knowledge is informed by both theoretical and practical perspectives.

In the remit of promotion and career progression, technical knowledge manifested in academic qualifications; particularly post-registration qualifications appears to be significantly weighted (Robinson & Griffiths, 2007). They noted the belief that knowledge within the profession adjudged knowledge quantifiable in terms of 'hard' outcomes – academic and vocational qualifications. Though, there is a view that it is difficult to quantify nursing knowledge as it is acquired from different sources. McDougall (2007) noted registered nurses use knowledge from biological sciences, physiology, social sciences and psychology. The wide range of sources is a mixture of types of knowledge, which makes it even more difficult to define what nursing knowledge actually is. This is a source of conflict within nursing between

practical/experiential knowledge and propositional/theoretical knowledge. Beesley (2004) observed that within an increasingly fragmented nursing workforce, the importance subscribed to aspects of professional knowledge was critical in deciding the worth of professional knowledge and the worth of the nurse's experience and practice.

However, this debate is not recognised by NHS in Scotland as nursing knowledge is legally located within the frame work of vocational and academic qualifications. Cowin (2002) noted that within the nursing vocation, competency was directly related to the acquisition of the relevant professional qualifications. The acquisition of qualifications enabled the nurse practitioner to enhance their nursing career and the scale and depth of these accomplishments. There were established protocols between academic qualification and progression into senior positions. The higher the grade, the greater the experience required, and the experience could only be achieved through considerable academic attainment or vocational practice. Recognised vocational or academic qualifications ensured that registered nurses contributed "*to high standards of clinical practice and quality of patient care in line with NHS quality priorities and standards*" (Pirie, 2004: 9). Beesley and Pirie, (2004) supported this argument by stating that qualifications ensured "*professional development which developed clinical competence*" (2004: 43).

Nursing knowledge is complex; however it is linked to vocational and academic qualifications and experiences. Post-registration qualifications are the standard in which experience/professional knowledge is measured. This strikes accord within the literature as it is difficult to reach a general consensus on a definition of commitment and knowledge that would allow for an understanding of these constructs. However, while many definitions are found in the literature, it is the methods of measurement used within the profession that is of interest to this research. Nursing operates within these circumstances as it is also subject to stereotyping and these will be examined in the next section.

4.4 Stereotypes and nursing

This sub-section will examine the overarching positions of gender perceptions, roles and stereotypes within the profession.

Evans (1997) observed that nursing was considered 'women's work' because of the attributes associated with the role and the gender stereotypes associated with women. These assumptions had profound and far-reaching implications for men and women within nursing, particularly in relation to role demarcation. Historically, men were employed as 'restraining orderlies' in 'lunatic' asylums whilst women were working in 'nursing' This very split demonstrates the basis for stereotypes - physical work and men, women and kindness and caring. 'Feminine' attributes shaped the discipline as the tasks involved were related to the stereotype. The caring qualities required in nurses were considered uniquely 'feminine' and created the illusion that nursing is the archetypal female occupation (Arvonen & Ekvall, 1999). Bolton, (2003) and Aarons and Sawitsky (2006) considered that the female nursing stereotype correlated well with the perceived affective nature and communal skills, such as nurturing, caring, tending, passivity, self-sacrifice, devotion and subordination which is assigned to, or assumed to be intrinsic with women. Due to the potency of these stereotypes, female nurses *"embrace a role and are embraced by it"* (Evans, 2002: 101). He acknowledged that many nurses embraced the stereotype to their own personal detriment.

However, Block and Manning (2007) contended that the gender stereotypes inherent within nursing were fashioned in dialogue with, and maintained by the external social discourse. Nursing as a product of social construction defined its roles within wider masculine and feminine terms. 'Masculine' attributes and 'feminine' attributes were considered as independent dimensions within nursing and they were treated as two separate constructs. Thus, an ideal nurse was not seen as stereotypically feminine but as someone capable of displaying feminine characteristics, that is, warmth, understanding, gentleness, helpfulness, kindness, as well as characteristics considered masculine - independence, decisiveness and strength. Gerova (2003) suggested that this established an internal dialogue which reinforced gender perceptions which reinforced the custodial nature of the discipline for women. Duffield *et al.* (2004) observed that the self-propagation of the 'female' stereotype in nursing and the over simplifications of gender stereotypes led directly to considerable gender inequality within nursing management. While gender stereotyping arguably operated to exclude men from the profession despite the low number of men, these stereotypes had a counterproductive effect on the female nurse's managerial careers. The upward

mobility of male nurses was a consequence of the advantage gender stereotypes produced 'masculine' stereotypes have considerable worth in nursing in terms of power, status and opportunity.

Evans (2004) argued this internal dialogue in relation to stereotypes restrict women to the subsidiary, while nursing management in comparison was rational, scientific and male oriented. Though female stereotypes were the accepted cultural model within nursing, they were detrimental to women in terms of promotion. The 'female' stereotypical characteristics that emphasised a caring role were a reflection of these stereotypes and not a cause of, the dominance of men in management. There was no difference between male and female professional attitudes in nursing but 'masculine' attributes were synonymous with the values of senior positions in nursing. Male stereotypes of strength, aggressiveness, assertiveness, self-control and leadership are prioritised above the nurturing and responsive caring feminine role of the nurse, 'naturally' ideal for management. Men were considered not in themselves 'natural' carers but were not 'incapable' of providing caring. Gender stereotyping propagated the 'myth' of the male manager to be reproduced and to be imposed. Connelly *et al.* (2003) argued that it was a misconception maintained in part by women to their detriment. The consequence of generic gender stereotyping was that nursing staff came to accept these over-simplifications. These were constantly reinforced through the social interactions within and out with nursing. Men take on 'feminine' gender role characteristics as occur in nursing, which posed a contradiction to culturally defined expectations.

Gender stereotypes within nursing build upon wider social perceptions are not divorced from these they are built upon them. The ideal nurse is female - 'natural' career while management is still stereotypical perceived to be 'masculine'. The power of gender stereotypes is significant in relation to careers when placed relative to the wider stereotypes associated with men and women. The measure of this will require to be examined.

4.5 Careers in Nursing

The previous critiques highlighted the debate concerning gender and careers in employment. Within the context of nursing, this relationship was observed within the literature with a host of explanatory critiques and opinions.

Goodman (2001) and Ring (2002) argued that careers within nursing were altered by the demands of expansion and the contraction of the internal domestic nursing economy whilst Singh (2002) considered that conscious and unconscious organisational barriers within the profession were instrumental to this process. These were the products of tokenism, informal and a hidden promotional system, culture, gender power dynamics, personal networks and social exclusion. Gough (2001) and Hallam (2002) observed that the greater success of male nurses compared to their female counterparts in terms of careers was directly related to historical division of labour and roles between medicine and nursing.

However, there was a view that this was simplistic and could not explain the contemporary career imbalances. This view located women's restricted careers as directly related to the agency of parenthood, children and the family, career breaks and geographical immobility (Radcliffe, 2000; Wilkin, 2003; Gates, 2007). It was observed that within nursing, women commonly have disruptions to their career due to family reasons - anecdotal evidence suggested the detrimental consequences of career breaks in terms of careers (Whittock *et al.* 2002). Muldoon and Reilly (2003) noted the negative careers following career breaks for women while positive careers were in favour of men who did not take career breaks. Women who engage in part-time employment in order to be able to meet the demands placed on them as primary carers in the private sphere had particularly reduced careers, whilst barriers related to part-time working constitute a structural block to the careers of many women. It was argued that part-time nurses did not subscribe the same importance or access to training as full-time nurses. This resulted in a situation where otherwise comparable groups of male nurses with equal experience were given unequal access to training which enhanced their careers (Larrabee *et al.* 2003). However, Loan-Clarke (1996) placed greater weight on the position that men's greater career flexibility enhanced their careers. Geographical mobility allows greater access to vocational training and the accumulation of experience and it was argued that men's perceived ability to be

more geographically mobile advantaged their career. In families where the wife works, relocation usually takes place in response to changes in the husband's employment and relocation usually hinders the career of the 'tied' follower.

It appeared gender was part of a wider set of explanatory variables in which tradition, qualification, employment procedure, working practices and the effect of the cohort effect in nursing appear to be engaged but which the impact of the family and parenthood are central within it.

4.6 Nursing management

This section will consider the debates, paradigms and positions related to nursing management. The debate examines the influence and power of perceived 'feminine' and 'masculine' attributes in management and also considers traits and styles of management. Within the literature there was an examination on men and women's styles of management.

Beesley (2004) observed that there was less emphasis among women managers on a 'traditionalist' style of management decision making with an emphasis on sensing as opposed to intuition and judging rather than perceiving. He identified a greater emphasis by women towards a 'transformational' approach to leadership which involved participation, motivation by inclusion and power by charisma rather than a 'transactional' approach. This involves motivation by exchange of rewards along with favours and power by position. Thus female managers tended to have wider goals with a desire to succeed, but also to make the work environment more fulfilling for everybody involved in nursing (Griffiths, 2009). He noted that within nursing, women described female managers as decidedly more deficient than male managers. It was only when the female managers were depicted as highly successful, that this gender difference in trait characterisations was found to abate.

Though Maben *et al.* (2008) considered that within nursing, for women, *"challenge and satisfaction in a particular job were more important than recurrent promotion for its own sake"* (2008: 23). They noted that women tended to stereotype the manager role in a traditional, 'masculine' direction more markedly than men. She observed that men in nursing described a successful manager with more feminine characteristics while women described the opposite valuing professional commitment above work

and life balance. The placement of operational criteria at the expense of personal considerations was a hallmark of nursing.

There were perceived differences in behaviours. Bolton (2003) noted differences in gender approaches in specific behaviours, notably, if staff were under performing, men were more likely to adapt their response to a perceived cause: if the problem was inability, they may use training; if the problem was lack of effort, they will punish. In contrast, women were more likely to adopt a consistent approach by either using training or punishing in every case. In relation to communication, Stryker (2002) described a greater tendency for women to use communication to connect or establish rapport, whereas men were more likely to communicate with the aim of conveying information, displaying expertise and challenging for status.

There was disagreement on the importance of traits and values in relation to nursing management. Thomson (2001) suggested that as organisationally nursing was hierarchical in nature, its very structure undervalued 'soft' 'feminine' approaches while valuing 'masculine' approaches. The preserved 'masculine' attributes of a management post even when the status of the job had been downgraded. Thus men's relative ability to retain management as a male domain was due to the skills that make up management as being rooted in 'masculine' attributes. However, Donner and Wheller (2001) noted that nursing creates and maintains masculine identities in management through the expression of gendered power and status in the workplace. She noted that 'masculine' attributes and management were not two separate concepts but those notions of 'masculine' attributes infused management and men and women who enter it. By adopting male characteristics, women were not seen as extending their femaleness but relinquishing it, whilst when men demonstrated a 'feminine' way of behaving. This was considered an addition to male virtues. There was pressure on women within nursing to 'prove' they were similar to men for them to earn credibility as managers. There was disagreement concerning the impact of women's 'attributes' in management, Cooper (2005) considered that the 'feminine' approach was not an obstacle to women's progression in management. As women's leadership involved more participation, motivation by inclusion, this was an advantage within management. As communication skills are essential in management, women's attributes in relation to them should be a distinct advantage. However, it is the

ecology of these relationships rather than the possession of them which is the critical factor in defining career progression.

A significant aspect of the literature considered the debate concerning management and the association of 'male' and 'female' perceptions within management but the paradigm here was acceptance and adherence. It was argued within the literature that women were the stronger adherents to 'traditional' perceptions however; men were the direct beneficiaries of their maintenance. However, progression into nursing management is dependent on several factors which appeared to be directly related to nursing values: principally commitment, working flexibility and professional knowledge.

4.7 Summary

Within the literature, there are different focuses in relation to motivational underpinnings of the profession. Despite differences in origins, language, orientation, and coverage, the theories have much in common. In most instances, the differences are a matter of emphasis rather than kind. Being and doing are both central features of nursing. The profession is defined by its values, notably commitment, the ability to work flexibly to the needs of nursing and professional knowledge. The interaction between these and gender appears to inform women's career progression. This is significant and raises the following key question:

- Within nursing, what is the impact of nursing values (professional commitment, flexibility and professional knowledge) on women's career progression?

This chimes with the previously discussed literature, particularly Legault and Chasserio's (2003) research that gendered perceptions and values, in particular those associated with parenthood, flexible working and commitment negatively impact on women's careers. It also relates to Heilman *et al.*'s (2004, 2007) position that gender perceptions are biased against women and this bias is facilitated by women against women, the combination of these reproduces gender inequalities in employment. To recap this raises the following key question:

- How do stereotypical assumptions of women in careers in employment (nursing) interact with stereotypical assumption of women as mothers?

Finally this links with Waldfogel's (1999; 2004; 2007) position in relation to gender and children and how this relates to 'human capital' which raises this marker for consideration:

- Is there a short and long-term gender disadvantage and if so, is there a *"childcare penalty"*?

These are the research questions from the literature and they provide a significant focus for investigation. It is appropriate at this juncture, to discuss the methodology to be applied to facilitate this exploration.

Chapter Five Methodology - The Art of the Possible

The truth is elusive but the search is compulsive. Harold Pinter, Nobel Lecture, 7th December 2005.

5.1 Introduction

The purpose of this chapter in the first instance is to review the methodological underpinnings of the thesis. Secondly, the methods of research namely quantitative and qualitative will be discussed. Thirdly, the research design applied will be considered including data analysis techniques, the selection, recruitment and piloting approaches applied, and the accuracy, reliability and validity of the findings. Fourthly the issue of researcher reflexivity will be explored. The chapter concludes with a review of ethical considerations.

5.2 Research Methodology

Research methodology, according to Silverman (1993: 2) is the 'general approach to studying a research topic'. This approach is underpinned by the researcher's understanding of the nature of the social world or simply put the researcher's philosophy. Indeed, all research is directly shaped by the researcher's philosophy including his/her ontological and epistemological positioning. Ontology refers to *"the nature of existence or being and reality"* (Gruber, 1993: 199) while epistemology concerns *"the theory of the origin, nature and limits of knowledge"* (Schiffer, 1996: 317). Kuhn (1970) considered that any approach to the systematic investigation of phenomena, rests upon epistemological and ontological assumptions, assumptions about the nature of knowledge (epistemology) and about the kinds of entities that exist (ontology). In the context of social scientific research there are two main philosophical approaches – positivism and interpretivism. A third approach, pragmatism, will be discussed as this, arguably, served to challenge the traditional belief in the incommensurability of the two main philosophical approaches and is importantly considered better able to address the research questions of this thesis.

5.2.1 Positivism

Yin (1993) considered that the 'traditional' approach to research is positioned within a 'positivist,' or 'empirical-analytic' frame of reference. Positivism is a philosophical

position which emphasises that truth, knowledge and understanding are objective, discernible and measurable with a fundamental belief that theories can be tested against observations, rather than resting solely on intuition, revelation or *a priori* reasoning (independent of experience). The verification of knowledge occurs by developing specifics through the application of logical principles (Hemple, 1965; Butchvarov, 1970). In positivism understanding is achieved through intellectual and mathematical examination and the assumption is that phenomena *"can be studied as hard facts and the relationship between these facts can be established"* (Latour, 1987: 89). In an epistemological sense then, positivists subscribe to objectivism in research and ontologically their approach is one of naïve realism.

Importantly, the positivist or empirical-analytic paradigm is the historical product of two apparently opposed conceptions of knowledge and investigation that turn out, on closer examination, to share a common, underlying ontology of two separate realms: mind and matter. These two are empiricism and rationalism. In rationalism, knowledge is the product of reflection and reasoning, based on fundamental formal (and hence indubitable) principles or axioms, from which subsequent truths are logically derived. An early form of this can be found in Descartes' writing, where the cogito ('I think, therefore I am') provided an Archimedean point from which to deduce the reality of ones own existence, the reality of the external world (Peters & Waterman, 1982).

Within empiricism, knowledge is the product of perception, observation, based in sense-data that are combined to form complex conceptions. These sense-data are interpretation-free facts that provide a foundation to knowledge, guaranteeing its validity. An early example is provided by John Locke, for whom the senses provided 'simple ideas' whose 'association' gives rise to 'complex ideas' (Doyal, 1993).

In both rationalism and empiricism it is believed that an objective epistemological foundation can be found that will justify claims to valid knowledge, without reference to authority (divine or otherwise), or to speculative metaphysics. For rationalism the foundation is provided by reason, rationality and logic. For empiricism it is provided by the brute data of sensation, of experience. The empirical-analytic conception of inquiry appeals to both of these foundations. In this conception, knowledge comes

from systematic testing. Measurement (including psychological testing) provides an objective, interpretation-free record of empirical regularities. Formal logic, especially the rules of statistical inference, allows both summary descriptive statements and testing of explanatory (causal) models.

An apparent challenge to positivism emerged from Karl Popper whose approach was deemed as post-positivism. The Popperian approach was based upon the belief that 'truth' cannot be 'proven' it can be only be refuted or justified whilst 'knowledge' can be invalidated or 'falsified' by alterations of perceptions of definitions of 'truth' (Popper, 1994). This seemed contrary to the fundamental tenets of positivism where observation and experimentation seek the 'truth', or realistically seek to move towards some 'truths.' However, this acceptance of the notion that 'truth' can be 'falsified' on closer examination is not essentially a radical departure from the ontological and epistemological underpinnings of a positivist philosophy in which verifiable statements concurred with ascertainable 'facts' of reality. So that post-positivists shared the same objectivist epistemological foundation as positivists albeit that ontologically they can be claimed to be 'critical' realists rather than 'naïve' realists.

There have been several critiques of positivism. First there is the claim that this approach is unable to provide comprehensive or adequate means to explore and examine human behaviours, particularly emotions and feelings (Berger & Luckmann, 1967; Cook, 1985; Seale & Silverman, 1997). This weakness renders positivism restrictive in application to many areas of research where interpretations are dependent upon perceptions. Second, according to positivists knowledge (mental) is about things in the world (material) (Bourke, 1962; Strauss & Corbin, 1990). Valid knowledge corresponds to the way things really are: but how can this correspondence ever be assessed? Neither observation nor reasoning can provide this guarantee--they are not the interpretation-free foundations they have been claimed to be. Third, Rand (1979), Singleton and Straits (1988) Lewis (1996) and Davies and Dodd (2002) considered that positivism's fundamental weakness was its failure to recognise that all 'realities' were socially constructed which is one of the key critiques of positivism from those who subscribe to an interpretivist approach as will be discussed in the next section.

5.2.2 Interpretivism

Interpretivism is a broad term used to describe a heterogeneous array of philosophical approaches including hermeneutics and constructivism. While there are some variants in these approaches, what binds them together is their opposition to the main epistemological and ontological tenets of positivism. In other words interpretive approaches operate with different assumptions about knowledge and being. For interpretivists reality is not rigid; reality does not exist within a vacuum: there is no single 'truth', but multiple 'truths' dependent on the context and the very constructions of these realities. Interpetivists therefore subscribed to relativist ontology. Interpretivists rejected the distance between the knower and the known thus adhering to an epistemology that is subjectivist. According to Henwood and Pidgeon (1993:16) interpretivism is often characterised by:

> *A commitment to constructivist epistemologies, an emphasis (at least in its pure ethnographic form) upon description rather than explanation, the representation of reality through the eyes of participants, the importance of viewing the meaning of experience and behaviour in context and in its full complexity, a view of the scientific process as generating working hypotheses rather than immutable empirical facts, an attitude toward theorising which emphasises the emergence of concepts from data rather than their imposition in terms of a priori theory.*

An interpretive philosophy draws on a 'phenomenological ontology' (Pietarinen, 2006). This is a non-dualistic ontology: one that seeks to avoid the Descartes dualism of mind and matter. Interpretive research can only be descriptive, not explanatory.

As interpretive research is often hermeneutic in character based upon the interpretation of messages and texts, a text must be read to make sense: one must first know the language in which it is written. Second, any text is open to more than one reading: texts show plurivocity and plurivocality. Third, texts are read in context: the text/con-text relation is a crucial one that is central to the investigation. But interpretive research works with action as well as texts; human action can be fixed as a text-analog (Grondin, 1994). There is a distinction between the hermeneutics of everydayness and a depth hermeneutics, or a critical hermeneutics. The latter is often

associated with the work of Freud, Marx, and Nietzsche, each of whom asserted that things are not what they seem, because of the operation of censorship, repression, ideology, oppression, systemic distortion, silencing, and coercion. A hermeneutics of everydayness seeks to illuminate and articulate what generally goes unnoticed because it is ubiquitous, common-place and every day. A depth hermeneutics seeks to uncover what has been hidden, covered over, and disguised (Putnam, 1994). A hermeneutics of everydayness is always needed first and enables discovery of interesting and powerful phenomena.

Interpretive research does not seek an epistemological foundation. Instead, inquiry begins with the ordinary, everyday human understanding we have of one another. It does not end there, but this is where it starts. It is based upon an insight, and sensitivity to what goes on in ordinary conversation and interaction; to the ongoing work of human relationship that we take for granted because it is ubiquitous. It is based upon the ability to challenge one owns perceptions and the interpretation of conceptions, to be reflective, self-critical, thorough, and to assume that what other people do is sensible and important. This questions not only the objectivity of meaning but of meaning itself. In questioning the apparently stable foundation of meaning on which traditional interpretations are situated and by raising doubts about the capacity to achieve ultimate clarity about the meaning of an analysis, interpetivism supported the contingent and constructed character of meaning itself.

Hedrick *et al.* (1993) and Audi (1999) observed that as interpretive research is not the norm, subscribers to this approach are frequently called to justify and explain their approach and its assumptions. One of the key criticisms of interpretivism relates to ideas of consistency for agreed meanings. According to interpretivists, meanings were contingent to each individual and every individual could decide on whether an interpretation was competent or incompetent (Bourdieu, 1993; Timberlin, 1999; Shenton, 2004; Temple & Young, 2004). If all meanings were contingent to each individual then it would appear that every person makes his or her own meaning, and there would be no generally acceptable criteria to enable people to judge whether an interpretation was 'truthful'. Within this critique there appears to only be interpretations: indeed a multiple succession of infinitely different interpretations

(Schwartz, 1994; Mouzolis, 1995; Timberlin, 1999) which can lead to an avoidable multitude of interpretation (Russell, 1946; Rorty, 1998).

It is important at this point to mention critical theory which is seen as a main school of thought which, like interpetivism, is opposed to the tenets of a positivist philosophy. Critical theory is an approach inspired by the neo Marxist teachings of the Frankfurt School (which included a prominent group of scholars namely Horkheimer, Adorno, Marcuse and later Habermas) who claimed to have an 'emancipatory cognitive interest' (Keat, 1981). However, the argument of critical theorists is that both positivists and interpretivists are too conservative and so are against social change. Still, critical theorists adhere too many of the tenets of interpretivism notably in terms of their epistemological subjectivism but they are different in so far as adherents to critical theory do not subscribe to relativist ontology. In this regard critical theorists believe that interpretivists, through their support of the existence of multiple realities, all of which might be equally 'truthful' fail to apprehend or to acknowledge the existence of dominant ideologies which seek to suppress and subjugate. Instead, critical theorists subscribe to critical realism but not in the Popperian sense of falsification. Rather critical theorists believe, according to Sherman and Strang (2004) and Hendricks (2006) that the destabilisation of the very concept of meaning must have an emancipatory agenda: to liberate meaning from dominant interpretations, which were perceived to be oppressive and coercive. Critical theory is therefore inherently a very politically motivated approach.

A chief criticism of critical theory is that its critical realist ontology means that it does not bracket an absolute reality. Burr (1985) and Sayer (2000) considered that this reinforced the idea of strictly objective knowledge, of 'facts' independent of interpretation. This ontological weakness in critical theoretical thought is stated cogently by Roderick (1986: 23):

> *How can critical theory locate the distortions in other modes of thought, and condemn them as ideology unless it itself is free from the distortions? To what can it appeal to justify its own fundamental critical norms and practical commitments? To locate the distortions in the thought of others implies the mastery of the distinction between distorted and undistorted thought.*

5.2.3 Towards a pragmatic philosophical approach

Based on the previous brief discussions of the main philosophical approaches in social scientific research it is evident that there are differences with regard to epistemological and ontological underpinnings. However the question for this researcher is whether these differences are incommensurable. In other words is it possible to draw on aspects of each approach in order to fulfil the research objectives? Should we perhaps adopt a more pragmatic approach where the key issue for discussion is not necessarily a philosophical one but rather the value of the research for practice? Certainly there are merits and demerits in each of the main philosophical approaches and perhaps what should concern contemporary researchers in the social sciences is the practical value of the research. Pragmatism has emerged as a philosophical approach which is intended to address these questions.

Yin (1994) considered that pragmatism was distinguished by the doctrine that the meaning of an idea or a proposition lies in its observable practical consequences. While Grondin (1994) argued that "truth" is not readily defined in pragmatism; they acknowledged James (1902) position that consciousness and reality jointly 'makes truth' (James, 1907). This philosophy has two senses: truth is mutable, (James, 1907) and 'truth' is relative to a conceptual scheme (Pietarinen, 2006). James (1907) argued beliefs are not true until they have been made true by verification; propositions become 'true' over the long term through proving their utility. The opposite of this process is not falsification, beliefs could pass into and out of 'truth' on a situational basis; 'truth' was relative to the specific (Pietarinen, 2006). Peirce (1958) considered the idea that beliefs are true at one time but false at another or true for one person but false for another. Peirce (1992; 1998) argued that the pragmatic view implies theoretical claims should be tied to verification processes and not tied to specific problems or life needs. Truth is defined, for Peirce, as what *would* be the ultimate outcome (not any outcome in real time) of inquiry by a (usually scientific) community of investigators. Dewey (1938), while agreeing with this definition, characterised truthfulness as trustworthy and reliable a constant in every conceivable situation. Peirce and Dewey connect the definitions of truth to warranted assert-ability. This internal realism centred on the belief it is true if it is ideally justified in epistemic terms. As Putnam (1994) argued:

> *Truth cannot simply be rational acceptability for one fundamental reason; truth is supposed to be a property of a statement that cannot be lost, whereas justification can be lost. The statement 'The earth is flat' was, very likely, rationally acceptable 3000 years ago; but it is not rationally acceptable today. Yet it would be wrong to say that 'the earth is flat' was true 3,000 years ago; for that would mean that the earth has changed its shape.* (Putnam, 1994: 55)

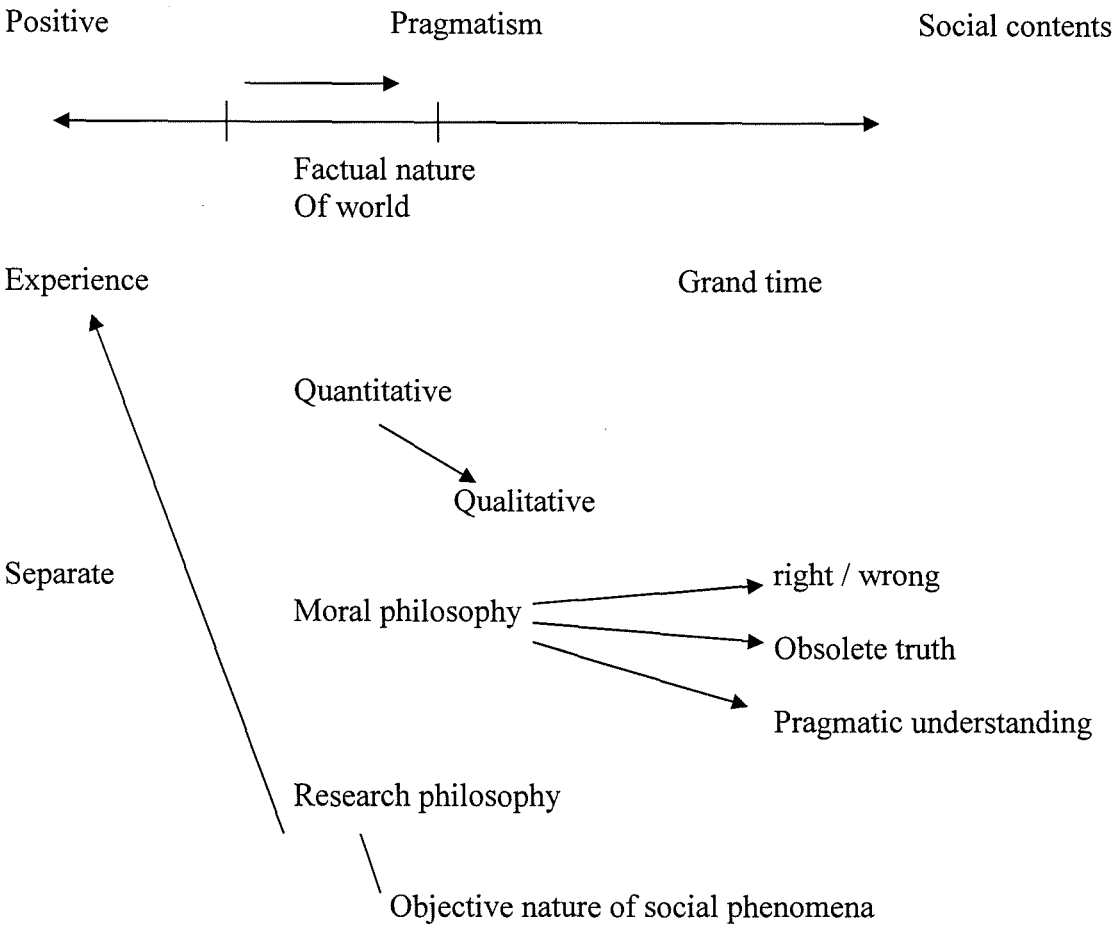
Thus for this researcher, pragmatism proceeds from the basic premise that the human capability of theorising is integral to intelligent practice. Theory and practice are not separate spheres; rather, theories and distinctions are tools or maps for finding our way in the world. It is not a question of theory versus practice but rather of intelligent practice versus uninformed practice.

In conclusion, the researcher's philosophy was pragmatism based upon *"reason as a source of knowledge or justification"* (Lacey: 1996: 286). It is an approach in which the criterion of truth was not sensory but intellectual and deductive (Bourke, 1962; Strauss & Corbin, 1990). Different degrees of emphasis on this approach lead to a range of rationalist standpoints, from the moderate position that reason has precedence over other ways of acquiring knowledge to the radical position that reason is the unique path to knowledge (Hedrick *et al.* 1993; Audi, 1999). Yet the demands of this thesis in terms of quantitative and qualitative research reconciled the researcher's pragmatism as the fundamental driver of design, interpretation, analysis and verification. This notwithstanding the following section will discuss the research methods applied.

Therefore, my research philosophy is pragmatic a fusion of positivistic and interpretive while aspects of the research paradigm are primarily descriptive and quantitative. The emphasis is on exploration and insight rather than experiment and the purely statistical treatment of data. Research set in this interpretive research philosophy addresses the questions about how and why something is happening. It addresses questions about what is happening in a wider context and what is likely to happen in the future – but as all things it can seldom do so with statistical confidence, because the 'truth' is not grounded in mathematical logic. The 'truth' has to be a conclusion in the mind of a reader (or listener), based on the researcher's power of

argument so different recipients of the research may come to understand different 'truths'. As table 5.1 conceptualises:

Table 5.1 Pragmatist diagram



(Munro, 2008)

The factual side of social/concrete phenomena which is demanded by this thesis in terms of research reconciled the researcher to the fundamental driver of design, interpretation, analysis and verification. This notwithstanding the following section will discuss the research methods applied.

5.3 Research methods

Research methods are concerned with the *"techniques for gathering and analysing data"* (Schwandt, 1994: 119). The research methods selected for a particular research project are necessarily influenced by the philosophical approach of the researcher. Simply, positivist approaches are normally associated with quantitative methods, interpretive approaches with qualitative methods while a more pragmatic approach

with mixed methods which draw on both quantitative and qualitative techniques. The following sub-sections will discuss quantitative methods and their strengths and weaknesses and this will be replicated in relation to qualitative research methods. The final section will discuss the rationale for combining quantitative and qualitative methods, in a mixed methods approach.

5.3.1 The strengths and weaknesses of quantitative research methods

Quantitative research methods are defined by the assumption that human behaviour can be explained by 'social facts' and can be investigated by methods that utilise *"the deductive logic of the natural sciences"* (Horna, 1994: 121). Kuhn (1970) and Nau (1995) observed that quantitative investigations distinguish these characteristics and their elemental properties within empirical boundaries which allow them to be measured the approach has strength and weaknesses.

A fundamental strength of this method is its flexibility in the treatment of data, in terms of comparative analyses, statistical analyses and the replication of data techniques in order to verify reliability (Huberty, 1993; Alford, 1998). Black (1993) and Rosenthal (1994) noted that statistical analysis allowed generic patterns to be ascertained while Minium (1998) and Brower *et al.* (2000) noted that quantitative methods permitted a simple comparative analysis which enabled enhanced reliability. This method facilitates a greater opportunity to compare data to ensure reliability and validity of large scale data, its collection and analysis at reasonable cost (Bird, 2002; Oliver, 2003).

Quantitative methods have weaknesses, Reason and Rowan (1981) and Potter (1996) failed to provide a completely comprehensive analysis. Quantitative approaches tended to have a restricted view of and a measure of behaviour, cognition or effect. It failed to ascertain deeper underlying meanings and explanations, *"people are reduced to a set of variables which are somehow equivalent across persons and across situations"* (Myres & Well, 1995: 142). Barnett (1991) considered that although quantitative methods can be used to measure certain factors, their appropriateness in explaining them in depth is restricted. Seale (1999a) argued there was a tendency to distort analysis by measuring certain variables at a specific moment in time exacerbated by a failure to engage with temporal and temporary changes which

cannot always be identified. Accordingly quantitative methods used in isolation affected validity whilst the residual practice of constructing a category system involved the risk of the researcher imposing his/her own interpretations (Patton, 2002).

Despite these criticisms, quantitative methods are critical to address research objectives of this thesis. Its ability to classify elements into categories affords the opportunity to develop frameworks which highlight issues that were not always obvious through impressionistic analysis. It provides the opportunity to investigate employment patterns. The forte of quantitative methods is the direction and structural framework that it provided its weakness lie in its inability to develop a comprehensive understanding. An analytic approach applied in isolation can not yield a full 'understanding'. Therefore other methods required consideration this led to a review of qualitative techniques which are discussed in the following section.

5.3.2 The strengths and weaknesses of qualitative research methods

The preceding section established that quantitative methods have strengths and weaknesses. Qualitative methods have strengths which partly compensate these weaknesses and these will be discussed in this section as will their applicability to this research.

Silverman (1985) argued that the fundamental strength of qualitative research was its ability to provide a deep, broad understanding of the issues under investigation. Patton (1987) and Jones (1996) argued that qualitative methods allowed the cognitive and affective components to be explored in greater depth than quantitative methods. This allowed an enhanced understanding whilst allowing issues to be viewed from the perspective of people being studied. Smith (1990) and Wolcott (1990) observed that this facilitated a greater understanding of the processes involved. Detailed descriptive data regarding social events and experiences contextualised issues and allowed complex social entities to be viewed holistically and to be understood in their entirety. It was argued that strength was built upon cognitive investigatory methods and interpretative approaches which engaged with participants' informed testimonies (Bouma & Atkinson, 1995; Cassell & Symon, 2004).

Wolcott (1994) and Delbridge and Kilpatrick (1994) argued this accessing of deeper meanings in relation to human issues and measurable behaviour gained an understanding of how the subjects themselves viewed their own particular situations. This prioritised issues and allowed the research beyond its pre-determined remit (King *et al.* 1994). LeCompte (2000) argued that the flexibility of qualitative methods encouraged the identification of longitudinal changes. King (2004) argued that these approaches facilitated a new insight or revision of previous work and research and in doing so developed a greater understanding. The strengths of qualitative research were clear but it is not without weaknesses.

There were concerned with validity and the difficulty in determining the 'truthfulness' of findings. Crotty (1988) observed that underlying assumptions made conventional notions of 'validity' and 'reliability' difficult whilst 'credibility' and 'plausibility' were at times potentially compromised. As descriptive data enables an understanding of underlying explanations to be developed, findings frequently fail to highlight the degree to which other issues impact (Beach, 1996; Frankel, 1999). Moreover, Gray (2004) noted that in general, due to the small size of samples involved in this type of research, findings were prone to be unrepresentative. Leininger (1994) and Maykut and Morehouse (1994) questioned the generalisations inherent within the opinions of the informants and the impact of collective memory, bias, the understanding of the interviewee and group dynamic, they were concerned that this approach by its very construct was intrinsically untypical. Holliday (2001) unfavourably compared subjective qualitative approaches to the objectivity of quantitative methods which he considered to be synonymous with rational research.

Aspects of qualitative research methods were essential to this investigation. It facilitates the identification of integral and distinctive patterns and issues. Accordingly the needs to consider a mixed methods approach emerged and this internal debate will be reviewed in the following section.

5.3.3 Mixed methods- combining quantitative and qualitative research methods

Jick (1983) observed that the scope of research directed the researcher to a single approach, yet this inhibited or compromised aspects of the findings. Jayaratne (1993) and Mason (1994) argued that in order to overcome this, different methods required to

be blended and integrated together to capture a more complete, holistic and contextual understanding of the research. While certain single methods have multiple strong points, it is in particular instances 'blind' to certain streams of data (Creswell, 1994). Nau (1995) advanced the advantage of this approach arguing that the weaknesses and limitations of each individual method were counterbalanced by the strengths of the other. This compensatory design exploited the assets and neutralised rather than compounded the liabilities of qualitative and quantitative research methods. Mathison (1998) and Begley (1996) argued blending qualitative and quantitative methods of research combines the strength of both and diminishes their weaknesses, *"qualitative data can support and explicate the meaning of quantitative research"* (Davies & Dodd, 2002: 117).

Adopting the assumptions of the previous statements ensured that this research method maximised the strengths and minimised the weaknesses of single method approaches. Quantitative analysis was appropriate in assessing descriptive components and guiding the initial phases of the research. This approach highlighted significant issues and determined the issues for further examination. These assisted an understanding of the underlying issues and were a conduit to the researcher developing an overall understanding of the subject under investigation – a mixed methods approach assisted, developed and defined the research whilst offering a comprehensive analysis and interpretation of data and perspectives. A mixed methods approach enhances the value of the research by offering flexibility, validity and integrity. For this approach to be effective the research design needed to be simple to avoid the debilitating effects of over complication and elaboration. It is this research design that will be discussed in the following section.

5.4 The Research design

There are two stages to this research - quantitative and qualitative methods. The quantitative research draws from both primary and secondary sources of data. Primary sources of data are those which have been directly collected by the researcher such as in surveys while secondary sources of data are those that already exist such as government reports. The research design evolved but it was initially driven by the availability of statistical data - the access to the NHS workforce database. The

qualitative stage of the research involved in-depth interviews; these methods will be discussed in this section.

5.4.1 Quantitative research

It was necessary to be logical and rational in addressing the issues that required consideration. The objective of these considerations was to construct a robust design that could be defended and justified. This could only be effective if the quantitative research process was accurate, valid and reliable and these objectives could only be achieved if safeguards were embedded within the research design and these will be discussed in this section within the context of the stages of the research. The quantitative design processes were directly focused on the objective of the research and the issues related to this.

The database used for this study is the Scottish workforce database of registered nurses in the NHS from 01st October 2000 to 30th September 2008. The Information Services Division (ISD) of the Health Department of the Scottish Government supplied the data. The data were supplied in various formats and required pre-processing to ensure accuracy. It does not include 'bank' nursing staff or external agency staff working on an ad hoc basis. The database included all registered nursing Grades from entry level – Whitley council Grade 'D' to most senior - Grade 'I' in both full-time and part-time employment. Part-time working is defined by the NHS as anything less than 30 hours worked per week (ISD, 2009). This data is presented in the graphs and tables in ten hour groups. As registered nursing Grades are an ordered category, it was appropriate to model all of the Grades simultaneously using Grade as the dependent variable with six ordinal categories, Grade 'D' (entry level registered nursing Grade) to Grade 'I'. Nursing promotions are a graduated system. While it is common for nurses re-entering the profession after a career break to re-enter at a lower Grade, reduced hours or both, promotion in general is an incremental process.

The reform of the NHS pay system, Agenda for Change, was agreed in December 2004 by the trade unions and employers and rolled out over the following years. This put nurses on bands between 2 (lowest pay) and 9 (highest pay). Unregistered nurses are employed in bands 2-4, with registered nurses (the subject of this paper) employed between bands 5-9. The system is built on the proposal of equal pay for work of equal

value. It applied to all staff across the UK who were employed directly by NHS organisations, except certain levels of senior management and medical staff. It was not fully implemented throughout the United Kingdom, NHS employees in England and Wales transferred to the new system and implementation occurred in the immediate period after the agreement, while the NHS in Scotland did not implement the system immediately. Whitley Council Grades coexisted with Agenda for Change during this period pending the appeals period. The small degree of differentiation had limited implications in terms of this research.

The information related to registered nurses whose children are now adults was not available. Those nurses with dependent children are categorised by the age of the children: 12-15 years old (sixteen being the earliest age a child can legally leave full-time education in Scotland), 5-11 years old (primary school period) and five years old and under (pre-primary school). Cross-sectional and longitudinal analysis by nursing Grade was undertaken using survival analysis, hazard functions and ordered probit logistic regression (proportional odds logistic regression) in order to provide a fuller understanding of gender, working hour differentials and causal inferences of school aged children upon career progression. The following section outlines the analysis applied.

5.4.2 Quantitative analysis

The statistical data was presented in two formats: descriptive and inferential. Descriptive analysis was used to summarise the numerical data and to graphically describe the data. Inferential analysis was used to note patterns within the data and try to account for variations and draw conclusions. The variables examined were assessed for statistical significant variations this section will explain the use applied, probability, Z-values (standard deviations) and odd-ratios.

A censored approach was applied to prevent bias in order to develop an understanding of differences in career progression (Rizvi, 1986). Kaplan-Meier Survival Analysis was used to test equivalence of survival across groups and to allow the survival curves to be plotted for different subgroups. The Cox Proportional Hazard Model Cox (1972) was used to ascertain the simultaneous impact of relative hazard on selected independent variables (continuous and categorical) on length of service and to

estimate the effect of a particular factor whilst controlling for the other factors. The Log-Rank test was used to examine whether subgroups have the same survival curves (Kleinbaum, 1995). The data was analysed using SPSS® version 17

The analysis examines the effect of each explanatory factor cumulatively. As registered nursing grades are an ordered category, it was appropriate to model all of the grades simultaneously using an ordered logistic regression (probit regression or proportional odds logistic regression). The data is laid out in terms of odd ratios for specific effects. These reflect the relative chance of an individual with particular characteristics - gender, working hours, dependent children and career breaks. The reference characteristics being compared with the reference that are greater than 1.0 indicates a greater chance of achieving the grade being considered, while those lower than 1.0 indicate a smaller chance. The further the odds ratio is from 1.0 (either higher or lower) the greater the effect. The desirability of the approach is based upon its clarity and level of understanding as factors that might increase or decrease the chance of career progression. Significant relationships between particular explanatory factors do not occur by chance (Pawitan, 2001).

Several other examinations were performed. Technically, a p-value of an experiment is a random variable defined over the sample of the experiment such that its distribution under the null hypothesis is uniform on the interval. Comparing the p-value to a significance level yields two results: either the null hypothesis is rejected, or the null hypothesis cannot be rejected at that significance level. The p-values are based on certain assumptions which are crucial to their correct interpretation. The lower the p-value, the less likely the result, assuming the null hypothesis, so the more "significant" the result, in the sense of statistical difference p-values of 0.05 or 0.01, corresponding to a 5% chance or 1% of an outcome that extreme, given the null hypothesis. The result of a test of significance is either 'statistically significant' or 'not statistically significant' (Cattell, 1965; Wholey, 1979). Z-tests are dimensionless quantity derived by subtracting the population mean from an individual raw result and then dividing the difference by the population standard deviation. The standard deviation is the difference between the measured or estimated values and the true values. The true value of the standard deviation is usually unknown and the use of the term standard error carries with it the idea that an estimate of this unknown quantity is

being used. It also carries with it the idea that it measures, not the standard deviation of the estimate itself, but the standard deviation of the error in the estimate, these can be very different (Asher, 1983; Fears *et al.* 1996). The standard formula:

$$z = \frac{x - \mu}{\sigma},$$

Where:

x is a raw score to be standardised.
μ is the mean of the population.
σ is the standard deviation of the population.

These test whether an independent variable has a statistically significant relationship with a dependant variable. It can be used in a great variety of different models including models for dichotomous variables and models for continuous variables. The concept of association was of particular importance to this research as quantitative analysis of the data set revealed significant variables in relation to gender. The data required further qualification Qualitative interviews provided the possibility to clarify and understand the specific characteristics of the issues and provided an opportunity to validate and verify them. The selection criteria and the interview processes applied require clarification and this will be discussed in the following section.

5.4.3 Qualitative research

This qualitative aspect of the research was designed to explore the various experiences of female registered nurses and to study the impact of gender perceptions on women's career progression. The qualitative methods relied primarily on in-depth interviews. Schutt (1996) and Flyvbjerg (2006) considered that interviews facilitated a greater understanding of the issues under consideration within context. The preparation of interview questions required consideration and planning. The questions were derived directly from the thematic framework in Table 5.2

Table 5.2 The Research framework

Debate, gaps questions, and issues in literature.	Key Issue	Research questions	Research design and approach
Parenthood - Waldfogel's (2004) argues the organisation of work and the practicalities of combining career and family responsibilities effect women's careers there is a 'family penalty'.	Do dependent children inhibit careers for men and women with children in registered nursing?	Does having children affect career progression?	Statistical analysis: Using ISD data base to ascertain the areas within Scotland where senior management has the numerical gender balance in nursing management relative to nursing overall and qualitative interviews.
Values - Legault, & Chasserio (2003) values and perception associated with gender inhibit careers. Griffith (2009): The relationship between professional values, principally commitment, working flexibility and professional knowledge and gender perceptions.	Individual choice and organisational values.	How do values operate in practice in nursing?	Qualitative examination: In-depth interviews.
Perceptions - Heilman *et al.* (2001, 2004): Gender stereotypes prevent women's' ascent up the organisational ladder. Heilman argued that gender stereotypes and the expectations they produce about both what women are like (description) and how they should behave (prescriptive) result in devaluation of their performance and denies and restricts career opportunities. Childcare has indirect effect – e.g. 'all women tarred with the same brush (will leave to have children or have children etc.)	Gender stereotypes and perceptions related to parenthood and motherhood.	How do gender perceptions impact on career progression and out-comes?	Qualitative examination: The areas with the greatest disparities will form the basis of the in-depth interviews.

Interview pre-testing ensured that the questions collected information which illuminated the issues under investigation and this issue will be discussed in the following sub-section alongside recruitment and piloting processes.

5.4.4 Qualitative data - Selection, recruitment and Pilots

The qualitative research is set within one Scottish health board. When selecting interviewees a quota method was utilised. This is a non-probability sampling method which ensures that specific groups are represented. This was the preferred basis of selection as opposed to random sampling which would not have ensured that the required groups were selected for interview (Cook & Campbell, 1979). Typical or average interviews are not always appropriate in providing informative data. Radical or atypical interviews can reveal detailed information due to their ability to examine in detail the dynamics of the issues under consideration (Halfpenny, 1982). It was

important to explore the under-lying issue rather than describe the phenomena under examination. It was appropriate to select an area and employees for the variety of experiences, movements and opportunities in relation to outcomes in registered nursing. The qualitative research involved the use of in-depth interviews and this group consisted of thirty-two female registered nurses with children and without children. They were employed in 'acute' nursing within a Scottish Health Board, aged between 25 to 60 years old and employed in registered grades 'D' to 'senior nurse manager'. They worked on a full-time or part-time basis, some, but not all, had taken career breaks.

The rationale for exclusively selecting women as opposed to a mixture of men and women is based on the need to identify and describe organisational, situational, and individual factors related to women with and without children. As men do not in general alter their work patterns to provide family care women would be able to convey the associations and determinations which affect their careers. This group through their direct experiences were able to identify current, historical, internal and external barriers to their careers. The interviewees' age range was selected because the statistics informed the research that in general 25 year olds were generally the earliest age group to have taken at least one career break or been promoted and 60 years was the latest age that nurses held these posts.

The setting was chosen because 'Acute' nursing is the largest numerical area of employment in registered nursing with the largest area of disciplinary specialties with a variety of careers. The Health Board selected is a major NHS employer in Scotland. This employer by virtue of its size has a considerable breadth of career movements, variety of working conditions and diversity of staff in relation to personal circumstances. These nurses were selected due to the extent and nature of their experiences acquired across different registered grades, employment conditions, nursing areas and their different family circumstances. Those interviewed had either worked whole-time continuously or had worked on various hours throughout their careers prior or had taken career breaks. Different backgrounds and experiences provided an opportunity to gain an insight in respect to influential factors related to gender perceptions and career progressions. The areas of examination were derived from the quantitative research and gaps within it. The following table describes the

details of the nurses interviewed; some of those nurses interviewed refused permission to have their details listed:

Table 5.3 Interviewees biographies

Nurse 'A'	A 43year old single woman with no children. She commenced employment with the NHS at seventeen attained registration at 24 years of age, subsequently gained post-graduate qualification. Employed continuously by the NHS exclusively on a full-time basis and has occupied all registered grades up to and including her current grade 'H' post.
Nurse 'D'	Commenced as a registered nurse in 1983 and worked on a full-time basis. On the birth of her first child she reduced her hours to 16 hours a week working exclusively at the weekend. After 9 months she completely ceased nursing for three years. Upon re-entry she has worked exclusively on the night-shift, this has allowed for greater ease in caring for her children.
Nurse 'F'	51 year old married woman with two children aged eighteen and sixteen years old respectively. She commenced employment with the NHS at eighteen. She has had two career breaks; the first occurred upon the birth of her first child and lasted twenty-four months. Prior to taking her break in service, she occupied a whole-time grade 'E' post and upon re-entry she returned as a grade 'D' on a part-time basis. During this period of part-time weekend working, she was promoted again to grade 'E' post. She took a second career break which lasted four years, upon return she again returned as a part-time grade 'D' nurse working on various levels of part-time hours.
Nurse 'P'	Is a 33 year old degree qualified registered nurse. She is unmarried with no children she is a grade 'G' registered nurse and is studying on a part-time basis for a PhD.
Nurse 'X'	Married with no children. In 2008 she was promoted to a grade 'H' equivalent post after seven years post qualification experience. Studied at a Scottish University prior to registration.
Nurse 'K'	Is a 56 year old grade 'E' registered nurse. Married with 3 children, 3 career breaks (taken after birth of each child) ceased working until children were of nursery/ school age. Her career breaks have lasted for three years on average. She has only ever worked on a part-time basis. She for many years worked at weekends or on night shifts due to the enhanced payments associated with these conditions and because this also fitted in with her family commitments
Senior nurse 'D'	48 years old, single Senior nurse manager with no children. After completing her nursing degree in England she has always worked on a full-time basis and has ambitions to complete advanced training and to attain post registration qualifications.
Nurse 'U'	Two girls aged ten and eight respectively. She took short maternity leaves, eight months off in total three months before and five months for the first child and six months before and five months for the second. She did not go part-time because of the income generated from her position as a senior post in nursing. The family employed a full-time nanny. Since the birth of her children she has always worked on a part-time basis and has worked on various hours, none of which has exceeded sixteen hours per week. Employed in various grades, currently a grade 'E'.
Nurse 'Y'	She left nursing upon marriage. After the birth of her children, began school, she re-entered nursing on a part-time basis working 12 hours a week. This career breaks cumulatively lasted the sixteen years upon re-entry into the profession she re-commenced as a grade 'D' nurse.
Nurse 'V'	Upon completing her training she worked as a grade 'D' and then as a grade 'E' nurse for five years. Upon the birth of her only child she ceased all employment for twelve years. Upon re-entry as a grade 'D' into the profession she has worked only on a part-time basis - twelve hours.
Nurse 'R'	After completing her graduate programme she was promoted rapidly and attained an 'H' grade before she was thirty. Has commenced a PhD on a part-time basis. No children.
Nurse 'W'	She described herself as coming from a working class background. After a two year sandwich course qualifying as a registered nurse in 2005, she was promoted into a grade 'E' post – three years ago. Married with no children.

Nurse 'I'	Originally she was turned down for nursing because she didn't have the relevant academic qualifications. However, she gained the relevant qualifications and commenced her nurse training. Two children aged between 11 and 18 years of age. Currently a grade 'E'.
Nurse 'Z'	Qualified as a registered nurse in 1982.After the birth of her first child she didn't work at all for five years. Re-entered registered nursing in 1995 as a grade 'D' on a full-time basis now a grade 'I' nurse.
Nurse 'N'	Degree gained at a Scottish University, four children – three boys and one daughter took three careers breaks. The first for one year, the second for three, the third for three years and the fourth for three year. During the gap period between career breaks she worked solely at the weekends on day shift or night shifts due to the enhanced payments associated with these conditions. This allowed her to look after the children during the week days. Upon re-entry she has continued to work on a part-time basis – 30 hours per weeks but reduced her grade on a voluntary basis.
Nurse 'Q'	Had Had children prior to entering nursing. After her children were adults she went to University to study nursing and became a grade 'D' registered nurse. Has occupied a number of different grades is currently a grade 'G'.
Nurse 'B'	She has been a registered nurse for 26years. She has 2 adult sons and two grandchildren. She was a single mother who worked on a full-time basis throughout her career and she was supported throughout this period by her late mother and father who assisted her in taking care of the children. Now remarried a grade 'H' nurse she is involved in caring for her grandchildren.
Nurse 'E'	She worked on a full-time as a registered nurse since qualification in 1975. No career breaks and now occupies a senior management position in nursing.
Nurse 'C'	She has 3 children two adult and one teenager. She completed her training in the military then commenced employment in the NHS where she has been a registered nurse for 23 years. Completed an Msc on a part-time basis and now occupies a senior position in nursing management.
Nurse 'Y'	Married with 2 daughters she commenced her nurse training 16 years ago. Upon the birth of her children, she took a complete break from nursing. Since her return she has never worked on a full-time basis as a grade 'D' nurse.
Nurse 'M'	She worked originally on a part-time basis for 6 years as a non-registered nurse. During this period she has two children. Upon the commencement of secondary school of the second child, she commenced her nursing training. Upon completion she began working as a full-time registered grade 'E' nurse.
Nurse 'J'	Commenced her nursing training in 1975 she has been married for 35 years and has 3 children and 2 grandchildren. She left the profession for a decade after the birth of her children and re-entered the profession on a part-time basis when her then youngest child commenced primary school. When her youngest child went to secondary school she went back to working on a full-time basis and was eventually promoted to a grade 'G' post.
Nurse 'S'	Began working as a registered nurse in 2000 as a grade 'D' nurse in a position she still occupies. She is 36 years old with no children.
Nurse 'H'	Married with adult sons. During her 23 year career she has had a cyclical career in terms of hours worked. She worked originally in a full-time basis then a part-time basis then back to a full-time basis. While she worked on a part-time basis she looked after her children then accessed further training. During the period she worked on a part-time basis she worked on average twenty hours per week. In 2002 she increased her hours to thirty hours per week then in 2006 she returned to whole-time working as a grade 'G' nurse.
Nurse 'T'	After her training as a registered nurse she expanded her career experience by working in various specialties and attaining post-registration qualifications. In a long-term relationship she has 2 children. 39 years old and currently a grade 'G' nurse.
Senior nurse 'C'	Began her nursing career graduating as an RGN followed by 2 years working as a Research Assistant. She has a partner and has no children.
Nurse 'G'	Attained registration in 2003. In 2007 reduced her hours by half and began working on a part-time basis - this was due to her commencing a PhD in nursing, She already possessed an undergraduate degree in health policy. Married – 31 years OLD.
Nurse 'L'	She commenced her NHS career by training as a psychiatric nurse. Upon her marriage she transferred to adult nursing. Both her children are adult and currently a grade 'G' nurse.

Nurse 'O'	Works as a grade 'E' nurse on a full-time permanent nightshift basis graduated with a degree in nursing from a Scottish University in 2007. She is married and has 2 school aged children but her career breaks have been restricted to maternity breaks.
Senior Nurse 'B'	Is married with no children and began her nursing career in 1979. She later moved into management roles where she obtained extensive experience in leading and developing the nursing profession. Currently a senior nurse manager.
Senior Nurse 'A'	26 years of management experience in nursing. Lives with partner and has no children.

Recruitment took place after liaising with NHS managers, nursing management and human resources. In the first instance the research structure and purpose was detailed to the senior managers via e-mail; face to face meetings then took place. Upon ethical approval advice was sought from these parties and personnel were then approached. Those invited to participate were approached by the researcher in writing – Appendix 2. Participation was entirely voluntary and those involved were fully informed of the purpose of the research. They then signed a formal consent form prior to the commencement of the interviews – Appendix 3.

Prior to the in-depth interviews, a pilot study took place with six interviewees. This pilot informed the researcher as to shortcomings and ambiguities in the questions and highlighted areas which required further consideration. The researcher realised after the first three interviews he was leading the interview as opposed to the interviewee, this was remedied by the sixth pilot. The importance of location and the time of the interview became apparent as a public location inhibited the interviewee and the timing was critical as after a night shift the interviewees were at times very tired. This process was highly beneficial, as they provided the researcher with meaningful and practical experiences for conducting interviews.

The findings produced by the quantitative analysis and refined by the piloting stage ensured that the questions as outlined in Appendix 4 were neither leading nor ambiguous. The interviews took the form of personal face-to-face interviews. Interviewees were invited to provide an account of their experiences. The interviewees were interviewed in their place of work and each interview was recorded and a full transcript of the discussion was produced. The researcher gave the interviewee the freedom and opportunity to expand on their opinions (Weinberg, 2002; Rubin & Rubin, 2005). It was important that the investigator presented coherent and easily understood questions that were consistent and developed knowledge from

the insight of the participants (Creswell, 1994). The use of pilots permitted the essential refining of this practice in context.

In designing the qualitative aspect of the research the aim was to ensure that the fieldwork explored and informed the research. If these processes were to be effective they could not be divorced from analysis and interpretation. It is this area that will be considered in the next section.

5.4.5 Qualitative data analysis

This sub-section will engage with the qualitative interpretation process applied, principally thematic analysis. This sub-selection will review the stages of this process and the rationale behind its application.

Hacker, (1986) and Jones (1993) observed that interviewees are often hesitant or unwilling to convey their personal opinions, as was the case here. A greater understanding was achieved through interpreting narratives contained within the interviewee's verbal communications. It was essential to go beyond what was being said; tone revealed more than what was said, it inferred meaning: *"the use of words teaches you their meaning"* (Bion, 1970: 152). The understanding of this was central to an understanding of the issues under examination. This afforded the opportunity to develop a deeper understanding of the issues. This facilitated an understanding of the interviewees' feelings and perceptions of the situation.

Patton (1987) and Coolican (1994) noted ethnographic thematic analysis identified themes and/or behaviour. Janesick (1994) and De Laine (2000) argued that it was possible and desirable to make inferences about individual experiences on the basis of their communications. The first step was to collect the data, these were audio taped and then transcribed. To begin the analysis, the transcripts were reread several times. Following this, each transcribed interview was highlighted and as different themes arose they were assigned a different colour to each theme. From the transcribed conversations, patterns of experiences can be listed. For example, all statements made regarding children were highlighted with the colour green and all statements relating to future changes that the nurses would like to see with regards to gender issues, were marked in turquoise and so on (Bernstein, 1983 (Hedrick *et al.* 1993). Similarities in the different women's accounts and issues became prominent and this was the basis

for the construct of the chapters. Having deconstructed and conceptualised the data in each transcription, it was easier to interpret and compare the experiences of the women interviewed.

The next step to a thematic analysis is to identify all data that relates to the already classified patterns. Interviews that fell under the specific pattern were identified and placed within the corresponding pattern. The next stage in the thematic analysis required is to combine and catalogue related patterns into sub-themes. Themes were defined as units derived from patterns such as conversation topics, vocabulary, recurring activities, meanings and feelings (Clarke, 1999; Hacking, 1999). Themes were identified by bringing together opinions and experiences, which often are meaningless when viewed alone. Themes that emerge from the interviewee's recollections were pieced together to form a comprehensive picture of their collective experience (Abbot, 1992, Chalmers, 1999).

When gathering sub-themes to obtain a comprehensive view of the information patterns emerge, when patterns emerged these were discussed directly with the interviewee. This was completed at the interview, the interviewer used the interviewees' comments to establish the next questions in the interview and this was incorporated into the theme analysis. The next step was to build a valid argument for choosing the themes. This was achieved by referring back to the literature. The interviewer gained information that allows inferences from the interview. Once the themes have been collected and the literature had been studied, the researcher formulated themes. When the literature was interwoven with the findings, the analysis that the interviewer constructs is the one presented. This robustness is not without its weaknesses the method potentially has an inbuilt bias exacerbated by its dependence on personal recollection which even with the most objective interviewee (Dey, 1993; Delanty, 1997). To overcome these reservations a clear route map was required to define the issues and avoid bias - appendix 5 provided a framework which linked individual profile to the issues under examination. This assisted in clarifying issues and provided an understanding of their occurrence and avoided false certainties in interpretation. The aim of this was to ensure the accuracy, validity and reliability of the findings and this issue will be discussed in the following section.

5.4.5 Accuracy, validity and reliability of findings

Analysis approaches were critically important to interpretations and findings within this thesis, but if these techniques were not accurate, valid or reliable the findings would be compromised. Therefore the accurate collation of data was essential to give confidence. To achieve validity, assumptions required to be challenged. For reliability to be achieved credibility and plausibility required to be attained.

Reduced accuracy, validity and reliability of statistics can be significant they can vary in their accuracy due to the method of compilation and therefore become misrepresentative and ambiguous. Statistical analysis can only be valid when the system applied satisfies the basic mathematical assumptions of the method (House, 1980). The misuse of statistics can produce subtle but serious errors in description and interpretation. They are subtle in that even experienced professionals at times make errors and serious in that interpretation can compromise the findings (Diamantopoulos & Schlegelmilch, 1997). Clarke (1999) and Long *et al.* (2004) considered that even when statistical analysis is correctly applied, the results could be difficult to interpret. McGuinness (1982) and Jones (1996) noted the statistical significance of a trend in the data, which measures the extent to which the trend could be caused by random variation in the sample, may not agree with an intuitive sense of its significance. To guarantee the accuracy, validity and reliability of these findings the data was requested in a raw format from the largest data base accessed worldwide. Logistical regressions were run by the researcher, ISD and the Scottish Government to ensured accuracy, reliability and validity. The interrogation of interpretations by the supervisory team ensured that interpretations were stringent and balanced (Bryman, 1988; Seale, 1999b).

Issues concerning accuracy, validity and reliability were not restricted to quantitative research methods. Qualitative interpretations required transparency, plausibility and persuasiveness. Yet in many ways there was no 'correct' interpretation of any qualitative data, as some interpretations are more plausible than others. Miles and Huberman (1994) and Madjar *et al.* (2002) were concerned with the quality, trustworthiness and authenticity of findings. Wolcott (1990); Maxwell (1992) and Mays and Pope (1995) were concerned with the accuracy of interpretation and believed that the ability to judge the research independently and objectively was

critical to this thesis. However, this was not a fool proof mechanism to address these concerns. Therefore substantive strategies required to be embedded within the validation process. The inclusion of extended quotations complemented interpretations and certified a 'validity check' between the data and the researcher's analysis and added the participant's 'voice' to the research (Bryson, 1983; Lear, 1998). To minimise bias, a careful analysis of comments and other non-verbal signals from the interviewees took place. Therefore to validate and verify this aspect of the research, supervisory team reviews and discussions were essential (Herriott & Firestone, 1983; Strauss & Corbin, 1990).

Although there may have been some concerns surrounding the validity of the conclusions which emerged from this study, this researcher attempted to validate and authenticate the findings in this analysis. The application of checks and balances in relation to the research design, and throughout the research process was designed to ensure as much as is possible objectivity in interpretation. Regardless of this, it is essential that the researcher's reflexivity is reviewed.

5.5 Researcher Reflexivity

This section shall explore issues of the researcher's positioning as a man investigating women's experiences in registered nursing. It will then review the assumptions underpinning the research and finally the personal experience of the researcher.

5.5.1 Positioning

There were many areas of consideration in relation to my position as a man investigating women's experience, particularly the contested theoretical debate concerning objectivity and gender centric bias.

Porter (1996) argued that research into women should be undertaken only by women. They argued that men do not have the knowledge of womanhood to engage in research on women and no man in touch with the feminine would attempt such research, because they would realise that it entails colonising the meanings and ideas that have been developed by and for women. This view argues that there is no place for men as researchers of women and furthers gender stereotypes. In other words being a man in a biological sense does not necessarily mean that one possesses

masculine tendencies and being a woman in a biological sense does not necessarily mean that one possesses stereotypical feminine tendencies. Further such an approach collapses the differences between women in terms of other factors such as class, sexuality, race and ethnicity. Is it appropriate for example for a white woman to conduct research on black women although both are women? Is it appropriate for a homosexual woman to conduct research with straight women? The argument here is not that there are no issues with male researchers exploring what are considered to be women's issues (and here note should be taken of the fact that while the majority of nurses are female there is also a small percentage of male nurses) but rather that researchers, whatever their positioning must take this into account in terms of how they interpret and present the findings of their research (Munro, 1999).

As nursing knowledge and skills were developed within a female frame of reference assumptions concerning women unique historical role do have validity. However, the foundation of the unique position does not support the epistemological assumption that only women can understand women's experience or that women have objective needs that men are incapable of recognising. Gecas and Schwalbe (1983) and Hoelter (1986) disputed the validity of this concept of 'group relativism' and the assumption that women's experiences constitute a different view of reality, an entirely different ontology or way of going about making sense of the world. They argued that the assertion of autonomy by women is counterproductive as it leads to the inability of members of one group to justifiably criticise the activities of others.

Critical subjectivity and reflexivity makes the processes understanding easier. I had never accepted the proposition that nursing was a 'soft' or a 'feminine' profession I was aware from my own upbringing that nursing while predominately female it ran counter in many ways to gender stereotypes – female nurses were 'tough'. Paradoxically this ran completely counter to public perceptions concerning the role of nurses, particularly female nurses. However, through my own personal experience I was aware the profession was 'female' but not 'feminine' in fact on many levels it was very 'masculine'. I was aware that this stoicism was the means to copying emotionally while providing care. I was also aware that 'caring' men tended to be perceived as aberrations within the profession, whereas women, particularly of a certain generation, were territorial about the profession in gender terms. While

women in general accepted that men are psychologically capable of care, reservations concerning 'suitability' were still prevalent.

I appreciate that this approach can be perceived unsympathetically I consider this more a reflection on the interpreter rather than the action. . As nursing organisational culture is multi-layered the issues that surface layers of visible symbols, artefacts and behaviours are underpinned by values which are, in turn, underpinned by basic assumptions about the nature of truth, reality, human relationships and so on. The latter are generally taken-for-granted, invisible and preconscious while their influence is profound it is not readily available to conscious reflection. Research has been significantly shaped by a male-dominated history while this has a contested legitimacy it still has implications. Notably, these factors may place researchers under pressure to adapt to established rules and norms in an attempt to legitimate their credibility. The research about women was shaped by framings of the world relative to gender assumptions.

Hermeneutic theory challenges the epistemological assumptions of separatist feminist arguments by asserting the ability of researchers to gain a full understanding of the experiences of their subjects, along with the phenomenological meanings that subjects give to those experiences (Coleman, 1988; Wilson, 1997; Grodsky & Pager, 2001). It argues that the disjuncture of male and female experience could be overcome by male researchers bracketing off their own personal biases and presumptions during research, so that they might be imbued with the undistorted experiences and phenomenological understandings of female practitioners (Cockburn, 1986; Dale, 1987; Witz, 1990).

The problem with such a position is that it cannot take into account the fact that all researchers come to the research arena encumbered with *"pre-understandings"* about the situation they are about to research, Stepping into the mind of the other, on the other's terms is simply not possible. Rafferty (1992) argued that hermeneutic understanding depends upon the interchange between two frames of reference or different cultural frames. This suggests that a man can gain only a partial understanding through a dialogue between his own cultural frame of reference and that of the female practitioners he is investigating. Rather than uncovering "authentic" female experience, a hermeneutic examination can lead to a fuller male interpretation

of female experience. The fuller appreciation that can be generated by hermeneutic dialogue is a considerable contribution to knowledge. Still, the gap generated by differences between male and female experience may be sufficiently large to preclude the development of adequate understanding on the part of male nursing researchers - hermeneutic research ameliorates the problem of male research, it does not solve it.

Regardless of this, the pervasiveness of gender norm did make some issues difficult to explore. These issues presented a challenge to this research of gender-related phenomena. I have no ready answers for escaping their potential circularity and the 'language traps' (Wittgenstein, 1953) into which they can lead us. More openly expressed reflexivity about assumptions and dilemmas, and more acknowledgement of the provisional understanding may at least make the edges of contentious territory clearer and available to be worked with. It is also valuable to interweave gender as a potential strand in more general analyses (Salter, 1998; McCaffrey, 2007), to complement, enrich and challenge more narrowly focused studies.

5.5.2 Qualification and Experience

The final argument I wish to address, involves personal qualifications and experiences. This addresses the assertion that the experience of the researcher should be central to the prosecution of the research.

The issue with accepting the proposition of understanding women's knowledge as unique and unknowable to men is that it slides into relativism which entails a rejection of the possibility of universally accepted criteria for the judgment of actions. I believe that the gender of a writer is significant but it is not the determinant. Understanding the circumstances makes possible a more discerning evaluation. The claim that certain of those circumstances are epistemologically significant, i.e. sex by no means implies that they are definitive, capable of bearing the entire burden of justification and evaluation. However, by claiming that the circumstances are not epistemologically definitive is quite different from claiming that they are of no epistemological consequence. Sex is one of a cluster of subjective factors which constitute received conceptions.

The logic of such a position for nursing research is that researchers are obliged to expose their experiences and theoretical assumptions to the gaze of the reader, a process known as reflexivity. As an experienced qualitative researcher I was aware of the ways in which self affects both research processes and outcomes, and the need to rigorously convey to readers of research accounts. By giving account to readers of an understanding of the circumstances as a male researcher I am able to make a more discerning evaluation of their research. Specifically, I am able to judge the degree to which my gender affected the nature of the research. As an experienced researcher, I drew upon my insight gained as a documentary film-maker to minimise inevitable inequalities in the research relationship by seeking out and taking seriously the opinions and experiences of their research subjects. Rather than deciding how the research should progress and what conclusions should emerge, the research process was one of dialogue between researchers and researched.

The lesson here for me as a male nursing researcher is one of humility. Justification for them carrying out research on female practitioners cannot be taken for granted; it needs to be earned. Male researchers should accept that, in all likelihood, the practitioners that they research will have considerably more knowledge, experience, and understanding of the craft of caring than they possess. This is not to obviate the possibility of critical research into practice. But if such an approach is adopted by a male researcher, to be at all persuasive his critique needs to be based on an appreciation of the authenticity of the experiences of his research subjects. The importance of experience requires me as a male nursing researcher, both to honestly reflect on and report the assumptions, experiences and circumstances that have influenced their research. There is a requirement to approach the research subjects with respect, accepting that in the entry into a predominantly female practice.

To summarise, if there is to be any justification for men presuming to research female practice and I will leave it to the arguments presented. First, they need to recognize their position of privilege, and women's corresponding position within a patriarchal society. Second, they are required to try to understand, and accept the validity of, women's experience. Third, given the cultural construction they need to recognise that, in nursing they have accumulated considerably cultural capital. These approaches were critical to developing a rounded analysis and were central to the

qualitative aspect of the research. This occurred within an ethical framework and the considerations which constructed this will be discussed in section 5.6

5.6 Ethical considerations

To facilitate research, acceptable ethics and ethical arrangements were critical. A failure to have these in place would have seriously affected access to the employees. Within this design there was a duty to meet ethical obligations to colleagues, Edinburgh Napier University, the NHS and the interviewees. The ethical obligations required understanding and respect. This translated in terms of the research to minimising any unnecessary personal or professional risk for everyone involved. It was also important to ensure that the interviewee was not compromised and that the research was non-exploitative and autonomous. The section will discuss these ethical considerations and the steps taken to satisfy these requirements.

5.6.1 Negotiating access

Gaining the co-operation of the institutional ISD was straightforward. An agreement in principle to provide access to data had been attained by the researcher prior to the commencement of the PhD programme. Despite the NHS undergoing an organisation review in the form of *'Agenda for Change'* the strong and trusting relationship built by the researcher with the data provider, both as a former employee and as an academic researcher, ensured that comprehensive and complete data access was gained. The formal request was required to be authorised by the Dean of Napier University Business School. This request had a number of stipulations which guaranteed confidentiality and security arrangements for the data. Once these guarantees were prepared and undertaken the data was released.

However, gaining qualitative access was not without its issues. To progress the qualitative aspect of the research, permission was required from the Associate Dean at Napier University Business School, the University's ethics committee and finally the NHS National Research Ethics Committees (NREC). The objective of these groups when considering a proposed study was to protect the rights, safety, dignity and well-being of all actual or potential participants (www.nres.npsa.nns.uk). It was incumbent upon the research not being, *"an intrusion into the life of the institution being studied* nor *should it disrupt routines for the institution and its members"* (Flick, 1998: 57). Thus gaining access, whilst not overly problematic, was time consuming this was due

to the time taken to prepare request submissions to and in awaiting to be interviewed by the Research Ethics Committee of the Health Board under examination. After approval was given, the process of recruitment commenced after all ethical considerations were examined.

5.6.2 Security and confidentiality of data

The data provided by ISD was extremely politically sensitive, it was essential to ensure the security and confidentiality of the data in line with Edinburgh Napier University's legal undertaking. These procedures were self administered by the researcher in consultation with the Director of Studies. This ensured that the integrity, confidentiality and security of the data were not compromised. The rights of the interviewees required the researcher to respect and uphold their statutory rights (European Convention on Human Rights, 1999 and the Freedom of Information Act, 2000). The researcher had a duty to the interviewees to avoid undue intrusion and to protect their privacy. This required sensitive material such as the name, location of work, age, grade of interviewees to remain confidential (Oliver, 2003; Israel & Hay, 2006). Williams (1996) and Sana (2000) stated that ethically any indicator of the interviewee's identity was also required to be kept completely confidential. The ethical conduct of the research required research questions to be framed clearly and transparently with the language used being straightforward and understandable to prevent misinterpretation. This maintained confidence and ensured that the conduct, management and administration of research were framed in a manner which was consistent with ethical principles. This ensured that the competency of the research process was not compromised (Furlong *et al.* 2000).

All interview material and transcripts were held at an agreed secure location and with consent of the interviewee they were tape-recorded and transcribed. The data was transcribed onto Edinburgh Napier University computers to ensure confidentiality in line with the Data Protection Act 1998. Personal data received was not divulged to any person whose name was not specified as a co-user of data nor used for any undeclared purpose. No data was available in a form which directly identifies individual data subjects or creates a risk of indirect identification or is covered by the intended use of data. The data was exclusively stored at Edinburgh Napier University Business School and will be destroyed on completion of the research programme

(including subsequent academic publications) to prevent any breach of confidentiality. Access to this data was restricted to the principal researcher and the supervisory team.

5.7 Summary

In this, chapter it was stated that this research utlised a mixed methods approach, investigating and identifying knowledge through both quantitative and qualitative observation and analysis. This method emerged from a philosophical approach underpinned by pragmatism. It was argued, that no analysis can reveal what someone 'really' thinks or feels because any truth is simply a construction. However, the value of these methods is in giving a voice to these feelings and experiences. This notwithstanding, it was also acknowledged that academic knowledge emerges through relentless, determined and thorough enquiry and it is dependent upon the construction of a robust research design. Within this research design, there was a distinction between quantitative and qualitative methods; quantitative methods primed a statistical analysis whilst qualitative techniques built upon them. If one mode of research had dominated, the interpretations would have been specialised and limited. Utilising a mixed method approach demonstrates the pragmatism and flexibility of the research, which is its greatest advantage. The following chapter examines the Scottish nursing workforce.

Chapter Six National Data - The Nursing Workforce

6.1 Introduction

This chapter is concerned with examining if the percentage representation of women decreases, the higher the grade in registered nursing. It will examine the composition of the national nursing workforce in terms of gender, grades and registered nursing. The data presented in this chapter is descriptive and its purpose is to establish the scale and pattern of gender differences in registered nursing in Scotland. It provides important contextualisation for the explanatory focus contained in Chapter 7.

6.2 The national nursing workforce

The NHS as the employer legally establishes the categories of staff who can be considered to be nurses. The following data relates to the nursing staff in post as at the 30 September 2008. Those included in this stage of examination are all nursing grades from non-registered nurses to senior nurse managers in both whole-time and part-time employment. Whole-time working in nursing is defined as 37.00 conditioned hours per week and part-time working is defined as hours less than 37.00 conditioned hours per week (NHS Circular HDL, 2006: 2). It does not include non-conditioned 'bank' nursing staff or external agency staff working on an *ad hoc* basis. The data related to clinical nurse managers who from 1 October 1993 transferred to senior management grades, is excluded. Though this reduced the level of available data, the level of reduction was negligible.

6.2.1 The gender composition of the nursing workforce

Table 6.1 illustrates the composition of the entire nursing workforce in gender terms.

Table 6.1 Gender composition of all nursing staff in Scotland

Nursing Staff	Male	Percentage	Female	Percentage	Total Percentage
Hospital	5866	10.77	48610	89.23	100.00
Community	609	6.33	9006	93.67	100.00
Other	167	1.94	8425	98.06	100.00
Total	6642	10.10	59139	89.90	100.00

(Information Services Division – NHS Annual Report 2008, Table E3, Scotland)

Nursing in Scotland was composed of 6,642 male nurses and 59,139 female nurses with women constituting 89.90% of the overall workforce. Men were most frequently employed in 'hospital' nursing. This observation is supported by tables 6.1 and 6.2.

Table 6.2 Gender composition of all whole-time nursing staff in Scotland

Nursing Staff	Male	Percentage	Female	Percentage	Total Percentage
Hospital	5238	16.94	25691	83.06	100.00
Community	549	12.13	3976	87.83	100.00
Other	111	17.37	528	82.63	100.00
Total	5898	16.34	30195	83.66	100.00

(Information Services Division – NHS Annual Report 2008, Table E3, Scotland)

From a male workforce of 6642 - 5898 were employed on a whole-time basis (88.80% of all male nurses) while of the 59139 female nurses, 30195 worked on a whole-time basis representing 51.06% of the entire female workforce. Men worked predominately on a whole-time base whilst their female colleagues are split evenly between whole-time and part-time working. When part-time working is examined, women's whole scale occupation in this type of employment is conspicuous as table 6.3 confirms.

Table 6.3 Gender composition of all part-time nursing staff in Scotland

Nursing staff	Male	Percentage	Female	Percentage	Total Percentage
Hospital	628	2.67	22919	97.33	100.00
Community	60	1.18	5030	98.82	100.00
Other	56	5.33	995	94.67	100.00
Total	744	2.51	28944	97.49	100.00

(Information Services Division – NHS Annual Report 2008, Table E3, Scotland)

This data reveals that the gender patterns altered relative to employment status. Women constituted 97.49% the part-time workforce: in essence, part-time working was female. Of the 744 men employed in part-time working 628 or 84.41% worked in the hospital environment. Male nurses were overwhelmingly employed on a whole-time basis in a hospital. Women were evenly employed in both part-time and whole-time posts. At this stage, the composition of the clusters in registered nurses will be examined.

6.2.2 The Scottish nursing workforce in terms of registration

The previous section observed the existence of an elementary gender pattern within nursing. To ascertain the nature of this upon registered nursing the composition of non-registered and registered nursing will be examined.

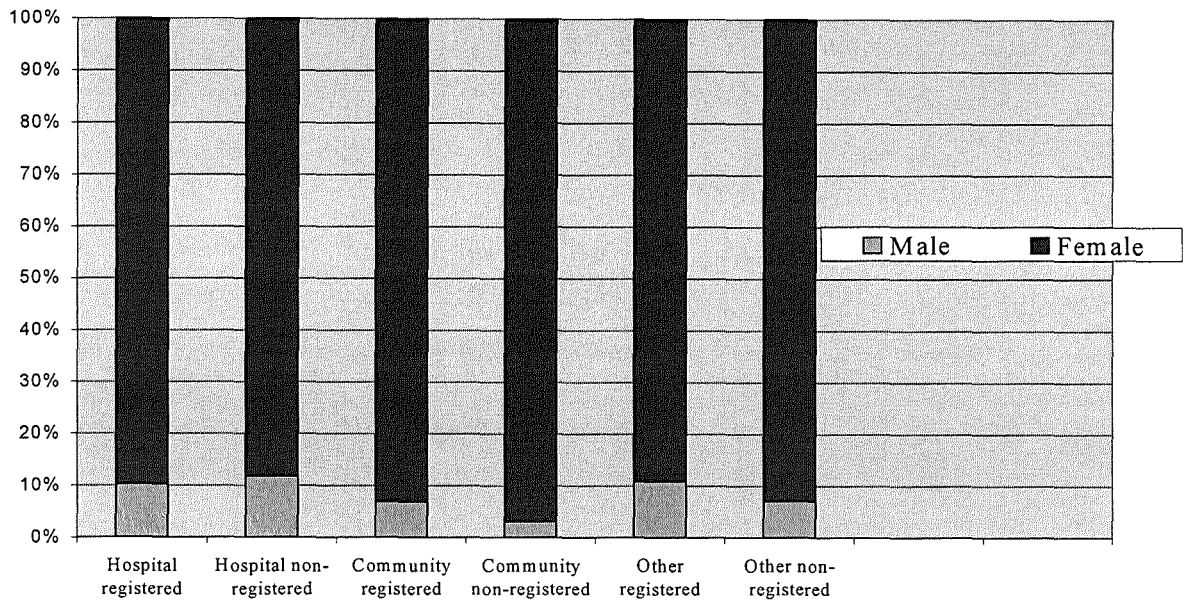
Table 6.4 Gender of registered and non-registered nurses in Scotland

Nursing staff	Male	Percentage	Female	Percentage	Total percentage
Hospital registered	3798	57.18	33165	56.08	100.00
Hospital non-reg	2068	31.14	15445	26.12	100.00
Community registered	570	8.58	7784	13.16	100.00
Community non-reg	39	0.59	1222	2.07	100.00
Other registered	138	2.08	1139	1.93	100.00
Other non-reg	29	0.43	384	0.64	100.00
Total	6642	10.10	59139	89.90	100.00

(Information Services Division – NHS Annual Report 2008, Table E3, Scotland)

These statistics revealed that 54,476 nurses were employed in hospitals of which 36,963 were registered nurses and out of these 33,165 were women. Women numerically dominated 'hospital' registered nursing as they did in all areas. Men were represented to their greatest extent also in this area – 88.32% of men were employed in 'hospital' nursing. The typical nurse, regardless of gender was a registered nurse working in a 'hospital' environment.

Graph 6.1 Gender of registered and non registered nurses in Scotland



(Information Services Division – NHS Annual Report 2008, Table E3, Scotland)

The graph on the previous page displays women's predominance of the profession. When the data is split into whole-time and part-time basis, the nature of the gender pattern becomes pronounced as table 6.5 demonstrates:

Table 6.5 Gender of whole-time registered and non-registered nurses

Whole – Time Nursing staff	Male	Percentage of male	Female	Percentage of female	Total percentage
Hospital registered	3560	15.46	19472	84.54	100.00
Hospital non-reg	1678	21.25	6219	78.75	100.00
Community registered	519	12.01	3801	87.99	100.00
Community non-reg	30	14.63	175	85.37	100.00
Other registered	100	18.35	445	81.65	100.00
Other non-reg	11	11.70	83	88.30	100.00
Total	5898	16.34	30195	83.66	100.00

(Information Services Division – NHS Annual Report 2008, Table E3, Scotland)

Men worked predominately on a whole-time basis. Of an overall male workforce of 6642 - 88.80% (5,898) was employed in whole-time in 'hospital' registered nursing. Whole-time 'hospital' registered nursing represented 60.36% while 'hospital' working nursing accounted for 88.81% of all men employed in whole-time nursing. However, the situation in respect to part-time working again exposes the gender polarisation in nursing employment as demonstrated by table 6.6:

Table 6.6 Gender of part-time registered and non-registered nurses

Part –Time Nursing staff	Male	Percentage of men	Female	Percentage of female	Total Percentage
Hospital registered	238	1.71	13693	98.29	100.00
Hospital non-reg	390	4.06	9226	95.94	100.00
Community registered	51	1.26	3983	98.74	100.00
Community non-reg	9	0.85	1047	99.15	100.00
Other registered	38	5.19	694	94.81	100.00
Other non-reg	18	5.64	301	94.36	100.00
Total	744	2.51	28944	97.49	100.00

(Information Services Division – NHS Annual Report 2008, Table E3, Scotland)

Women occupied the overwhelming majority of part-time registered nursing posts representing 97.49% of the nursing workforce. There was a clear relationship between women and part-time working. The relationship supports Fagan and Rubery (1996), Edward and Robinson (2001) and Yeandle *et al.* (2006) observation in relation to women's occupancy of part-time employment. This data highlights that part-time employment is predominantly occupied by women. This exposes potential gender differences men and women who choose to work in different areas because they see themselves as having a comparative disadvantage or advantage in their speciality, though it must be acknowledged this is not prescriptive. Certain areas offer fewer obstacles for family-friendly patterns of work. This data exposes that registered nursing is the major employment area within nursing and where gender, as a meaningful comparator of career progression and outcomes can be examined. Therefore the following section examines the composition of registered specialties.

6.3 Registered Nursing

The previous data observed that there was a correlation between gender and certain conditions of service within nursing. To ascertain the nature of this whole-time and part-time registered nursing, all registered grades up to and including senior nurse manager will be examined commencing with the national composition.

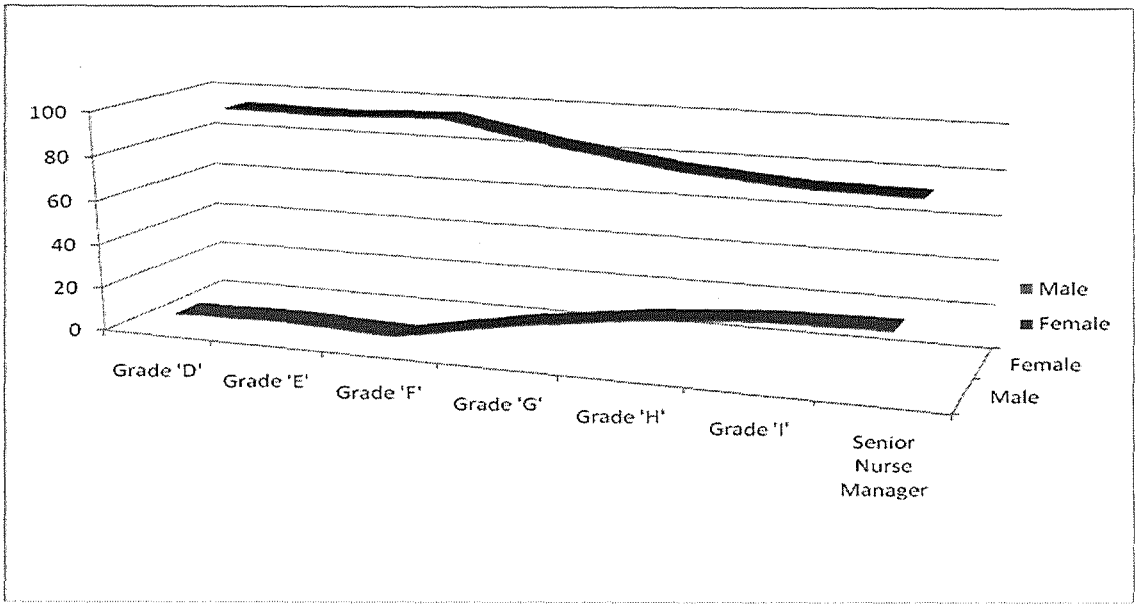
Table 6.7 Grading of registered nursing in Scotland by gender

Registered nurses	Male	Percentage of male	Female	Percentage of female	Total Percentage
Senior Nurse Manager	8	27.59	21	72.41	100.00
Grade 'I'	230	26.68	632	73.32	100.00
Grade 'H'	761	22.34	2646	77.66	100.00
Grade 'G'	1172	15.07	6603	84.93	100.00
Grade 'F'	60	5.35	1062	94.65	100.00
Grade 'E'	1206	7.29	15359	92.81	100.00
Grade 'D'	1069	6.35	15765	93.65	100.00
Total	4506	9.67	42088	90.33	100.00

(Information Services Division - data request)

Table 6.7 highlights differences between the male and female nurses in careers – male nurses were more likely to occupy a senior nursing grade. Male representation in the lowest registered nursing grade. Grade 'D' was only 6.35% in comparison to female colleagues but as the grades ascended in seniority, ultimately reaching senior nurse manager posts, men's proportion of occupancy reached 27.59% of the available posts. Women throughout the grades represented the numerical majority. However, the percentage of women occupying the post from grade 'G' gradually decreased while the ratio of men relative to the seniority of the position increased. Men were statistically found in greater proportions in 'G', 'H' and 'I' posts: the converse obtained in 'D', 'E' and 'F' grades. Statistically and numerically women occupied more 'E' grade than the grade 'D' grade posts. For men and women, a gradual redirection in their careers occurred at grade 'F'. The following graph demonstrates this occurrence:

Graph 6.2 Percentage of male and female registered nursing by grade in Scotland



(Information Services Division - data request)

The gender pattern that was present in registered nursing had a pronounced pattern – men's representation increased the greater the seniority of the position in nursing management, an upward 'arc' for men and a downward 'arc' for women. To ascertain the extent of this phenomenon, whole-time registered nursing requires examination and this area is reviewed in table 6.8:

Table 6.8 Whole-time registered nurses in Scotland

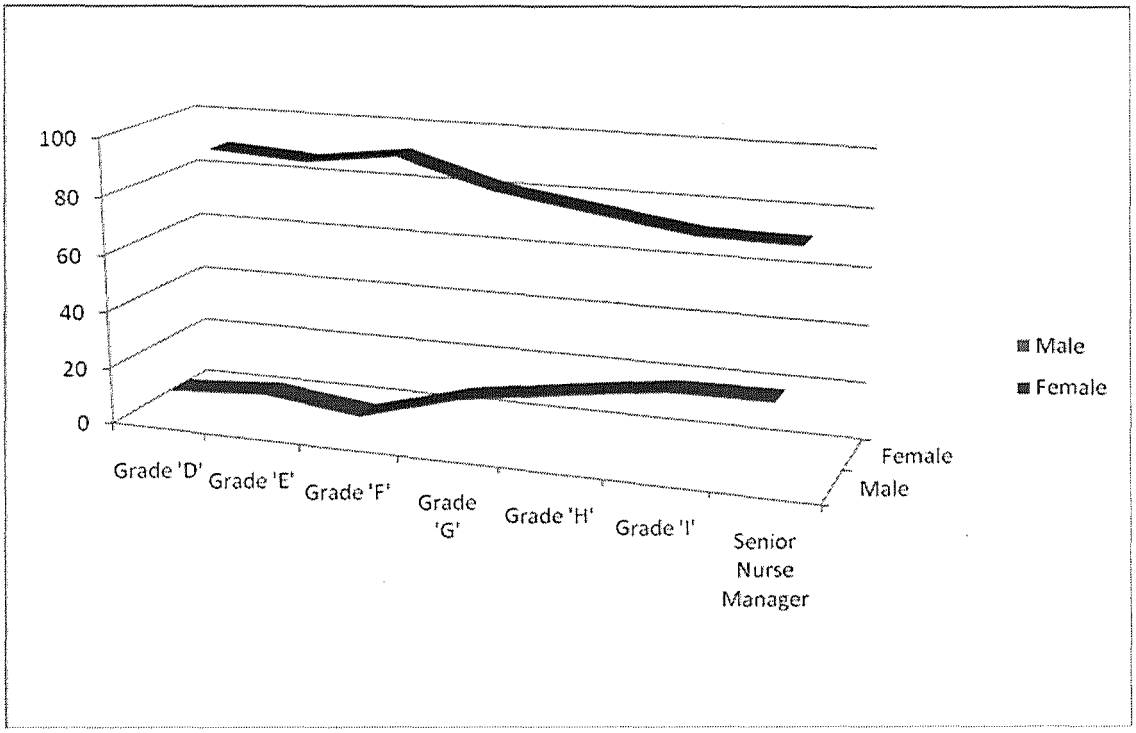
Registered nurses	Male	Percentage of male	Female	Percentage of female	Total Percentage
Senior Nurse Manager	8	28.57	20	71.43	100.00
Grade 'I'	230	28.15	587	71.85	100.00
Grade 'H'	759	23.36	2490	76.64	100.00
Grade 'G'	1138	18.27	5092	81.73	100.00
Grade 'F'	51	8.67	538	91.33	100.00
Grade 'E'	1141	12.77	7796	87.23	100.00
Grade 'D'	852	10.59	7195	89.41	100.00
Total	4179	14.98	23718	85.02	100.00

(Information Services Division - data request)

The data showed that 85.02 % of nurses in whole time employment were female and 14.98% were male. The percentage of male nurses from grades 'D' to 'I' increased disproportionately relative to their numeric size with the exception of the 'F' grade. The statistical data relating to senior nurse managers was difficult to analyse

comprehensively due to the relative smallness of the workforce under examination. Regardless of this, men's representation in whole-time working from grades 'G' to senior nurse managers markedly increased at a steeper rate than the entire workforce, as the following graph demonstrates:

Graph 6.3 Percentage of male and female whole-time registered nurses by grade in Scotland



(Information Services Division - data request)

For whole-time registered nurses, the pattern was clear in grade 'G' post with men emerging as a significant group. Male whole-time registered nurses had greater outcomes in occupying a grade 'H' post rather than a grade 'E' or 'F' post. In whole-time registered nursing, female nurses still occupied the majority of posts but the likelihood of them occupying the more senior grades in registered nursing gradually declined in comparison to men. To ascertain if this changed relative to condition of working part-time registered nursing requires examination.

Table 6.9 Part-time registered nurses in Scotland

Registered nurses	Male	Percentage of male	Female	Percentage of female	Total Percentage
Senior Nurse Manager	0	0.00	*	100	100.00
Grade 'I'	0	0.00	45	100	100.00
Grade 'H'	*	1.27	156	98.73	100.00
Grade 'G'	34	2.20	1511	97.80	100.00
Grade 'F'	9	1.70	524	98.31	100.00
Grade 'E'	65	0.85	7563	99.15	100.00
Grade 'D'	217	2.48	8570	97.52	100.00
Total	327	1.75	18370	98.25	100.00

* = less than five (Information Services Division - data request)

Though part-time working represents 39.29% of the registered workforce above 'G' grade, they represented only 7.87% of the entire registered workforce. In relation to part-time, nursing men were unlikely to be employed in part-time nursing positions and accordingly less likely to occupy the available senior positions in part-time nursing. Although men worked on a part-time basis - no senior nurse managers who worked on a part-time basis were men. Overall, there was a consistent pattern: whole-time male nurses had a greater likelihood in occupying a more senior post in registered nursing than their female colleagues. The likelihood of occupying a senior post was linked to working condition. Part-time nurses where underrepresented in highest grades in comparison to their whole-time colleagues. Registered nursing, due to its 'professional' status, is the critical arbiter in terms of careers. This would support Darton and Hurrell (2005) position of professionalisation and demonstrates the important relationship between whole-time working and senior positions in registered nursing.

6.4 Summary

This chapter establishes that though women still represented the numerical majority of all nurses, a gender pattern emerged which demonstrated a greater male prominence relative to their demographic size and working patterns were a condition of the likelihood in a nurse occupying a senior position in nursing. It is possible that men and women's occupation of certain disciplines, areas and working hours are facilitated by certain factors and these factors are not gender neutral but gender active. The research noted the following:

- While women numerically dominate the profession, men within registered nursing within the NHS in Scotland are relatively more successful than their female colleagues in attaining senior posts. The percentage representation of women decreased the higher the grade in registered nursing.

- Women were significantly more likely than men to be working on a part-time basis regardless of area. Men were more likely to work as a whole-time registered nurse.

- It established that part-time nurses had restricted progression opportunities in comparison to their whole-time colleagues in registered nursing.

- A career upward 'arc' emerged the representation of women decreased and men increased, the higher the grade in whole-time registered nursing and this decline was at its most acute in the more senior positions – grade 'H', 'I' and senior nurse manager, the anvil of this process was grade 'G'.

This chapter has examined an analysis of the workforce and noted differences in the positions of men and women in nursing grades in areas of concentration and working hours. However, as nursing is a complicated profession to analyse, certain areas and issues require further examination. Therefore, the next chapter will begin to explore factors which contribute to the differences outlined in this chapter.

Chapter Seven National data – Differences in career progression of male and female registered nurses

7.1 Introduction

This chapter will review career progression of female and male registered nurses. As nursing promotion in general is an incremental process career progression will be measured from a lower to the immediately higher grade. In the first instance, it will review the whole-time and part-time composition of registered nursing. Secondly it will examine gender and working hours then the impact of dependent children upon both sexes. Finally, the relationship between career breaks and careers will be considered.

7.2 Composition of workforce

Within table 7.1 there are small yet significant differences in the proportion of full-time registered nurses by sex and by dependent children according to nursing grade. While men only represented 14.97% in the full-time workforce they occupied 20.66% of the senior grades (grades 'G' to 'I'). Within the full-time grades men's representation in comparison to women incrementally increased in the higher grades, for example at grade 'G' they represented 18.27% of the workforce, at grade 'H', 23.36% and at grade 'I' 28.16%. There were no major percentage differences between 'G', 'H' and 'I' grade male registered nurses with children of a school age and those men without. This is consistent with the considerable literature identifying lack of disadvantage, or even advantage, that men with children have compared to men without. However, there were significant differences between grade 'H' and 'I' female registered nurses who were much less likely to have children 16 years of age or under than female colleagues on grades 'D', 'E', 'F' and 'G' grades. This may be a straightforward function of age – 25.57% of grade 'H' and 34.30% of grade 'I' female whole-time registered nurses were aged 50 or older, compared with 17.59% of grade 'D', 12.92% of grade 'E', 15.99% of grade 'F' and 16.98% of grade 'G' whole-time registered nurses (see appendix 11 & 12).

Table 7.1 Composition of full-time registered nurses with and without dependent children: Grades 'D'-'I'

Status	Grade 'D'		Grade 'E'		Grade 'F'		Grade 'G'		Grade 'H'		Grade 'I'	
	Women	Men	Women	Men	Women	Men	Women	Men	Women	Men	Women	Men
No children of school age (18027)	62.78% (4517)	73.94% (630)	60.93% (4753)	59.95% (684)	59.67% (321)	62.75% (32)	65.59% (3344)	63.80% (726)	77.11% (1920)	63.77% (484)	79.39% (466)	65.22% (150)
Youngest child 12-16 years of age (2894)	6.92% (498)	5.05% (43)	8.32% (649)	8.24% (94)	12.25% (66)	13.73% (7)	16.40% (835)	17.22% (196)	10.32% (257)	18.97% (144)	11.07% (65)	17.39% (40)
Youngest child 5-11 years of age (3547)	12.10% (870)	6.69% (57)	13.75% (1072)	12.88% (147)	16.03% (86)	13.73% (7)	14.81% (754)	14.06% (160)	9.00% (224)	13.57% (103)	6.47% (38)	12.61% (29)
Youngest child under 5 years of under (3401)	18.20% (1310)	14.42% (122)	17.00% (1322)	18.93% (216)	12.05% (65)	9.79% (5)	3.20% (159)	4.92% (56)	3.57% (89)	3.69% (28)	3.07% (18)	4.78% (11)
Total M (4171) W (23698)	100% (7195)	100% (852)	100% (7796)	100% (1141)	100% (538)	100% (51)	100% (5092)	100% (1138)	100% (2490)	100% (759)	100% (587)	100% (230)

Source: author from ISD data

When children are considered the percentage representation of women without children consistently increased incrementally from the lowest to the highest grade. In terms of grading the opposite was the case when the representation of women with children was considered. Representation of women with children incrementally decreased in the higher grades, the younger the child the lower their representation. Women with children, particularly those with children under twelve and under five years of age, were strongly represented in the lowest grades - grades 'D' and 'E'. Female 'F' grade registered nurses were less likely than male registered nurses to have children aged 12-16 years of age. When women without children are examined in comparison to their male equivalent at the senior grades (grades 'G' to 'I') they are represented at a greater level and at an even greater level than their female colleagues with children.

A consistent pattern emerged whereby full-time male workers had relatively more senior career positions in comparison to their full-time female colleagues, particularly in relation to the senior registered nursing posts (grade 'G' to 'I') (see appendix 11 & 12). When the age of the child was considered, men with dependent children under twelve and under five years were generally represented at greater levels than the equivalent female colleagues with the exception of grade 'G' women with children aged between 5 and 11. The higher the grade the less likely women are to have children of a school age, women who do not have children of a school age have a

greater likelihood in occupying higher graded posts than their colleagues with children of a school age. However, this does not convey the full extent of the impact of the family and children as they do not factor the data relating to nurses with dependent children who have completely left the discipline or work as a casual 'bank' nurse (i.e. women and men who have left nursing to look after children are not included in the data).

When the demographic characteristics of the staff in relation to dependent children is analysed a stark relationship between grading and gender emerges. Women with younger children were in general located in these grades, particularly the lowest grades 'D' and 'E'. This confirms that women with children under five years of age are more likely to be located in low paid and lower graded employments; while this is not a new finding the age of the child appears to be the critical arbiter. Moreover, it supports Ekin's (2007) position that once a child reaches secondary school age, around 12 years of age, women have more career 'flexibility' this is evidenced by their prevalence in the higher graded posts - 'G' to 'I' although this is also correlated with age and experience. When children reach twelve years of age there may well be some form of career 'catch up' for women. This career position may be linked to women's 'newly' undisturbed flexibility in relation to work. Hence having dependent children is important to women's career as is full-time working. Part-time working is equally important as is observable in table 7.2:

Table 7.2 Composition of part-time (under 30 hours per week) registered nurses with and without dependent children: Grades 'D'-'I'

Status	Grade 'D'		Grade 'E'		Grade 'F'		Grade 'G'		Grade 'H'		Grade 'I'	
	Women	Men	Women	Men	Women	Men	Women	Men	Women	Men	Women	Men
No Children of a school age (7314)	37.37% (3203)	46.08% (100)	39.49 % (2987)	66.14% (43)	40.84% (214)	66.67% (6)	40.83% (617)	76.47% (26)	48.08% (75)	100% (2)	91.11% (41)	100% (0)
Youngest child 12-16 years of age (3911)	20.57% (1763)	20.74% (45)	21.23 % (1606)	18.48% (12)	19.08% (100)	33.33% (3)	21.11% (319)	23.53% (8)	32.69% (51)	0.00 (0)	8.89% (4)	0.00 (0)
Youngest child 5-11 years of age (4217)	20.98% (1798)	22.91% (50)	23.99 % (1814)	15.38% (10)	27.67% (145)	0.00 (0)	24.75% (374)	0.00 (0)	17.22% (26)	0.00 (0)	0.00 (0)	0.00 (0)
Youngest child under 5 years of age (3254)	21.08% (1806)	10.27% (22)	15.29 % (1156)	0.00 (0)	12.41% (65)	0.00 (0)	13.31% (201)	0.00 (0)	2.01% (4)	0.00 (0)	0.00 (0)	0.00 (0)
Total W (18369) M (327)	100% (8570)	100% (217)	100% (7563)	100% (65)	100% (524)	100% (9)	100% (1511)	100% (34)	100% (156)	100% (2)	100% (45)	100% (0)

Source: author from ISD data

Table 7.2 reviews the proportion of female nursing staff working part-time by the age of their youngest child of a school age. While part-time registered nurses represent 40.15% of that workforce they only represented 14.51% of the senior grades in nursing. Men in general were concentrated in full-time registered nursing posts and underrepresented in part-time posts. They occupied 327 posts in a part-time workforce of 18696 and were not present in the senior grades. 98.25% of part-time nurses with school-aged children are women, 53.63% of all nurses worked on a part-time basis. Of those nurses, 88.58% worked in lower graded posts - Grade 'D' – 'E'. It is striking that the grade 'D' nursing had the greatest occupation by women with dependent children under five years of age but this was closely followed though at a slightly reduced level by the other two categories. In the higher graded grade 'E' posts women with children under five are significantly less prevalent than in the lower graded grade 'D' posts. There is a reduction of 36% between grade 'D' and grade 'E' this not consistent with the other two categories their representation actually increases for the under 12 years of age category by 1% and only reduces in the under 16 years of age category by less than 1%.

The significance in the table lies in the size of the female workforce with school aged children occupying the two lowest grades - 5367 (62.63% of 8570) at grades 'D' and 4576 (60.51% of 7563) at grade 'E'. This is in stark contrast to the 310 (59.17%) grade 'F' female nurses with children of a school age which is one fifteenth the size of the grade 'E' female registered nurses. The concentration of women with children of a school age is in the lower graded posts. The higher the grade the relatively fewer women with children of a school age are present, particularly those with children under five years of age. The scale and preponderance of women with children of a school age working in lower graded part-time registered nursing supports the position that women, parenthood or motherhood and low grades are connected. While the data provided did not differentiate between those nurses whose children are now adults it does show that senior registered nurses, grades 'H' and 'I' were much less likely than lower grades to have dependent children, especially children under 12 years of age. In grade 'I' no children under 12 years of age were present. This pattern reinforces the connection between career position and parenthood but it adds a new dimension, the higher the grade the older the child. As this data does not clarify those nurses without children who have other dependants, i.e. grandchildren or other family dependents,

principally older parents one can conjecture that if this data was available a different pattern may emerge which emphasises the even greater disadvantage women have in terms of career position. Regardless of this, a gender pattern emerges which demonstrates that the age of the child clearly impact on the career position of the woman.

It is this that possibly explains the accelerated position of men in comparison to women and men disproportionate representation in comparison to the numerical size in this workforce. When full-time and part-time equivalents are considered, women without children in full-time working out represented their male equivalents at the senior grades, however in part-time working; men without children out represented their female equivalent in all grades. The exact opposite is the case when the child is under 12 and under 5 years of age women representation is always greater than their male equivalents. This is not the case when the child is aged between 12 and 16 years of age; there is relative parity. Regardless of this, full-time working is the critical arbiter for both men and women's career positions, however for women this impact of the age of dependent children is an equally important factor. The part-time workforce is 98.25% female confirming that part-time working in nursing is currently *de-facto "women's work"* (Whittock *et al.* 2002). While this is an accurate statement on one level it is less clear on another; part-time working is clearly linked to lower graded posts and women with children. Their presence in such numbers and as a percentage of the workforce strongly supports Gregory and Connolly's (2008) position that the price of reconciling part-time working and families is paid by women in terms of their career position. It is women with children of all ages who work on a part-time basis work in the lower graded posts whether this is due to availability, personal choice or a mixture of both remains unclear; however what is the case is that they are concentrated within this area. It is not unreasonable to suggest that a major advantage of part-time employment was that it facilitated the combination of paid and unpaid work, particularly for women with children of a school age. This notwithstanding, within the data there is a relationship between full-time working and the occupation of senior registered nursing grades. Indeed only one senior nurse worked on a part-time basis. The prevalence of women with dependent children within senior positions in registered nursing incrementally decrease and the severity of this link is directly

related to the age of the child. The impact of this relationship is made transparently clear when gender and working hours is examined.

7.3 Gender and working hours

Over the period examined the survival functions indicates that there is a relationship between gender and hours worked and sustaining employment.

Table 7.3 Summary of Survival analysis for categorical demographic variables

Factor	Group	Median length of time in months	Relative Hazard (95% CI)	*P*	Relative Hazard controlling for other variables (95%CI)	*P* (controlling for other variables)
Male	Full-time	90	1.339 (1.073-1.671)	0.001[1]	1.170 (0.936-1.463)	0.1679[2]
Female	Full-time	53	0.538 (0.485-0.597)	0.001[1]	1.271 (1.048–1.542)	0.0148[2]
Male	Part-time	36	1.334 (1.158-1.536)	0.001[1]	1.370 (1.184–1.586)	0.001[2]
Female	Part-time	77	1.160 (0.948-1.420)	0.171[1]	1.097 (0.896-1.342)	0.3693[2]

[1] Log-Rank test for equality of distribution
[2] Wald Test

The reference characteristics being compared with the reference that are greater than 1.0 indicates a greater chance of achieving the grade being considered, while those lower than 1.0 indicate a smaller chance. The further the odds ratio is from 1.0 (either higher or lower) the greater the effect.

Men who worked on a full-time basis were the group of employees who stayed in post for the longest uninterrupted period. Women experienced more months of non full-time employment than their males colleagues. The median length of time in post for female full-time nurses is 53 months and for male nurses 90 months. The figure in relation to men is remarkable in as such that there is 96 months in the period under examination. Analysis of the data by full and part-time staff is unambiguous. The median length of time in post for part-time male nurses was 36 months, whereas it was 77 months for women. These findings confirm full-time men stay in post longer than any other group apart from female part-time nurses. This is interesting, the data suggests that once women enter part-time position they stay in these positions for a considerable period while full-time women are a third less likely than their full-time male colleagues.

Men and women are not comparable groups - men regardless of working hours have relative parallel horizontal trajectories, however this is not the case for women the hours worked clearly impact on length of time in post. The likelihood of a woman sustaining a career once gender, grade and hours were combined was lesser than male colleagues. Career progression is linked to working hours as the following table establishes:

Table 7.4 Odds ratio (95% confidence interval) of career progression - gender and employment type

Status	Grade D to Grade E	Grade E to Grade F	Grade F to Grade G	Grade G to Grade H	Grade H to Grade I
Gender (probability of female vs. male)	1.064 (0.976, 1.161)	0.72 (0.549, 0.946)	2.199 (1.675, 2.889)	1.000 (0.895, 1.118)	1.733 (1.451, 2.070)
Employment Type (part-time vs. full-time)	0.786 (0.752, 0.821)	1.026 (0.907, 1.161)	0.303 (0.266, 0.346)	0.208 (0.176, 0.247)	1.216 (0.865, 1.708)

The data is laid out in terms of odd ratios which reflect the relative chance of an individual with an attribute or particular characteristics progressing from a lower graded post to a higher graded post. The influence of particular explanatory factors is observed by comparing the odds ratios for men compared with women without the explanatory factor. If the odds ratio for men compared to women alters when the explanatory factor is included, it has agency in contributing to gender difference. Odds ratio values less than 1.0 suggest a protective effect while values greater than 1.0 suggests an adverse effect of exposure. If the odds ratio increases, then taking account of the explanatory factor reveals that the difference between men and women was greater than it initially appeared (Harrell, 2001).

Differences between men and women and part-time and full-time nurses are very apparent. This shows the likelihood of a male moving from Grade 'E' to Grade 'F' is less than three-quarters (0.72) that of a female. Being a male nurse is associated with enhanced progression at the higher grades particularly 'F' to 'G' (where males are over twice as likely as females to make this progression (2.199) and 'H' to 'I' (where males again are 1.733 more likely to move from Grade). For moves from Grade 'G' to Grade 'H' and 'D' to 'E' there is no significant gender difference. Part-timers are three-quarters (0.786) to move from Grade 'D' to 'E' less than a third (0.303) as likely to progress from Grade 'F' to Grade 'G' and a fifth (0.208) as likely to move

from Grade 'G' to Grade 'H' than a full-time nurse. For the other Grades ('E' to 'F' and 'H' to 'I') there is no significant difference at the 5% level. Overall, being a full-time man enhances your career position and your likelihood to progress within your career. Working on a part-time basis regardless of sex is detrimental to their career outcome. When length of time in post is brought to bear a noticeable picture of reduced career progression emerges for women and this is observable in table 7.5:

Table 7.5 Odds ratio (95% confidence interval) of progression - gender and employment type and length of time in post

Status	Grade D to Grade E	Grade E to Grade F	Grade F to Grade G	Grade G to Grade H	Grade H to Grade I
Gender (probability of female vs. male)	1.096 (1.004, 1.196)	0.779 (0.593, 1.023)	2.184 (1.662, 2.869)	1.066 (0.952, 1.193)	1.840 (1.536, 2.204)
Employment Type (part vs. full-time)	0.782 (0.748, 0.817)	0.960 (0.848, 1.087)	0.306 (0.268, 0.349)	0.197 (0.166, 0.234)	1.133 (0.805, 1.596)
Length of time in post (part vs. full-time)	1.025 (1.022, 1.027)	1.035 (1.028, 1.043)	0.994 (0.986, 1.003)	1.032 (1.026, 1.038)	1.022 (1.012, 1.033)

Males were more likely to progress from Grade 'D' to Grade 'E', 'F' to 'G' and 'H' to 'I' than female nurses. Part-time nurses were less likely to progress from Grade 'D' to Grade 'E', 'F' to 'G' and 'G' to 'H' than full-time nurses. Odds of progression increased with length of service for all grades except grade 'F' to grade 'G' (which was not significant). When length of time in post was considered the gender effect for progressing from Grade 'E' to Grade 'F' was non-significant. The association of part-time employment and reduced likelihood of progression was not significant for moves from grade 'E' to 'F'. This association is small but statistically significant at the 5% level. The odds ratio has been presented as a per year increase in age. The odds ratio for five-year increase required the raising of the estimates and confidence interval by the power of 5. i.e. 1.025 (1.022, 1.027) becomes 1.131 (1.115, 1.142). In testing the inclusion of square of length of service to allow for the possibility of non-linear effects of age it was marginally significant for some categories but the odds ratios were very close to 1.0.

The major findings are that part-time nurses are least likely to progress within nursing. Full-time males have significantly greater enhanced career progression in comparison to their female colleagues. When considering the quadratic component for length of time in post it is clear from these findings that female nurses progress more

slowly than male nurses having controlled for the effects of part-time working and length of service. The results found that continuous participation in the workforce offered a career advantages for men. Women had different outcomes whether this was related to dependent children will be examined in the following section.

7.4 Dependent children

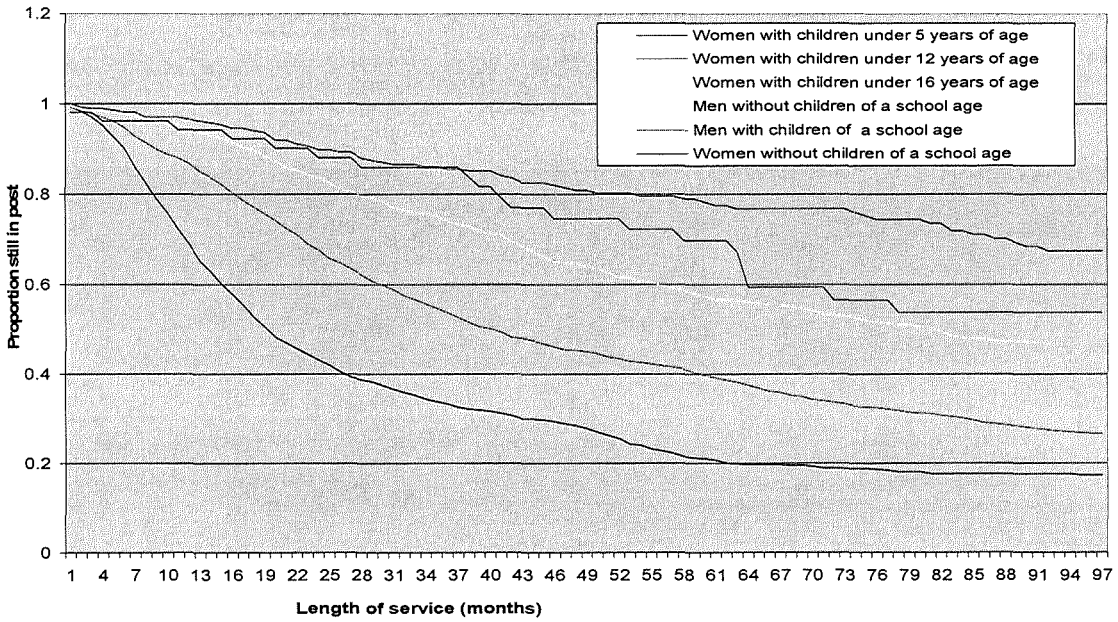
This section will examine the impact of dependent children upon a person's career progression. In the first instance an amalgamated variable group which is ordered as male (reference category) is created, female without dependent children and female with dependent children then by age grouping.

Table 7.6 Dependent Children

Dependent Children	No	Yes	
Female	22,449 (53.3%)	19,618 (46.6%)	42,067 (100%)
Male	2,868 (63.7%)	1,630 (36.2%)	4,498 (100%)

Female nurses tend to have more dependent children than male nurses (46.6% versus 36.2%). The number of male nurses is relatively small, so the influence of dependent child may not be so easily seen. Although given the degree of difference remaining, it may be of less importance to career outcomes than the explanatory factors that are directly considered. However, this is not the case for women - the survival curves (their length of service in nursing) of all nursing staff with and without school aged children are shown in Figure 7.3. Men with children are displayed as a single curve rather than individual curves by age of youngest child because they were indistinguishable on the graph.

Figure 7.3 Proportion of staff with and without dependant children



Women with children under five years of age did not sustain their employment at a comparable level to all other groups of nurses. Women with no dependent children who remained in the workforce during the period examined had significantly higher grades than women with young children, particularly compared to those with dependent children under five years of age. Men regardless of their circumstances were the least effected by children in terms of sustaining employment. Having school aged children is a major arbiter in relation to women maintaining their employment the younger the dependent child then the less likelihood of sustaining a career. The age of the child and the likelihood of sustaining a career are clearly linked, the younger the child the greater the inhibiting impact in terms of sustaining a career. This supports Paull's (2008) position that children have little impact on the career progression of men regardless of the hours worked but the hours worked by women has a material impact on their careers. Results from the proportional odds model convey the impact upon career progression (Table 7.7):

Table 7.7 Odds ratio (95% confidence interval) of progression - gender, employment type and presence of dependent children

Status	Grade D to Grade E	Grade E to Grade F	Grade F to Grade G	Grade G to Grade H	Grade H to Grade I
Employment Type (part-time vs. full-time)	0.786 (0.751, 0.822)	1.027 (0.905, 1.166)	1.130 (0.793, 1.273)	1.242 (0.881 1.753)	1.255 (0.888, 1.773)
Presence of dependent children (yes vs. no)	1.027 (0.982, 1.073)	0.986 (0.872, 1.116)	0.877 (0.768, 1.001)	0.845 (0.710, 1.006)	0.659 (0.602, 0.722)
Female nurses without children (vs. male nurses)	1.029 (0.907, 1.168)	1.377 (1.044, 1.816)	1.199 (0.875, 1.389)	1.389 (1.252, 1.540)	1.308 (1.099, 1.557)
Female nurses with children under 16 years of age(vs. male nurses)	0.950 (0.869, 1.038)	1.370 (1.033, 1.817)	1.054 (0.966, 1.15)	0.861 (0.774, 0.958)	0.819 (0.686, 0.979)
Female nurses with children under 12 years of age(vs. male nurses)	0.949 (0.867, 1.040)	0.781 (0.746, 0.817)	0.658 (0.517, 0.837)	0.504 (0.443, 0.573)	0.417 (0.314, 0.555
Female nurses with children under 5 years of age(vs. male nurses)	0.728 (0.554, 0.955)	0.510 (0.270, 0.655)	0.479 (0.363, 0.632)	0.310 (0.271, 0.355)	0.236 (0.198, 0.280)

It has already been established that working hours is important when analysing the effects of dependent children. The likelihood of progressing from Grade 'E' to Grade 'F' is higher for females than males (the same finding as in previous sections). The inverse of 1.37 is approximately 0.73 which was the odds ratio in previous sections (the reference category previously being women). At the higher grades, the likelihood of progression for women is lower compared to men, with women having dependent children more severely affected (i.e. the odds ratio for women with children of a school age < odds ratio for women without children of a school age < odds ratio for men). When dependent children are factored in women's career progression are restricted.

Having dependent children appears to be associated with lower likelihood of progression at the higher grades (e.g. from grade 'G' to grade 'H'). Once, gender differences have been taken into account, women with children of a school age are even more disadvantage compared to all other type of colleagues across all of the grading outcomes under consideration. The presence of dependent children is significantly associated with restricted career progressions, particularly at the highest

Grades (from Grade 'H' to 'I'). Women without children, in comparison to their female colleagues with dependent children, have greater career progression than their female colleagues with children. However, this is deceptive as female nurses with children under 16 years of age have virtually the same career opportunity at the lower graded post (Grade 'E' to 'G') as those nurses without dependent children. The converse is the case in relation to the higher graded posts (Grade 'H' and 'I') the differences in progression for women are incrementally increased when the age of the dependent child becomes younger. However, this is not significant when initial movement from grade 'D' to grade 'E' is considered for nurses with dependent children under 12 years of age, but this is an isolated case.

Not all levels of career movement for women are equally detrimentally affected by dependent children. The relative disadvantage is most pronounced for women with dependent children under 5 years of age and is particularly pronounced at the higher grades (Grade 'H' and 'I'). Women with children aged 12 to 16 years old had greater career progression than their female colleagues with children under 12 years of age but the group with the most reduced career progression were women with children under five years of age. The explanatory factor of the age of dependent children was highly important in terms of career outcomes. The age of the children significantly affects women's career outcomes and strongly suggests that dependents of a young age (under five years old) have a particularly inhibiting impact on women's career progression. This implies that the standard comparison between women with and women without children of a school age in nursing is inadequate as it underestimates the impact of young children on women's career progression. As previously stated this thesis does not consider the responsibilities connected to family and parenthood represented by older relatives and grandchildren it must acknowledged that these may have a significant impact on women's career position.

Regardless of this, it was clear that gender, the age of the child and the hours worked influence a person's opportunities in relation to career progression. It is evident that women with dependent children cannot be seen as a homogeneous group as within this group differences in their career progression are observed. A picture of changing disadvantage emerges for women, the younger the child the greater the relative disadvantage in terms of career position. At the higher grades, the likelihood of

progression for women is lower compared to men, with women having dependent children more severely affected (i.e. the odds ratios for women with children of a pre-school age < women without children of a school age < men). The group with the most reduced career progression were women with children under five years of age. Fatherhood had no discernibly negative impact on men; in fact notionally the opposite is true their career progression is enhanced as suggested in the literature (e.g. Paull, 2008). However, this is only notionally the case while men with dependent children had greater career progression than their male colleagues without dependent children the difference is so small as to be statistically insignificant.

This research vindicates Waldfogel's (2007) position that there is a *"family penalty"* ' for women in terms of their career progression but the evidence suggests that incremental disadvantage is experienced by women with younger children, particularly those with children under five years of age. Women's career positions are thus defined by two factors: the age of the children the age of the child; and the hours they work. Men's careers do not suffer a career disadvantage because they work predominately on a full-time basis and their career positions are not affected by extraneous factors, such as children. Herein lies the nub of the issue, full-time working and dependent children are the central relationship which define career positions but it is the inter-relationship between these factors which shapes career outcomes. As dependent children are still primarily cared for and nurtured by women the exchange between this and careers ultimately makes this issue a matter of gender. These penalties for women are virtually universal while their impact in the short and medium term is pronounced, however it casts an even longer term shadow on women's careers; one which the degree of career relative disadvantage in terms of position and progression becomes more pronounced when compared to men. It is conjecture but is not unreasonable to propose that the impact of parenthood on women's career progression would have been demonstrably greater if it had been possible to factor into these calculations those female nurses who work solely as a casual 'bank' nurse or care for 'other' dependents. There was a gender difference not just between men and women but critically between women without children of a school age and women with children of a school age and within this latter group a further disadvantage emerged in terms of career progression relative to the age of the

child. In terms of career trajectories, career breaks are a frequent occurrence within the profession and it this area that will be discussed in the following section.

7.5 Career Breaks

The previous section illustrated the significance that having dependent children has in relation to the career progression of men and women. As breaks in service would reasonably be considered to have an impact on career progression this section will consider these. The data relating to the employment status of career break practitioners was not easily available. It was very difficult to establish leaving and returning grade, conditions of service and personal circumstances of practitioners without manually reviewing the records. Therefore the material is related to, and presented in relation to gender. The following table outlines those who took a career break.

Table 7.8 Length of career breaks of registered nurses who took a career break

Length of longest break	All registered nursing grades	
	Women	Men
< 1 year	55.05%	69.97%
> 1 – 2 years	9.29%	12.81%
> 2 – 5 years	16.57%	9.13%
> 5 years	19.09%	8.09%
Total percentage	100.00%	100.00%
Number	16969	782

Women were more likely to take a break than their male colleagues. Women were also more likely to have taken a longer break; whilst 30.03% of men who had taken a break had done so for more than two years, compared with 44.95% of women. These lengths of breaks after one year incrementally decrease for men but incrementally increase for women. Men generally took only one break whilst women continued to take career breaks after their re-entry into nursing.

Table 7.9 Model showing odds ratios for taking career breaks: grade 'D' – 'I'

Cumulative breaks from nursing	Grade D to Grade E	Grade E to Grade F	Grade F to Grade G	Grade G to Grade H	Grade H to Grade I
Female < 1 year	1.00	0.98	0.98	0.97	0.96
Male < 1 year	1.76	1.95	2.01	2.84	3.40
Female > 1 – 2 years	0.98	0.92	0.84	0.66	0.58
Male > 1 – 2 year	1.89	2.09	1.75	1.97	2.31
Female > 2 – 5 years	0.86	0.77	0.88	0.55	0.34
Male > 2 – 5 years	1.64	1.75	1.22	1.02	1.01
Female > 5 years	0.72	0.63	0.59	0.33	0.21
Male > 5 years	1.87	1.81	0.00	0.00	0.00

The odds ratios for men compared with women in relation to career breaks were significant. A career break made no difference to men or women at grade 'D' which was the entry level for registered nurses. At grade 'E' it only had an impact after a break of greater than five years and this was the case in grade 'F' also. However, an entirely different situation occurred for men - their odds ratio increased incrementally with every career break. Once the effect of taking career breaks had been taken into account regardless of the circumstances, career breaks had a positive for men. When comparing these odds ratios it is apparent that career breaks are an important factor in gender career outcomes. The odds ratios were substantially reduced - women's opportunity of being in senior grades consistently declined. Taking a longer career break significantly decreased the likelihood of reaching any senior grade in registered nursing, a break of five years made the opportunity to attain an 'I' grade position negligible. For men career breaks had a positive impact on accessing grades 'G', 'H' and 'I' regardless of the length of break. However, the opposite was the case for women - their outcomes were particularly diminished in relation to 'H' and 'I' grades. Female registered nurses who had taken a career break were less likely than those who had not taken a break to reach any of the senior grades, whilst men were more likely to attain a senior position. There is sufficient evidence to suggest that career breaks have a negative impact on women's career progression and has limited impact on men's careers and this area is reviewed in table 7.10.

Table 7.10 Odds ratio (95% confidence interval) of progressing –after career breaks

Career Break	From Grade D to Grade E	From Grade E to Grade F	From Grade F to Grade G	From Grade G to Grade H	From Grade H to Grade I
Female nurses < 1 year (vs. male nurses)	2.019 (1.682, 2.423)	1.678 (1.396, 2.019)	1.019 (0.742, 1.149)	0.978 (0.893, 1.273)	0.995 (0.888, 1.170)
Female > 1 < 2 years (vs. male nurses)	1.161 (1.091, 1.257)	1.048 (0.960, 1.142)	0.932 (0.819, 0.980)	0.864 (0.721, 1.037)	0.804 (0.730, 0.886)
Female > 2 < 3 years (vs. male nurses)	0.786 (0.751, 0.822)	0.663 (0.625, 0.734)	0.504 (0.443, 0.573)	0.461 (0.374, 0.508)	0.419 (0.386, 0.479)
Female > 3 < 4 years (vs. male nurses)	0.558 (0.517, 0.637)	0.450 (0.409, 0.538)	0.417 (0.374, 0.455)	0.310 (0.271, 0.355)	0.236 (0.198, 0.280)
Female nurses >5 year (vs. male nurses)	0.427 (0.305, 0.466)	0.343 (0.296, 0.411)	0.243 (0.143, 0.259)	0.095 (0.029, 0.170)	0.023 (0.019, 0.094)

The cumulative effect of career breaks is detrimental to career progression across most grades, particularly the more senior grades. This detriment becomes pronounced after a break of more than two years. These nurses are less likely to move beyond the lowest grade – grade 'D'. This exploration of the influence of gender and career breaks on career progression is significant. Male registered nurses consistently occupied higher graded posts with a greater frequency than their female colleagues. The career progressions of female registered nurses are reduced in comparison to male registered nurses. It is important to note that the greater the cumulative break the less likelihood of career progression the exemption is when the break is less than two years however, these breaks are more favourable to men – men have greater likelihood of progression in all cases when compared to women. One could conjecture that the restrictions faced by women as observed in previous sections are either compounded or originate in the career breaks taken. Career breaks would point to a reduction of skills but the gender difference suggests this is not the case. It is possible that the men who take career breaks either work in private practice, similar employment or attained further training at a university or an equivalent while women are either completely or partially disengaged from their profession (for instance linked to childbirth and childcare). This would support Crompton's (1996) position in relation to the impact of the acquisition of human capital and its profound impact on career progression.

With greater data on individual circumstances there is the strong possibility that the analysis could have expanded. Regardless of this, the relationship between gender, career breaks and the length of career breaks demonstrates that men generally do not take as many career breaks, or for as long, as their female colleagues and that it is this does influence career progression. The impact of career breaks would support the position of Griffiths (2007), that women's career position is impacted by career breaks whilst male career outcomes are enhanced. It would not be unreasonable to suggest that a female nurse's accumulation of human capital is negatively affected by career breaks.

7.6 Discussion

These finding support Gregory and Connolly (2008) and Paull (2008) who argue that women's short and long-term career progression are detrimentally impacted by women's childcare responsibilities. However, this research suggests a more complex picture; women are not a generic group and their career progressions in general are incrementally reduced relative to the age of the child - the younger the age of the child the greater the relative disadvantage for the woman. It is the explanatory factor of the age of the dependent children which is critically important in terms of career progression for women. This supports Waldfogel's (2007) and McQuaid's (2009) position that there are *"penalties of motherhood"* for working women with children. However, this is a limited as the current research makes clear that some women with children are 'more' disadvantaged than others with children; there is an age penalty which is directly linked to the age of the child. Indeed, the standard comparator in relation to women's relative disadvantage in career progression does not fully convey the degree of disadvantage faced by women with children.

Employment continuity is crucial for income. Waldfogel (1999) argued that women with dependent children who avoided a career break were not disadvantaged in terms of income compared to women without dependent children. There seems to be two reasons, which *inter alia* could combine to produce this income penalty. First, women who take career breaks interrupt their accumulation of human capital and pay a penalty in terms of lower earnings (unless the career breaks is for work-related reasons, such as gaining an advanced degree). Second, women in nursing who take child-related career breaks might are not often be able to return to their former job or

grade. Dependent children are the major contributory factor both directly and indirectly to women's career outcomes, while parenthood had no discernibly negative impact on men. As women combine motherhood and employment, they face both penalties and costs, particularly if they have taken a career break and reduce their hours to take care of their children. Once the age of children is further broken down an even greater understanding of their reductive effect on career outcomes will be provided.

The research clearly suggests that the relative disadvantages experienced by women due to children during the phases of their career cannot be compensated for during the later stages of their working life. Children appear to have a lasting negative impact on income levels across women's entire career. The effect of this shadow on the future of women's career outcomes is an area requiring further research. It would also have been appropriate to include all dependents, particularly grandchildren and older relatives to facilitate a more complete and accurate assessment of women's career progression. However, these data are unavailable, so we cannot fully gauge the long-term impact of having had children, who are now grown up, as the evidence here suggests that having had children is likely to caste an even greater shadow over career outcomes. It would not be unreasonable to opinion that the effects of these dependents last throughout their entire careers of women and they would experience an even greater relative disadvantage in terms of their career outcomes once these are considered.

Gender appears to be indelibly linked to part-time working. The part-time workforce is 98.25% female in composition and the data show a career plateau for women in part-time nursing. Few jobs in nursing are available at the highest level, there are only 5.22% part-time Grade 'I' posts; whether this is through the preference of the workforce of the design of the management is unclear. However, the sheer numbers of full-time higher graded posts in comparison to the dearth of senior posts at a part-time level suggests a preference by the NHS for full-time workers as opposed to part-time workers at a senior level. This supports Ginn and Sandell's (1997) view that the full-time model of continuous working with progressive upward mobility is the preferred model in nursing. Children are a critical factor for women in part-time nursing, in particular in the lower graded registered posts. Part-time working is indicative of a

division between different nursing groups, notably women with and without school aged children and amongst subgroups. There is a relationship between children, parenthood, working patterns and career outcomes. The majority of female registered nurses generally worked in full-time employment, but once children were factored into the registered grades, regardless of condition of service, children were detrimental to women's career outcomes, however the younger the child the greater the impact. The cumulative consequence of this suggests that part-time working restricts staff in developing their careers.

There is a tangible "child penalty" for women, which does not exist for men. This penalty is most pronounced the younger the child, particularly those with children under five years of age. When this is combined with part-time working, women in general and those with dependent children in particular have difficulties in sustaining or fully developing their careers in comparison to their male colleagues. This is a major contributory factor both directly and indirectly to women's short-term career progression and long-term career outcomes. As women combine motherhood and employment, they face both penalties and costs, particularly if they have taken a career break and reduce their hours to take care of their children. Dependent children cannot be examined in isolation as women frequently have more than one child. It is not unreasonable to opinion that the impact of having a number of children would be even more detrimental and have a more sustained impact on the career outcomes of women. It would exacerbate the complex relationship and interactions between all of the factors examined. As dependent children are still primarily cared for and nurtured by women the exchange between this and careers ultimately makes this issue a matter of gender. These penalties for women are virtually universal while their impact in the short and medium term is pronounced, however it casts an even longer term shadow on women's careers; one which the degree of career relative disadvantage in terms of position and progression becomes more pronounced when compared to men. It is conjecture but is not unreasonable to propose that the impact of motherhood is the key detriment on women's career progressions.

These factors do not operate in isolation, there are complex relationships and interactions which are symbiotic in nature but which cumulatively and adversely

affects the career progression of all women, regardless of personal and professional circumstances.

7.7 Summary

The key findings are that dependent children have a regressively detrimental impact on women's career progression and that the younger the age of the child the greater the reductive effect. Career progressions are indelibly linked to gender and the hours worked by the individual initially and throughout their careers. Career breaks were linked to this. The findings can be summarised as follows:

- The career progression of female registered nurses with dependent children of a school age is lower in comparison to male registered nurses with or without children and female registered nurses without children.

- The age of the child has a major impact of women with dependent children career progression; the younger the child the greater the inhibiting factor. This factor incrementally increases the younger the age of the child.

- Part-time working has a negative effect on career outcomes regardless of gender or parental circumstances.

- The length and frequency of career breaks has an impact on career progression; particularly breaks greater than two years cumulatively have a particularly debilitating impact on women's career progression but has no discernable negative impact on their male colleagues.

There is a complex relationship between gender and career progression it is this along with many others issues that will be examined in the following chapter.

Chapter eight - Understanding the Voices

Women are more demanding on other women than any man. If one of the girls says, 'my child's ill' then I'm thinking 'Why?' Nurse 'I'.

8.1 Introduction

There are three major sections in this chapter which address three central areas established in Chapter 7, the role of children, part-time working and career breaks. These are followed by a discussion in which the material from the interviewees is related to the literature and professional values in relation to work. The chapter finishes with a discussion of these issues. At this juncture, it is important to note that the written transcripts fail to convey the force and the degree to which these sentiments are held by those thirty-two nurses interviewed. Many of these statements are applicable to several aspects of the findings due to the strong inter-connections between these complex issues.

8.2 Children First

It became very apparent from the interviews that regardless of the age, class or ethnicity of those interviewed there were powerful, dominant perceptions. These were that nursing is a nurturing profession; however the fundamental role of women was as mother and nurturer to their children and family with employment being secondary to this but equally powerful.

This perception has considerable agency within nursing and, of those women interviewed, there were very fixed views on the role of women in relation to the family and their employment in nursing. Nurse 'Q' a senior nurse with several adult children reflected the consensus of those interviewed when she stated, *"I actually think, I'm a bit old fashioned here and people might find me a bit of a contradiction but I actually think it's a woman's responsibility to look after their children"*. This view was particularly fixed in relation to young children under five years old. Nurse JP stated that *"if children are at pre-school the mother's time is limited"*. This was a telling statement frequently repeated, one which clearly linked the woman with the nurture and care of children. The potency of these perceptions as stated previously occurred regardless of the age of the women and an area where this was most evident was with nurses under 35. In this regard when Nurse 'X' was asked what nurses of

her age were intending to do with their career in five years time she stated, *"We go and have babies"*.

However when the subject of employment versus work-life balance was raised those interviewed in general emphasised the latter at the expense of the former. This exposed a critical contradiction with nursing culture. There was an orthodox belief that women's central responsibility, was to the family but when this directly clashed with the supremacy of the profession, *"the jobs must always come first"* (Nurse 'F') the starkness of this apparently irreconcilable position was highlighted. As the comments of nurse 'Q' exposed, *"I'm not personally saying nurses with children of a school age should sacrifice their careers but they have choices – it is one or the other"*. She added, *"Nursing's duty is towards the patients, nurses have no 'divine' rights – the profession isn't run for the benefit of nurses at the expense of patients"*. Their inability to reconcile these diverse viewpoints exposed hostility between women with children of a school age and those without. Surprisingly there was 'soft' hostility between women with young children and women with older or adult children. The lack of sympathy was highlighted in Nurse 'D' who commented that she was *"unwilling to support another women life style choice"*. The central contradiction between the importance subscribed to the family and the significance attached to nursing was exposed by nurse 'B's remarks, *"Nursing as a profession is 'conscious' of the demands that young children present, nurses in my opinion with young children are not 'really' suitable staff. Not because the value of their work is less but they are compromised by their family commitment"*.

These were significant remarks which exposed a paradox at the heart of the profession. This paradox pertained to a profession with a public persona intrinsically linked to caring, which simultaneously 'promotes' traditional family roles whilst rejecting certain aspects when they impinge on the profession. Often the remarks exposed a powerful perception which had agency within the profession regardless of age, experience or circumstances of those interviewed. A conformity of belief emerged concerning these issues, as the following comments demonstrate:

Children should always come first, nursing and children is like juggling, fine when you keep all the balls are in the air. However, if I had to choose between two people for a job with identical skills, one a man or an older woman, against a woman with young children or a younger woman, I'd go for the one without the outside commitments .... (Short pause) This is not just about the having of children but the potential to!

There appeared to be an even greater bias amongst those interviewed against nurses with 'younger' children (under five years old), Nurse 'E' a senior nurse manager with twenty-five years of experience tellingly said, *"These nurses forget their responsibilities – its greed not need."* She added that, *"Everything is focused on the under five's and my children now are not under five, not that it helped me any when they were, and now I'm thinking it's easy when they're under five - nurseries are very available."* These comments were repeated on several occasions by several nurses though none were under-forty years of age. Nurse 'K' was a very experienced nurse in her late fifties but this view was not isolated it predominated irrespective of circumstances. Nurse 'A' in her mid-forties, a professed 'career nurse' with no children stated ardently:

I avoid employing nurses with young children on a full-time basis. If I could avoid using them in any nursing post I would. It is just not practical - even on a part-time basis it's difficult. It's virtually impossible on a full-time basis. I, like many others in nursing, simply find ways not to employ them within my ward. The interview is still a wonderful medium for selection.

The extent and scale of this was revealed by the comments of nurse 'P' who was in her early thirties and had experienced accelerated and rapid promotion, *"If you were talking about someone just married or young enough to have children or who talks about having children quite a lot then, you would have to think about that. It's really got nothing to do with the children it's the hazard of them".* After being prompted she qualified this statement, *"If you promoted them, then a year down the line or even less they end up pregnant and they then take a year out, well.....(long pause), if we can cope without them for a year we can cope without them for good."* The latter sentence of the previous statement suggested that women in nursing discriminated against other women who were of child bearing age and that the interview process was a conduit to

facilitating this practice. On further examination this appeared to be a frequent experience amongst nurses. Nurse 'H' recollected:

> *I remember being turned down for 'G' post twenty years ago when I was in my twenties, I was later told informally by a member of the interview panel that it was because they were sure I would have babies in the near future... (Short pause) I don't know if she was just saying this to make me feel better but having children has always affected (a) women's career, they still do.*

The extent of this experience was common even amongst nurses in their late thirties but there was a resentment of this prejudice and its prevalence and propagation by women against other women. Nurses 'B' stated, "*The worst aspect of this is that in practice a woman carries the burden. What is unacceptable is that it is women who do this to other women.*" There was strong evidence that women were more hostile to each other than male colleagues in respect to children. Nurse 'T' who had children encapsulated these sentiments:

> *I am harder than my male colleagues would be because I've been there, I've wrestled with the conflicting demands of the family and the home and I feel let down if women don't anticipate the difficulties and if they had anticipated them, we could have solved that problem together rather than been in a situation where the profession had been let down. So in that respect I think I'm tougher but it also makes the antennae pretty sensitive and it now makes me anticipate a bit further so on my check list I think, Ah, I'd better ask so and so some 'what if' questions and had you better have a fallback position in place. So I've learnt the hard way as well.*

The hostility that women with children under-five encountered was even more pronounced. The following statement demonstrates this and exposes the different approaches of men and women. Nurse 'I' was a senior nurse with a considerable breadth and depth of management experience yet she was unremitting in her expectations:

> *I think we all accept and if you talked to my colleagues they would say to you as they've said to me, that the men at this hospital are extraordinarily understanding about women's family situation. By the same token I as a*

woman and as a nurse have less sympathy with that because the needs of young children can be predicted and anticipated.

There was a difference of opinion and emphasis amongst those interviewed whether this was a direct product of gender or a product of the organisational culture in which nursing operated. Nurse 'O' argued that it was predominately cultural but acknowledged that values related to gender were intrinsically a part of this culture, "*There are many dinosaur attitudes in nursing they are not just attached to gender roles. Where these attitudes do exist they do impact on women's careers.*" She added:

> *Too many talented female nurses do not achieve their potential because of the discrimination these attitudes encourage. Nursing is a schizophrenic - professionally progressive in relation to care, conservative in practice. To attain any meaningful career progression a nurse must conform to certain orthodox values and traditional beliefs, it's' probably no different to a lot of other professions. It's like a religion and like most religion(s) they don't like deviation.*

This was supported by nurse 'G' in her mid-thirties who reflected upon this situation, "*On paper the nursing profession looks great and is superficially making great strides towards beneficial change. In practice it is a different story its values in relation to the perceived role of women are like something out of the Old Testament.*" Nurse 'J', a nurse due to retire, noted that "*Nursing values are conservative there is a reluctance to change. In my thirty years in nursing it hasn't changed one iota. The pervasiveness of these values changes people not the other way about.*" Nurse 'R' offered an insight and explanation of how this situation emerged:

> *There is a conflict within nursing - it is still rooted in the medical model with outdated attitudes and a reluctance to change. For newly qualified nurses who are still unsure of their capabilities and perhaps lacking in some experience, there is a need to make a good impression and "fit in". Newly qualified nurses allow themselves to be changed by the culture of the ward and nursing as it is, rather than endeavouring to evoke the changes learned during the 3 years training.*

Nurse 'P' elaborated further, *"instead of using their enthusiasm to help promote positive change, the need to be accepted overrides this and they allow themselves to be "sucked in" to the ward politics and outdated attitudes."* She stated that this had greater agency than *"stress, the need for 24/7, real costs, staffing problems and patient's expectations"*. She further stated that she found:

> *Those nurses who have been a long time on the job and who are just biding their time until retirement are not really interested in change and it frightens them. Therefore, they underhandedly or subconsciously work towards keeping the status quo. I've seen newly qualified nurses being bullied into submission and told to keep their new ideas to themselves. Or, they argue for keeping their old ways and then make life difficult for the newly qualified nurse. In the end, beaten down or fed up fighting against the river, the newly qualified nurse falls into line and the ward stays as it always has been. So instead of affecting the culture, the culture affects them.*

These statements suggested that those nurses interviewed were resistant to change and possibly nursing culture was in general apprehensive of change. Nurse 'T' considered that, "*Women can fall back on traditional roles as an excuse because perhaps they're afraid to face the challenges of working life and society*". There was an alternative explanation as to why the *status quo* went unchallenged; these were the economic and financial needs to be in employment. Nurse 'E' stated, "*I'm not going to fall back on excuses. It's all about money at the end of the day people need to work. Fresh air doesn't pay the bills. Nursing needs a major shake-up and not just on paper."*

The potential conflict between staff with young children and other staff in different circumstances was highlighted during holiday periods, particularly Christmas. Nurse 'Y' crystallised these sentiments, "*Sometimes when it was Christmas time and off duty came on and you would get these mothers who have got children and they just expected 'we should get Christmas off because we have got young children.'*" She added, *"People forgot that even though there is a girl that is single she has still got a family and she is entitled to get Christmas off."* It could be argued that this was a product of organisational pressures but fundamentally the personal had greater agency than the professional and the locus of this dispute was not limited to young children but extended to all children, Nurse 'K' supported this position, "*You have got*

somebody whose family has grown up; they have still got a family so they are entitled to have it off. You come into the job you know the conditions of the job you have got to work these hours you have got to work these shifts." However her following remark conveyed a frequently held sentiment that nurses were often unwilling to support other nurses, "*You know (you) have just got to adapt round these situations. Every nurse' has to.... (Slight pause) it's expected.... (Slight pause) it makes the place function, that the job you sign up for!"* As stated previously as much as there was strong support for these sentiments amongst many of those interviewed, Senior Nurse Manager 'C' eloquently conveyed the actualities, sentiments and outcomes of this process:

> *When you've created work to suit child-rearing regimes and still the person concerned is not performing their duties, it's something you have to take on. I've always managed to resolve it but it can be pretty difficult particularly with the women who are in more senior posts, you can't just leave it, you are representing the service. In one case we tried to make sure that she didn't have a lot of evening shifts, the closest male colleague and I would take the evening meetings because she had a young family and this happened for a considerable period. When her circumstances changed she was still pretty reluctant to do any evening work, this caused a lot of resentment - it was grossly unfair on her colleagues.*

From those nurses interviewed they had contradicting views which existed simultaneously. There was a conflict in the value those interviewed ascribed to the priority given to the family and children and the importance ascribed to the profession. A central issue was the hostility to the needs of female nurses with young children. This group were seen to be personally and professionally compromised by these responsibilities. There appeared to be a belief which held the 'profession' as paramount and personal circumstances subservient to its needs. These findings support Wajcman's (1998) position that the exchange between personal needs and organisational culture is significant in affecting career progression. However, these are tied to gender stereotypic norms, as Heilman *et al.* (2004) notes these dictate the ways in which women should behave, and the disapproval and approbation women experience for violating these "shoulds". Reactions to actual violations of prescribed

behaviours are conspicuous amongst many of those interviewed, grounded in acceptance of perceptions associated with women's role in relation to children. The impact of this in part creates a profession in which gender perceptions linked to parenthood and childcare were detrimental to career progression of women despite policies and legislation which attempted to address this. Moreover, inferred violations of gender norms are heavily penalised by other women, amongst many of those interviewed those nurses who varied from these perceptions were disliked and derogated as a consequence of this variation this is in line with Heilman's previous observation. The dynamics underlying this process results in women penalising women, whether men also are subjected to these penalties is unclear but it is clear that the female role intensifies or ameliorates these effects. The tenacity of stereotype-based expectations appears to make them resistant to disconfirming information. This research is an example of what Heilman calls 'attributional rationalisation' process, in which women are judged by a different set of standards. Ultimately perceptions of the female role, principally motherhood and dependent children exacerbate stereotyped-based bias.

Gender perception associated with women, in particular women with children of a school age, had agency in nursing. However this is too simplistic a statement; perceptions concerning the duties and responsibilities of women with children under-five has considerable agency. Yet even this is perhaps too superficial an analysis as perceptions concerning commitment and continuity linked these issues. Nursing appeared to be in juxtaposition to what it values and what it aspires to. The profession's emphasis on task at the expense of the personal circumstances of nurses by default reinforces and maintains the organisational culture. There appeared, amongst those interviewed, to be an acceptance of perceptions associated with women's role in relation to children. The impact of this in part created a profession in which gender perceptions linked to parenthood and childcare were detrimental to career outcomes despite policies and legislation which attempted to address this. However this was part of a larger process, and perceptions concerning commitment to continuity of service appeared to have considerable impact and this will be discussed in the following section.

8.3 Perceptions concerning working commitment

Amongst those interviewed there was a debate between the prioritisation and importance of family commitment in comparison to professional commitment. This debate exposed schisms within nursing and appeared to be directly related social and generational values.

There was a general unanimity amongst those interviewed in the belief that women's commitment lay with their children, although there was a markedly more strident response from nurses over 50 years of age. Nurse 'B's comments were indicative of this age group, "*I wasn't prepared to sacrifice the upbringing of the children for my career. Before the children started school they needed me at home – that's when children most need their mother.*" However though these sentiments were accepted the actualities were contested. The comments of nurses in their thirties and early forties put these into stark relief. Nurse 'T' encapsulated this, "*My ward manager said 'I don't know why you're doing this because you've got a lovely baby. Why do you need to work'*" Her reply summed up the dilemma many face, "*'I need the money.' In an ideal world we would all spend the 'right' time with the children but we don't live in an ideal world!*"

Regardless of this, these perceptions are powerful in terms of their impact on nursing and in forming the expectation that women have of other women in nursing. This exists despite, or possibly because of, their experiences and expectations. As Nurse 'L' stated, "*I was never really aware of there being any discrimination or negative attitude until I had the first child. It came as a bit of a shock. I wasn't expecting it. Thinking about it, quite possibly I had and have the same attitudes myself.*" When pressed upon this 'attitude' she cryptically added, "*When women have children their priorities and commitments change. As a woman and mother I know and understand these demands.*" This was significant amongst those interviewed and there was an opinion that upon the birth of a child a nurse's life and career relationship and priorities equivocally altered. This view only relaxed as the children got older and began school at around five years of age. However, this assumption only appeared to apply to women, men having children was not perceived to be an issue. This perception in relation to lack of commitment was concentrated upon women with children of a school age, particularly women with children under five who worked on

a part-time basis. As chapter six and seven demonstrated, a significant majority of staff who occupied part-time posts were women with children of a school age who occupied the lowest grades in registered nursing. There appeared to be a clear link between part-time working and reduced career progression and outcomes with the former informing the latter. There was evidence that part-time posts offered, for the employer, lower costs due to reduced national insurance contributions. As senior nurse manager 'X' stated, *"Part-time nurses are highly cost effective. In terms of budgetary considerations this group of nurses have great worth."*

Nurse Manager 'A' observed that it was more cost effective to *"bring in someone for half a day is financial better than a full timer who has to come in for the whole or agency staff that cost the earth"*. She argued that, contrary to public belief, NI contributions were a minor and insignificant issue, she stated, *"It has nothing to do with NI contributions but everything to do with staffing flexibility.....(slight pause) bring in someone for half a day is more cost effective than a full timer having to be allocated for a full day"*. She added that there was an even greater advantage, when the nurses employed were *"a part-time experienced nurse covering a lower grade post"* She added that, *"this is true regardless of the grade, the speciality or the area"*. Part-time nurses were used to achieve flexibility and economic savings.

This notwithstanding, amongst those interviewed there was a perceived lack of career commitment by part-time staff. Flexibility in nursing in this context was considered to offer compromised or limited flexibility in terms of working pattern. (Sicherman & Galor, 1990; Ratcliffe, 1999; Paull, 2008) Those interviewed, in particular those who had exclusively worked on a whole-time basis, considered that part-time nurses were rigid in relation to working hours in comparison to the perceived flexibility of whole-time working. Nurse 'S' claimed that *"part-timers generally cannot normally work additional hours and this is the degree of the commitment this service must have from its manager. You must be able to rely on the manager to 'fill' in an emergency – they can't 'just' go home"*. Nurse 'Q' considered that the restrictions imposed by the family and external responsibilities outside the working environment had *"an unsurprising debilitating effect upon women's capacity to perform their duties."* She added:

Part-time workers usually have major external commitments; nurses generally come into part-time working because of other responsibilities, usually children and the family. Understandably they can't be as flexible as someone without these responsibilities, particularly at short notice. As the majority of part-time nurses have children, or are working around childcare, they are unable to provide the dedicated commitment which is an essential requirement for highly responsible posts, particularly management posts.

This concern were reinforced by nurse 'C' a 'career' nurse in her late forties who stated that, "Part-time nurse's principal commitment is outside work, it's not reasonable to assume that they can be 'really' flexible in relation to the job." She repeated the often held view that, *"these priorities are understandably paramount for these nurses but they have made a choice - children or their career, it's one or the other."* This challenges Hakim's (2000) theory in relation to preference as for many of these nurses there is no discernable 'choice' and so these nurses had no detectable preference. It was part of a more complex and deeper situation that is consciously and subconsciously pervasive within many professional and social interactions.

These comments crystallised the negative opinion held by 'career' registered nurses concerning the 'professional' commitment of their part-time colleagues. Nurse 'D' who had worked on both a part-time and full-time basis throughout her extensive career conjectured, *"In my experience part-timers are inevitably less committed because they are trying to balance more than one thing. Accordingly the focus of the full-time staff is higher than the part-time staff"*. The consensus of those interviewed was that senior posts required full-time staff even by those who had worked on a part-time basis. Nurse 'V' who had worked the majority of her career on a part-time basis and had taken several career breaks to have children supported these concerns in relation to part-time nurse managers. She said that *"I don't want to work with a part-time manager on a ward, it may work elsewhere in nursing but it can't work effectively in a ward. There may well be a division of responsibility on paper but it destroys 'real' ownership of the nursing task"*. Nurse 'J' was equally dismissive; she had worked for both part-time nurse managers and those who occupied their posts on a job-share basis. She stated, *"Part-time managers end up not doing some aspects of the job, they can get away with this in care of the elderly but you can't do this in*

critical care". When pressed on this she elaborated, "*There are jobs and there are jobs in nursing. Not all senior jobs have the same pressures. High profile 'prestigious' jobs have greater demands. In these jobs there can be no grey areas there can be no lack of continuity of process*" She added with a strong verbal emphasis on the following statement, ***"no matter what"***. This demonstrates the importance of this type of nursing to the practitioner and the difference and division both of perceptions and practice between the disciplines.

This was evidenced by the use of the concept of 'continuity' in the discussing of commitment. Nurse 'H' who had worked in different disciplines in registered nursing with senior nurses who occupied various hours noted, "*It is difficult to justify anything but full-time, how would there be really meaningful continuity of process.*" There was a debate concerning continuity and commitment - one appeared to be mistaken for the other. In her interview nurse 'H' qualified her remarks, she considered that it was not desirable to have part-time nursing managers in certain areas because of, "*unequal responsibilities and workloads*" She stated:

> *The volume of work involved with management posts are not suited or appropriate for part-time staff in certain areas. There are different divisions of responsibilities in nursing and they are not equal. In nursing one cap can't fit all. In principle you can have part-time nurse managers; in practice it's not that easy. When you examine nursing you will see that the limited amount of job shares or part-timers senior posts are centred in 'soft' nursing area and are usually a million miles away from critical care. When it has occurred the division of responsibilities has ensured a cascade effect; the work still needs to be done – it's just done by the other full-time managers. Even when you're full-time you still can barely manage it!*

In posts in areas with prioritised skills base or areas where there were skills shortages, the employees have greater leverage and control in the hours that they wished to work. The type/area of job is perceived to be crucial with some areas/disciplines needing greater 'continuity' and these may also be staff/skill shortage areas. It possibly suggests a conflation between the two issues, regardless of this it is apparent that perceptions concerning commitment, whether it is flexibility or continuity, has considerable agency within nursing. The belief that these nurses could not provide

the continuity of service appeared to lead to a prejudice against younger part-time nurses with children of a school age. This would suggest that part-time nurses with children of a school age endured as a group considerable career disadvantage. The extent of this disadvantage was made clear by Nurse 'P' who stated she would *"only consider the part-time option for a senior post if I were forced to do so by circumstances.....if I faced difficulties in recruiting full-time staff".* In her elaborations she gave prominence to the virtually encompassing beliefs that management posts were the sole preserve of full time employees, *"senior posts in nursing are full-time for a reason. It is not really possible to have part-time manager, these posts need full-time commitment."*

The interviews exposed that cultural values had leverage within the profession. Regardless of those interviewed there were issues centred on the quality and calibre of skills that part-time nurses possessed. Nurse 'S', a nurse in her thirties who had always worked on a whole-time basis, argued *"Part-time nurses lack the quality, range and depth of experience of full-timers".* This view was contested, Nurse 'T' argued, that part-time staff were *"in many ways more qualified than their full-time colleagues."* She distinguished between younger less experienced part-timers and older experienced practitioners who have perhaps downshifted a grade and are vastly more experienced than new nurses at that grade, *"Very experienced nurses return after long breaks on lower grades and reduced hours and there is a growing tendency for older full-time nurses to reduce their working hours working near the end of their working lives."* The quantitative analysis in chapter seven and eight supported this observation – older nurses regardless of their sex reduce their hours when they near the end of their careers. This comment of those interviewed, however, exposes a perceived difference in skills between part-time and full-time nurses. This is unsurprising but there does appear to be differences in skills acquired as Nurse 'R' considered that part-time nurses in general, particularly younger nurses have a reduced skills base, *"part-timers have less time to attend training. It is critical in a clinical setting to up-date skills. Sadly there is only twenty-four hours in a day and you become aware of that when you are holding down a job and looking after kids".*

This accentuated one of the key barriers to part-time nurses achieving greater career progression. That is, within nursing there was a resistance to the very concept of part-

time nurse management. Those interviewed, even those who worked on a part-time basis, considered it essential that senior posts be filled on a full-time basis. They found any alternative difficult to accept. Senior nurse manager 'A' stated, *"most senior posts* ***cannot, I repeat cannot*** (considerable emphasis was placed on these words) *be part-time, they are full-time jobs...there is literally too much work for one person to do, particularly on a ward"*. There was a weight placed on full-time working as opposed to any alternative arrangement of working in senior or management posts. Though this restricted career progression enhanced career outcomes within nursing are denied, there was an overwhelming acceptance of this within the cohort interviewed. It is not unreasonable to assume that the prevalence and significance ascribed to this attitude constrained job opportunities for well-qualified experienced female nurses who had re-entered nursing on a part-time basis and at a lower grade.

However, amongst those interviewed there was a divergence of opinion on returning staff re-entering nursing at the same grade or an approximation of it. Nurses over fifty years of age were sympathetic to those nurses re-entering on a part-time basis retaining their grade where possible whilst the greatest resistance to this came from younger 'career - minded' nurses under thirty-five. Nurse 'D' stated that she *"would like to see a climate where part-time working is encouraged at all levels of nursing and where it wasn't seen as negative"*. But she caustically added *"the careerist won't have this, this would be too much of a threat for their precious careers"*. It was apparent that this strong relationship between higher graded posts and full-time working was sacrosanct to those who believed that they had *"not just made sacrifices for their careers but invested in it"* (Nurse, K). This nurse's comments were indicative of the strong sentiments of this group of career focussed nurses because it seems that female nurses seeking a career may have sacrificed having children, it is perhaps less surprising that women have the greatest antagonism towards opportunities for other women who have children, otherwise their 'sacrifice ' may seem in vain.

Though, there was a powerful yet vocal minority that held these views to be detrimental not merely to women's career progression but the operational efficiency

of the profession. Nurse Manager 'B' conceded that these values were indelibly linked to nursing *"obsession"* with professional status:

> *Whole-time working is not essential to the management of nursing. Nursing management can and is performed on a part-time basis but you cannot isolate nursing's long campaign for 'professional' recognition with the strong desire to ensure the integrity of the profession.*

She added, *"In my experience senior nurses view part-time working as a compromise they may not say this but they give this impression they treat it like it is a threat to their profession."* This need to justify whole-time working was a theme repeated by nurse 'Z', one of the more experienced nurses interviewed. She was ardent in her advocacy for a *"full–time professional service"*. She elaborated further, *"The regulations do not state that whole-time working is essential - the only criterion is the 'contingencies of the service'."* There is a case to argue that the 'professionalisation' of nursing is driven by several coinciding factors. Firstly, that the nursing hierarchy have the aspiration and are not unduly concerned about the basis on which it is established. Secondly, that it has arisen out of political necessity, to address devolutionary changes that have affected the traditional entry group as professionalism certainly has been seen as a way of appealing to a wider candidature. Thirdly, it is beneficial for the dominant culture, to exert control by distorting the use and meaning of terms, in order to manipulate a group of staff by encouraging them to believe they have one status. Apparently the combinations of these factors might render many nurses vulnerable to suggestion and direction from the centres of responsibility.

However, the argument based around the range and multiplicity of tasks associated with senior posts in nursing does not survive a rigorous examination as Nurse 'P' proclaimed, *"these posts can only be completed on a full-time basis. It is in the best long terms interests of nursing that this status quo changes."* Her latter remarks exposed who she considered the major actors and agents in propagating this culture, *"The RCN was and is not prepared to concede any devolution in terms of professional practice. Nurses are the custodians of practice. It is 'undesirable' for the profession to accept many of these changes in relation to accepted practice."* Though there was an acknowledgement that part-time nursing was eminently fitted to certain

nursing tasks and management responsibilities, Nurse 'P' argued, *"Effective management is effective management regardless of who delivers it.* She added, *"There is no intrinsic operational requirement for full-time working or that full-time working needs to be an operational norm in nursing, it's perfectly acceptable in care of the elderly".* It appeared that in certain areas part-time working was acceptable but by implication not in other areas of nursing. This raises concerns over generalised studies (Maben, 2007; Mannion *et al.* 2009a) looking at mixed areas of practice without recognising and dealing with the specifics of this complex issue.

The last quotation in the last paragraph was frequently made and starkly exposed the difference in pressures in different areas that both had an impact within the profession and appeared to affect career progression within it. Regardless of this, certain clinical areas and branches of the profession considered themselves as an elite and that certain areas, notably care of the elderly were 'back waters' of the profession. These differences possibly reflect substantive differences in posts, different personal requirements and cultural differences. Though disentangling these conflating issues is not straight forward, i.e. to what degrees are there 'real' differences and if so do they make part-time working more difficult in some areas or is it values related to 'custom' and 'tradition'? This is not completely a value judgement, though it may be a reflection on differing jobs and pressures – oncology is not the same as dealing with a continuing care/ elderly person who requires different skills, produces varying stress factors and produce divergent career progression. However, it would not be unreasonable to state the combination of the discussed perceptions facilitated and maintained a situation where full-time working and senior grades were synonymous in high profile areas. Although it should be acknowledged that this position was not universally accepted, Nurse 'C' believed, *"Nursing is losing out on top class people - there is no need for this. A lot of these views are just pure snobbery, totally misplaced a reflection on a loopy value system."* She emphasised this point by stating, *"This should not be but it does matter if you work in oncology or care of the elderly a patient's shit is as a brown there as it is anywhere else."* This was an acknowledgement that the essentials of nursing were the same, there was a recognition that time pressures and forms of stress were different, 'different' not 'better' or 'more worthwhile' all are notionally considered worthwhile but it was

apparent amongst those interviewed that the value system had considerable agency within the profession.

This minority opinion of those nurses interviewed was formed by nurses who had occupied full-time and part-time posts and a wide range of grades throughout their careers. This group in their reflections considered that change was essential. Nurse 'G' considered that whilst nursing is a unique profession built upon consistency and continuity she acknowledged that there will be variation in certain areas. Continuity of care may be provided by health care assistants who provide the personal care but she considered that, *"reconciling this with variations in working and individual needs of nurses is not insurmountable."* The need to coherently and consistently address collective responsibilities and individual working needs was considered by Nurse Manager 'J' as operationally desirable, *"Within (an) increasingly fragmented nursing workforce, perceptions concerning the necessity of full-time working in senior positions deny nursing access to individuals who would be able to make a significant contribution to nursing."* She added that, *"Change would enable the profession to make the most of all the talents present in the nursing workforce."* She acknowledged that change would be difficult for some in nursing:

> *Nursing is terribly snobbish and at times downright reactionary, we all really know at all levels of nursing there must be an attempt to address the issue of part-time working and management opportunities. This will be difficult as there are many extremely conservative elements in nursing who still have considerable influence and agency - the 'blessed' RCN for one.*

She believed that nursing and the NHS would develop strategies to encourage greater acceptance of part-time nursing managers and these policies would cover recruitment and promotion processes but that cultural attitudes would be much more difficult to address. She believed that *"only God or time can change this."* The extent of gender disadvantage in nursing is complicated as it goes beyond the male/female comparisons identified, to reveal a more complex picture. As women predominantly occupied part-time posts in nursing, the low status of part-time working was a significant contributory factor in restricting the career progression of female nurses. These were exacerbated by the restricted access part-time nurses had to training to up-grade and enhance their existing skills. This was conveyed by many of the nurses

regardless of their personal circumstances. There was an overall inadequacy of provisions to enable women to combine paid work with 'other' responsibilities and issue of fairness, in particular those without children of a school age having to maintain the operational burden of those with children of a school age in terms of hours and holidays. The lack of suitable provision and potent perceptions had great significance in restricting women's career progression despite the existence of statutory legislation and formal NHS policies to promote flexibility and equality of opportunity in relation to gender.

There was an opinion offered by a significant segment of those interviewed that a 'like with like' culture in relation to the replacement of posts exacerbated this situation. Nurse 'K' stated, "*Not a lot (of) thought goes into considering the hours required for jobs or reviewing its grade. When a nurse leaves, the nurse manager doesn't normally think, 'can things be done differently?'*" This 'like with like', part-time with part-time, full-time with full-time and grade with grade, it was argued maintained existing employment patterns within nursing. Nurse 'F' observed that, *"Part-time nurses are always going to stay part-time on a lower grade because of this unthinking practice. This approach creates a situation where there (is) no real opportunity to break through - nursing sleep walks into this"*. It became apparent that this organisational *etiquette* would seriously restrict career movement. Posts constructed on one basis are likely to remain fixed at this point or juncture regardless of other circumstances. Those interviewed stated that nurses for these positions would normally be expected to increase their hours as opposed to alterations of the conditioned hours. Nurse 'L' displayed the embedded relationship, *"senior grades have to be completed on a full-time basis – nursing is not run for the benefit of nurses"*. The detrimental consequences upon the career progression of women with external responsibilities are apparent.

Indeed, this was very apparent in terms of restricted training. Nurse 'B' conveyed this and her frustration, *"It's annoying because though I was willing to go to training courses I couldn't go to them and gradually I didn't have certain technical competencies which are essential for promotion."* She added "*I have nine years experience and yet someone with far less 'real' experience will get the post because they work full-time and can go to all the training available."* The above comment

was not unusual. Nurse 'P' reiterated this and outlined the difficulties she had recently experienced, *"When I returned from my career breaks, it was difficult combining work with childcare. I applied to take courses but they were rigidly timetabled, I couldn't go to them. Though I wanted to develop my skills I was presented with no options".* She was asked whether they had offered an explanation or offered to rearrange it and she said, *"When I asked about it, I was told that due to demand timetables could not be individually tailored. They said if they could they would but that those providing the training could only do it at that time".* The importance of this was clearly significant, if career opportunities were indelibly linked to the qualifications and enhanced skills, the inability to acquire these qualifications and skills would severely restrict the practitioner's career progression. All interviewed acknowledged that skill accomplishments were a critical component of career progression. There appeared to be an established protocol between recognised skills and enhanced career progression, this is an important point in relation to continuing professional development and access to training. The organisation of training and its scheduling affected all areas of nursing not just part-time but unsocial hour's workers, notably night-shift workers. Nevertheless, part-time workers appeared to have a greater handicap as full-time workers regardless of their conditions had flexibility of hours and leverage within their hours to accommodate training scheduling. The combination of this with perception and practice in relation to working hours effectively reduced the career of an entire cohort of women.

Perceptions concerning commitment, as Legault and Chasserio (2003) contend, have influence but in nursing commitment is a metaphor for continuity of treatment. The concern of those staff was centred on a personal commitment informed by the need for a professional continuity of service. It is a simplification to suggest that this was a unilateral perception - it was part of a wider fabric of perceptions associated with women and their flexibility in relation to working patterns. The belief that the manager must possess at a practical level, flexibility in relation to working-time in tandem with technical skill, knowledge and experience appeared to be a critical factor in career progression. These prescriptions when cumulatively combined seemed to restrict women's career progression at a senior level in nursing. Nursing appears to be in juxtaposition to what it values and what it aspires to. The profession's emphasis on

task at the expense of the personal circumstances of nurses by default reinforces and maintains these perceptions.

Career progression in nursing appears to be impacted by adherence to an established orthodox view. In part this vindicates Legault and Chasserio (2003) observation concerning the negative impact that the organisation of work and the practicalities of combining working and family responsibilities has on careers and Wajcman's (1998) position that cultural constraints and family life were a critical arbiter of female progression. In nursing one was embedded in the other, gender stereotypes could only exist within the framework of the wider organisational culture. The view that it is one or the other is too simplistic an analysis, Women's career progression in nursing are impacted by gender stereotypes, the stereotypes associated exist in relation to the associated gender perceptions this being that women are less 'committed' in terms of work due to dependent children. The degree to which this value system is related to gender perceptions is critical. It is possible to argue that the preference for full-time working as opposed to part-time working is an example of the pervasiveness of gender associated perceptions in its impact on career outcomes. There was an equally strong view amongst those interviewed, that career breaks had an equally significant impact but yet again these appear to be intrinsically linked to gender and its impact will be discussed in the following section.

8.4 Career breaks

The previous sections observed that gender perception, particularly those centred on the role of women in relation to children, had considerable agency in nursing. Also associated gender perceptions linked part-time working had serious impacts on the career progression of female registered nurses. This was linked to career breaks and this will be discussed in this section.

There was a consensus amongst those interviewed that career breaks had a detrimental impact on the career progression of returning nurses. Though career breaks occurred for a multiplicity of reasons the most frequent explanation for taking a career break amongst those interviewed was maternity leave. However, there were differences but they were still overwhelmingly associated with parenthood or childcare, e.g. break due to the residual effect of having children.

Those interviewed intimated that career breaks in general resulted in reduced hours and lower graded posts for returning registered nurses. As chapter seven and eight identified, women who had previously worked in senior grades on a full-time basis frequently returned on a part-time basis and/or at a lower grade. Those interviewed considered this both as an unfair process and an inefficient use of resources which could not be justified. Nurse 'C' stated, *"If a nurse was a 'G' grade as a full-timer it's unfair they return on a lower grade when they return as a part-timer. Nurses still have the same competencies and experience after a career break."*

However this gave prominence to a fissure at the heart of the profession - there was a belief amongst those interviewed that the length and frequency of career breaks impacted on the practitioner's skills base. A greater length of break was perceived as compromising to the practitioner, in particular their technical competencies. Nurse 'C' stated, *"Career breaks interrupt this experience and compromise it. Good practice is dependent on maintaining and continually updating skills. If a nurse has a long term break 'her' skills can quickly become redundant."* Those interviewed strongly believed that those who had taken career breaks which accumulated to over five years in length were considered less qualified in terms of clinical knowledge. They became, in essence, disqualified for senior nursing posts as nurse 'X' elaborated:

> *Clinical knowledge and experience are the cornerstones of nursing. Professional practice changes so rapidly that when someone takes a break of a few years that in-depth understanding of technical competencies quickly becomes obsolete - 'core' competences never really alter but they are an essential but small part of 'acute' nursing.*

Amongst those interviewed nursing practice and the ability to develop and maintain that practice appeared to be intrinsically linked to continuous service and continuous career development. This relationship between the quality, depth, range and length of nursing practice were perceived to be critical arbiters in career progression. Nurse 'T' acknowledged, *"When a nurse takes a career break apart from their service being broken, a nurse's experience and knowledge is compromised. Nursing changes so rapidly, any break in service has a serious implication."* Those interviewed strongly believed that career breaks have a detrimental impact on career progression because

there was a perceived link between unbroken continuous service and the quality of the practitioner. Those interviewed overwhelming held the opinion that career breaks had the greatest negative impact in 'highly technically skilled' areas of nursing, for example, surgery and intensive care. Nurse 'B' stated, "*Technical knowledge quickly becomes obsolete and career breaks severely impact and 'profoundly' diminished*". There was a suggestion that in areas of nursing perceived as 'less skilled' the impact of career breaks were less important. These areas were considered not to require the same levels of knowledge and skills. In these areas career breaks were acceptable as it did not 'greatly' affect nursing practice. Nurse 'T' stated;

> *Look, in care of the elderly you can leave and come back and re-enter the profession because the skills needed to do this job don't really change but that is not the case throughout nursing. In certain environments this is certainly not the case. The skills needed for working in intensive care nursing are far more advanced. If you are really serious about making nursing standards these skills have to be continually maintained and safeguarded - nursing is not a hobby to be fitted in, it is a career.*

These remarks exposed a contentious aspect of nursing the differentials between care and task provision in nursing. Nurse 'W' believed that these are pivotal perceptions which define career progression, "*Care skills never leave you, it's like riding a bike, but technical knowledge must always be updated, that's the nature of the beast.*" She added, "*Some people who never take a break are bloody hopeless and some of the best people I've ever worked with have had five kids and as many breaks of service.*" There was a consensus that career breaks reduced a nursing practitioner's level of knowledge and experience. Senior nurse 'B' argued:

> *Career breaks invariably leads to a form of restricted working. Usually in areas of nursing which require the minimum levels of technical proficiency. These areas do not provide any form of career development or training and by default career opportunities become limited. 'Care of the elderly' is the graveyard for nurses for that very reason. The nurse becomes trapped in a 'catch 22', one that is very difficult to break out. Simply, once you take a break, your knowledge depreciates; if you go part-time the opportunity to address this is very restricted.*

There were strong opinions amongst a significant number of those nurses interviewed that the lack of appropriate training to up-grade skills either when in post and in particular upon re-entry in the profession was a key issue. Part-time working becomes a circular trajectory – no training therefore no promotion and consequently no incentive to change working condition or patterns. These concerns were particularly strong amongst returning practitioners after their career break that experienced the absence of the availability of training. Nurse 'J' stated, *"Nursing skills have to be upgraded if returning nurses are to be allowed to perform the whole task. They need the former to complete the latter."* Nurse 'B' was more adamant, "*It is essential in nurse practice that the practitioner possesses the vocational knowledge to resolve clinical issues. If returning nurses are to develop their careers they need training to upgrade the skills.*" If the nurses interviewed are indicative of the general values prevalent in the profession then it appears that nursing acknowledges the need for training but is unable to reconcile this with the profession's values. As nurse 'A' stated, *"As a general 'rule of thumb' nurses with continuous service have a greater knowledge, they (have) got the time to update their skills".*

However, it was clear that this had an effect on nurses returning from career breaks who in significant numbers returned on a part-time basis, amongst those interviewed avoiding problems associated with lack of childcare and inflexible working hours was significant though there were other reasons for wanting to go back part-time, particularly work-life balance issues. This group of women found themselves excluded from training courses and by default occupationally restricted. These barriers inhibit the type of disciplinary employment in which women can engage in the first instance, but more covertly it directly affects women's acquisition of the skills and education, which would enable them to progress within their career. Advancement in nursing appeared to be based on full-time and continuous employment which is not possible for many women with dependents, particularly children under five years of age (and those with older children). This casts a shadow over the future as the effect of past breaks is mitigated by the profession's apparent inability to overcome the long term effects of career breaks. However it should be acknowledged that nurses with older children may still want part-time work for work life reasons but this does not negate the power of these previously discussed issues.

For returning nurses there was in general an absence of training courses especially specialised nurses, nurse manager 'B' stated, *"My first career break lasted for a few years and I was a bit rusty when I returned but there was nothing there for me in surgery, such was the degree of the problem I had to leave"*. Those nurses who had received training had seen a material benefit in terms of their career progression, nurse manager 'D' highlighted this, *"I received training upon my return and it made a world of difference in terms of grade, I went from an 'E' to 'G' quite rapidly.... (Slight pause) I think I got it within two years"*.

Career breaks clearly had a material impact on career progression and access to training opportunities. Short breaks, as demonstrated in chapter seven, had less impact upon career progression but longer breaks in particular those which accumulated to greater than two years in total were associated with a perceived reduction in technical knowledge. It was apparent that the issue of the length of break was important but was only so because of what occurred after it – frequent instance of part-time work and restricted and limited access to training. These appear and are believed to have a fundamentally debilitating impact upon the practitioner's career.

As Griffiths (2007) notes as nursing is a task orientated and a task led profession, perceptions concerning the perceived (or actual) loss of professional knowledge and technical competency severely impacted on female registered practitioners. These perceptions reflect internal values and as career progression in nursing is dependent upon both values and perceptions it us unsurprising that career break negatively affect career progression and outcomes. When this is considered in tandem with the apparent low status ascribed to part-time working within the profession, due to a perceived lack of flexibility/continuity a situation is created which facilitates restricted career outcomes for women, particularly those women with dependent children. Thus career breaks had an impact in explaining the different career progression of men and women in registered nursing. They appeared to have a considerable agency in explaining why men have a greater possibility than women of possessing a qualification higher than a nursing certificate. There was an undoubted relationship between career breaks and the restricted career progression of women with children of a school age this does support Griffiths position in terms of impact but this is a complicated area confused by cause and effect - women re-entering the

workforce in nursing after a break in service do not generally re-enter at the same grade and they almost invariably re-enter on reduced hours and a lower grade. Regardless of this, career breaks and their frequency regressively impacted on career progression and this worked in tandem with the low status associated with part-time registered nursing. While men have uninterrupted career breaks this produces for women a *"Snakes and Ladders"* effect in terms of their career progression – a few step forward in terms of grading prior to a career break then they slide down the nursing grades after it.

8.5 Discussion

The evidence of this chapter locates career progression within the locus of gender stereotypes which are firmly rooted in perceptions associated with dependent children. Those interviewed highlighted that the perceptions associated with gender and parenthood, particularly a perceived inflexibility and an overall lack of commitment were serious issues. These are major obstacles to women's career advancement but they are exacerbated by the evident restrictions to access training, particularly for part-time nurses, nurses working on an unsocial basis or returning after a career break but gender and perceptions associated with influenced career progression and outcomes.

Gender and perceptions associated directly with it are crucial to career progression. Amongst those interviewed there were areas of agreement, principally on the role of woman as mother, there was a remarkable consensus amongst nearly all members of staff interviewed that *"the family comes first"*. These values affected even the newest and youngest members of staff who appeared to be influenced by the profession into accepting this orthodoxy. The tension between the home and profession commitment are significant, the perceptions are powerful and suggest that the impact of parenthood in relation to women's career progression has still not been fully recognised. At this juncture it should be noted that these values are different and adaptive, that is, they do change relative to the role and types of nursing and this needs to be placed in context. Certain roles have dissimilar circumstance with disparate impacts, e.g. care of the elderly and 'emergency service' type jobs have different operating considerations. In certain areas the impact of physically missing a colleague on the actual service provided to patients and on colleagues is tangibly and is operationally detrimental.

Regardless of this there is a tension between individual circumstances and the profession's values and gender stereotypes. Aspects of this relationship, supports Heilman *et al.'s* (2004) position that the tenacity of stereotype-based expectations and their resistance to change negatively impact on women's career progression. This 'attributional rationalisation' process results in many women being judged by a different set of standards in comparison to their male colleagues. Perceptions of the female role, principally motherhood exacerbate stereotyped-based bias. These bias as observed manifest themselves in gender stereotypic perceptions, particularly those associated 'commitment' and are frequently maintained and upheld by women to the detriment of other women. This research supports Heilman's observation that women judge women on different and harsher standards that they would judge men. These gender stereotypic norms, dictate the ways in which women should behave, and the disapproval and approbation women experience for violating these "shoulds". The dynamics underlying these process penalties women's career progression and outcomes being a woman within nursing makes women subject to gender stereotypic behaviours.

Perceptions and values related to expectations concerning working flexibility and commitment exacerbated the impact of gender stereotypic behaviours and values. These values and perceptions appeared to be so entrenched that initiatives in themselves have been unable to overcome them. Legault and Chasserio's (2003) position that the nature of perceptions concerning commitment is significant, in view of the taxonomy of work and its impact on career progression and outcomes. However, this does not reconcile itself to individual circumstances since commitment is a multidimensional issue; it possesses several factors that influence and cause impact in one and/or in another dimension. Nevertheless, within the thesis certain fissures related to their critiques become apparent. In some instances the 'hostility' between women with dependent children and those without appear to have a greater influence on career progression and outcomes for women than Legault and Chasserio envisaged. Professional commitments and gender stereotypes are not incompatible; it appears that within nursing they are entirely compatible but to the determinant of women's career progression.

These values bind the staff together and forge a self-propagating camaraderie; however, within the thesis certain fissures related to their critiques become apparent. In some instances the hostility between women with children of a school age and those without within the context of perceptions are rejected. It appeared that these perceptions were maintained and upheld by a majority of those women interviewed; it appeared women without children of a school age were advantaged in career outcomes possibly due to less competition for these higher level posts but regardless of this those with children of a school age were disadvantaged. However, they may have these views before joining nursing but nursing may attract people with such 'views' and such views may not be due simply to conditioning. These stereotypes were exacerbated by perceptions and values related to expectations concerning working flexibility, commitment and continuity of care. Working approaches appeared to be underpinned by these powerful perceptions. These values and perceptions appeared to be so entrenched that initiatives in themselves have been unable to overcome them. Organisational processes in conjunction with gender perceptions operated were detrimental to the career aspirations of many women.

The interviews suggest that parenthood and children have a detrimental impact in terms of career. The evidence for this is manifested in women's relationship to certain employment conditions i.e. part-time working. Women when returning from a career break frequently returned on a lower grade, reduced hours or both. Consequently this *"snakes and ladders"* effect on women's career progression was pronounced interrupted careers which in general resulted in them recommencing their career at either the original commencement point of their career or in conditions of service which significantly reduced the access and receipt of training which could enhance their career outcomes. This thesis supports Griffiths (2007) position that, continuity is positively recognised by employers and a career break is a brake on career progression for whatever reason it is taken. However, this is located within a wider gender discourse one in which women make their career decisions as a compromise between their opportunities in the public sphere and the demands upon them from the private sphere. For women with children, overcoming the advantage men and women without childcare responsibilities have in achieving senior positions mainly involves positioning themselves to enable them to work without taking career breaks. These findings highlight a key debate about women's commitment to paid work, especially

those who work part-time. Amongst many of those nurses interviewed it was acknowledged that part-time nurses can be as 'committed' to the profession as full-timers but there was a widely held view that the profession was best served by whole-time nurses. This creates and reinforces an ideology where part-time workers are perceived to lack the commitment of full-time workers; differences arise in career progression, not only between women and men but also between women working on full-time and part-time basis this is not divorced from gender perceptions but is synonymous with them. In registered nursing the career progression of women with dependent children detrimental is affected by perceptions concerning commitment to the job to such a degree that career progression is available only for the unencumbered nurse. This manifested itself in many women being denied the access and receipt to training and this casts a shadow on the career outcomes of many registered nurses.

Evidence from the interviews strongly suggested that access to and receipt of training was of significant importance in terms of career outcomes for women with dependent children. Women who were of a child-bearing age or perceived to be likely to have children were affected by this. This practice of gender stereotyping was linked to a value system which propagated the belief that the professional commitment, the ability to work flexibly in terms of hours and professional knowledge was central to the fulfilment of the aims of nursing. There appeared to be a relationship between career progression, access to and receipt of training and nursing values which were located within gender perceptions and gender stereotypic values. These relationships were the mechanism of transfer of disadvantage for women in relation to career progression.

8.6 Summary

Ultimately the restriction of certain women place upon some women's career progression can be summarised as follows:

- Gender perceptions directly affect career progression. The loci of these are firmly rooted in perceptions associated with dependent children and women role as primary carer - *"the family comes first"* syndrome. When this was combined with professional values and perceived operational requirements

this creates a tension which directly reduced women's careers. Those interviewed highlighted that the perceptions associated with parenthood, particularly a perceived a perceived overall lack of 'commitment' from *women with dependent children*, was an important issue. When this was added with values related to professional knowledge a situation was created that actively reduced careers for all women.

- Perceptions related to women with dependent children's ability to work flexibly frequently lead to restricted access to the receipt of training and this consequently affected their career outcomes. Crude gender stereotypes directly affected career progression, for example expectations that a woman of child-bearing age would have a child lead at times to direct gender discrimination in relation to promotion and recruitment. The propagation of gender stereotypic values by women in relation to other women repressed women's career progression by creating barrier through which it was difficult to break without personal difficulties.

- Career breaks, and their length, had a particularly debilitating impact on women's career progression. Career breaks are linked to children. Women take a career breaks to have children or to take care of children, men do not take a career break for this reason. With a career break of greater than two years the human capital of the nurses acquired prior to the break appears to become obsolete or redundant or simply becomes undervalued. Career break creates a *"snakes and ladders"* effect detrimentally affected women's long-term careers. This effect was so called because women commenced their career progressed through the career grades then took a career break and frequently returned on a part-time basis, crucially in a lower graded posts than their previous posts or experience, or both, merited. They effectively recommenced their careers and as men's careers were in general uninterrupted this effect partially explains men's greater career outcomes in comparison to women in registered nursing.

There is a need to distinguish between evident barriers from 'pure' perceptions though it is difficult to not to overstate the importance of gender stereotypes and there

negative association with the female role. The following chapter will extend the findings generated by the qualitative interviews.

Chapter Nine Voices made clear

I think women are good enough to do whatever they damn well like and step by step they will make their way through. Nurse 'O'

9.1 Introduction

This chapter develops an argument that nurses can be divided into two broad groups – traditionalists and modernists, which are explored through four important issues. The first will involve an exploration of the circumstances under which certain nurses voluntarily elect to work below their potential in grades not commensurate their qualifications or experience. The second discussion surrounds an investigation of the extent to which the partners/husbands of female nurses influence their career progression and outcomes. The third reviews the impact of childcare provision on nurses' career outcomes and the fourth and final issue to be explored in this chapter is the role of the nurse manager in the change process. The chapter finishes with a discussion of these issues.

9.2 Working below qualification and experience

For many of the female registered nurses interviewed, voluntarily working below potential during their career was a typical and frequent occurrence. Potential is defined in this section as working in a grade at a lower grade than previously occupied and is not commensurate with experience or qualifications. This had an impact at different times throughout a nurse's career. However this was not the sole rationale and there were other reasons, particularly work- life balance and the pressure of work which induced many women to voluntarily work below their 'potential'.

Many of those interviewed considered that the *'pressure of work'* both physically and mentally directly led them to reducing their hours of work or leaving the profession. Nurse 'M' stated, *"I wasn't going to be a martyr or some kind of saint - I physically couldn't do the long hours or with the pressure of responsibilities anymore."* She explained that the centres and levels of responsibility were both characterised by stress but these forms of stress were different, one did not supersede the other. This was particularly the case in certain areas Intensive Care Unit (ICU) but was also the

case in a continuing care ward whilst being in many ways the same was different. She provided an example of the degree of this level of stress:

> *I first ran a ward when I had one child and then I became pregnant and that was quite something being in charge of a ward and being pregnant - that was a first and my successor did exactly the same thing as well which was interesting but the physical and emotional pressure of running a ward and having two young children just about killed me. Something had to give it was either my health or my sanity, so it became simple - I left* (Nurse 'N').

Women who re-entered nursing on reduced grades or hours or both contrasted their current job and its relative lack of responsibilities and their previous posts in terms of stress and anxiety. Nurse 'N' who had been a senior nurse practitioner considered that her personal life priorities made her leaving her previous post inevitable:

> *I was never prepared to hide the fact that I had kids and I tend to prioritise my life around them. Accordingly this created some problem not with my immediate colleagues but with certain 'female' senior managers. I was open about my priorities but there were powerful expectations and these expectations were very powerful and negative. This pressure made my departure inevitable."*

This experience was shared by nurse 'H' who explained, "*There is an opinion at a senior level in nursing that women with children of a school age just want, want, want and want."* She added, *"For me, it seemed at times my own sex my fellow women were anti-women. I became very resentful and really couldn't work under this additional pressure."* The physical and psychological pressure did not merely result in the termination of employment but the migration of higher graded nurses to lower graded posts. Nurse 'R' stated that consequently, *"there's an inevitability to downgrading",* particularly when a nurse sought to balance work and private life. She considered that the critical factor in deciding to reduce her hours and level of responsibilities was the conflict and indeed incompatibility between professional life and the family:

I always did more than my share; I never avoided responsibilities even when there were huge emergencies at home. I also never missed something that was critical for my children, in the long term that takes a toll. It makes it inevitable that something had to give – I couldn't get rid of the kids though sometimes I wanted to! So I looked for a job that gave me respite and that was lower down the pecking order.

Many of those interviewed considered that working below their potential was a consequence of organisational rigidities. Nurse 'C' explained, *"The expectation in nursing is that the job is not nine to five - it is twenty-four seven, particularly senior posts."* She outlined the consequence of these expectations:

At first I started to miss family things which initially I thought really wasn't a big deal. Eventually my youngest said 'why weren't you there' and I told her that I really couldn't come because of work. When I tried to alter things at work there was a lot of pressure from above to put the job first. I didn't want or need that kind of stress.

She added, *"Though it was financially difficult, it was emotionally easier to work on a lower grade without the unique stresses that a management job produces in nursing."* This was brought into stark relief by Nurse 'F' who had extensive experience both as a mother and a senior nurse manager, *"In the job you've got to be a role model with a different way of approaching life. To be successful you need to show that you can work and that the external needs don't interfere with the job. For most people with children of a school age that's very difficult."* These views seem to suggest that it was not merely the perception that this was their 'duty' but that the physical pressure of reconciling two apparently conflicting demands on their time resulted in a stark choice – their careers or their families.

It was this choice that persuaded many amongst this group to reassess the role of work in their lives and seek to 'improve' their work - life balance. Nurse 'B' considered that the pressure of work and the nature of responsibility in her previous disciplinary area led her to revaluate her career choices, *"Working in surgery was like being on a runaway train in terms of pressure. It was harrowing to say the least. I made a deliberate choice to leave to get the balance right in my working life. I had no real*

option." This was not an isolated opinion, regardless of the professional position, experience or location as Nurse 'O' explained:

> *When I asked for time off when I worked in care of the elderly it often caused a big who-ha. There was a big focus on coverage but the direct consequence was that there was little support in relation to a positive work-life balance. I had to leave, working there was intolerable.*

This group consisted of nurses' less than 40 years of age who had recently had children and whose combined family income was relatively low. Their altered personal circumstances resulted in changes either to working area or working conditions or both. As Nurse 'Q' alluded:

> *Children are a pressure in themselves they do have impact on career choices, for example hours and days worked for example. The pressure that can come from the kids being sick or having problems at school or just being on holidays is terrific. When combined with a lack of time to complete it, it becomes unbearable.*

She added, *"The cumulative pressure this brings makes it an easy decision to reduce my hours. I went one stage further. I worked part-time nightshift and thankfully because of the enhancements my wages were not reduced by much."* There appeared to be different types of stress and pressure within the profession. Different posts in disparate areas had contrasting pressures and stresses, however this seemed to exacerbate a sense of grievance as Nurse 'D' exposed when prompted, *"yes, care of the elderly is a stressful job but they do get the time to prove care"*. This feeling is not directly related to gender perceptions but it is indicative of subtle differences of perception which do influence professional values and beliefs and which then become linked to gender stereotypes.

This financial concern was a significant issue in tandem with the pressures of managing family and work commitments and this dilemma was brought into stark relief by the nurses who were single parents. Nurse 'G' conveyed this consideration, *"When I and my boyfriend split it was very difficult, I had to make sure my children were ok."* She added, *"To maximise earnings you go for enhancements rather than*

grade, working at the weekend or unsocial hours is where the money is and when my mum could most help out!" This was an important issue for many nurses who choose to work at a lower grade as they sought to work in positions that maintained or enhanced their income. These nurses sought posts with enhanced conditions of service, particularly un-social payments. Nurse 'R' stated:

> *There is a lot of bullshit about this grade or that grade. Do you think I'm knocking my pan in for an extra fifty quid a month? I'm better off financially being at the bottom of the pile but working at the weekend than being a higher grade during the week. This way I can look after the kids during the week and hubby can do at the weekend. Look it is not a case of being content to work below potential; it makes sense financially for me to work below 'potential'!*

She offered advice at this juncture, *"Be careful how you ask that question..... (Slight pause) The drama queens on this ward play up to be martyrs with their grade 'A' bullshit, excuse my French but they are at times complete arseholes of the highest order."* It should be noted that part-time working and working on an unsocial basis was considered as essential to the nursing task and vitally important to nurses who wished to reconcile parenthood and paid work. It was a contested terrain and exposed clear differences in values. For the practitioners who worked on unsocial working, either, weekend working, night-shift or back-shift, in terms of remuneration and reconciling work and life it was highly beneficial. However, this was not universally approved with the profession, particularly amongst nurses older than 50 years of age. They acknowledged that whilst this type of work was of critical importance they contrasted it with their own experience and considered this type of working to be an unacceptable personal 'compromise'.

Nurses who were either married or in relationships with husbands or partners had their circumstances altered by combined earnings this group appeared to have made choices which were relatively unhindered by financial considerations. Apart from exposing a difference in background and circumstances it exposed a difference in perceptions and values. These nurses had occupied senior nursing posts and had elected to work in lower graded posts. However, this was not a black and white issue as these nurses despite the stress still remained in post. Their reduction in hours was tied to stress and pressure or there was no clear impediment to them remaining in post

it was their choice to downgrade. Regardless of this, this group acknowledged that the previous posts were highly demanding but overtly highlighted their own economic circumstances. Nurse 'Z' stated:

> *I was a ward manager. I did it full time for five years and it was good but it was very stressful with long hours. It was just too much in the end. I did enjoy the job but stressful without the support...my final decision to take a lower grade was quite simple – I could afford it, my mortgage was paid off and as a couple we had enough money to live well."*

This was reflected in the comments of Nurse 'E', a nurse who had occupied very senior grades but now occupied a lower grade on reduced hours and who explained:

> *Men traditionally have a professional career and on the side of it is a family. Nursing is the opposite. We have a career with the family central to it. The working life balance is holistic, my husband and I recognise that. I recognised that choice when it came and it wasn't just financial.*

The extremity of these differences in perceptions and values were demonstrated by the group of nurses who were grandmothers, who despite their qualifications and previous experience were content to work below their potential and had no plans or desires to recapture their previous place within the profession. This predominantly is an age/ stage of life issue, the nurses interviewed over fifty years of age generally had fewer financial worries their mortgage were either small or nearly completed. Amongst this group, there was a strong sentiment that they were content to work below their potential because of the pleasure they received from their external life, principally the provision of care for their children and grandchildren. Nurse 'J' stated, *"As a woman nothing makes me happier that being with my grandchildren."* She explained, *"If I have to change my duties 3 times in a week because it's my grandchild's first week at school or there was a problem, well it's no contest."* Aged from 50 to 60 they considered the other aspects of their lives were more important to them than the discipline. Nurse 'Y' stated, *"There really are too many things going on in my life to worry about the pressures of the kind of nursing job I had in the past. I don't need it. I help with my two grand children and doing all my little jobs. I am perfectly happy."*

The rationale for some nurses working below potential was emotionally based and not decided by factors associated with the family. These nurses who were generally near retirement age often had a high degree of emotional investment in the posts they occupied. They believed that their jobs enriched their lives to such a degree that any career enhancements were irrelevant. Nurse 'K' encapsulated these sentiments *"I like where the ward has gone over the years it's developed and we've built up a great team. So for me that has been rewarding. I do not want to change now."* Amongst this group the camaraderie and companionship provided from their own female colleagues appeared to be a powerful factor in their decision to work below their potential. Nurse 'V' highlighted this phenomenon:

> *I've got a friend who's part-time and I have a pact with her for many years. She works 20 hours a week. She always does on average of twenty hours a week over so many weeks, eight hours a day. Working with her is great. I work the same hours. We don't do it for the money, we work here for companionship and the love of the job – there's nothing for a woman like the bond and friendship of another woman.*

Yet whilst these nurses were content there was a cohort that considered that working below their potential was not a voluntary decision but one that had been imposed upon them. . These nurses were of the same generation and Nurse 'Z' expressed these feelings, *"I didn't have a choice, the kids left me with a fait accompli. It wasn't about having a nice balance or going shopping or getting the washing done."* Others expressed their regret about decisions they made in the past which had led to a long - term loss of job status. Nurse 'J' stated "*I do not think it was good to completely give up working when I had the children. I should have carried on, even working a few hours. I should have pursued more of a career."* She reflected, *"But now I have come to the decision that it is not worth me going full time. I am not now going to get anywhere. .... (short pause) For a lot of older nurses once the mortgage is paid off needs change the work impetus is really altered."* Nurse 'Y' supported this position, *"Some people give up working completely when they have children, in which case they're consigning themselves to never getting a senior job. So there's definitely a choice that people have to make somewhere along the line."* There was a conspicuous lack of sympathy amongst nurses without children of a school age to nurses with

children of a school age. Nurse 'R' highlighted this, "*You have to take all the Mother Teresa nonsense with a pinch of salt; some of them* [women with children of a school age] *are just deluding themselves.*" She added, *"It was their choice to put family responsibilities first and who says they would have been promoted anyway, when the going gets tough ...and you know the rest of that line."* What is revealed by this examination is that women working below their potential occur for many reasons including emotional, social and financial. The financial aspect for many was often directly linked to the lucrative remuneration accrued by unsocial working. These enhancements ensured that the economic well-being of many of those interviewed was preserved without the requirement to achieve greater career development in terms of grades. This allowed many of those nurses interviewed the opportunity to reconcile their family needs and their careers.

This prioritisation by individual nurses of the family and their children above their careers supports Legault and Chasserio's (2003) position that personal values hinder rather than support female career progression, particularly those women with childcare responsibility. It validates their view that overall women with dependent children were actively deterred from occupying senior level posts. Many of those nurses interviewed worked below their potential because of social factors linked to the family and children. Some felt forced to leave their full-time jobs at a more senior level because of the pressures they experienced in reconciling their jobs to their family commitments. The long-hours culture and the range of demands on nurses forced some of these women to 'demote' themselves to low graded part-time jobs, in an effort to achieve a better work-life balance. They considered that a lack of genuine and effective support for a healthy work-life balance was conspicuous by its absence. In general for this category of women, the opportunity to periodically voluntarily control their hours of work, the absence of pressure and responsibility and the opportunity to devote time to housework and childcare, outweighed any desires in relation to their careers. The majority of women interviewed were not choosing to work below their potential they were constrained by family needs and inhibited by social values and perceptions in many ways this runs completely counter to Hakim's (2000) preference theory argument as these women have no choice they do not even have the illusion of choice. For women this ties into two hard realities - gender and economics once which exist frequently in symbiosis.

This is complicated by the profession's operational requirements - the absolute necessity for practitioners to provide care timeously with the minimum of disruptions to patients and clients. These operational requirements informed values concerning 'acceptable' and 'good' practice; while these values were not a product of gender perception they appeared to have a symmetrical relationship between them. The meanings and expectations associated with nursing are reinforced by social values which individuals reinforce through this these perceptions and values become entrenched and dominant. This is a product of professional, personal and social relationships. These are perceptual biases; they were not functionally related to the situation or to individual behaviour, goals, and motives. However, the outcome of this normative fit is that when employee needs are in conflict with professional values the employees needs become secondary and subservient. The organisations emphasis on service prioritisation is important but cannot be divorced from other considerations, particularly those related to their husbands/partners employment and this will be explored in the following section.

9.3 Impact of the partner's employment

The last section, observed that many women due a host of professional, financial and personal circumstances were content to occupy posts below their qualification and experience in lower graded posts or in part-time posts rather than at a senior level within registered nursing. However, it illustrated that equally many women felt restricted with the workplace and the disciplines by restricted access to and receipt of training. This section will engage with a topic that appeared closely linked to the previous section and provides a context in which to reassess the situation, therefore this section will analyse the impact of a nurse's partner upon their career progression.

The research found that amongst those interviewed a vast majority prioritised their male partner's careers over their own. The rationale for this was varied but converged on two factors, one which can be perceived as involving socially constructed norms about the role of women, and the other based on pragmatic economic considerations. With regard to the former, there was a view amongst a section of those interviewed that it was their role as women and mothers to support the family and by default their husbands. These women thus believed that the onus on working flexibility rested with

them. In terms of the latter, economic considerations about short- and long-term earning outcomes predominated.

Amongst a number of those interviewed there were differences in emphases with regard to their own individual and immediate earnings as opposed to men's long term earning outcomes. This consideration was particularly prevalent amongst nurses at the relatively early stages of their careers or who worked on a part-time basis. The belief that partners/husbands had the opportunity for greater earning capacity in their careers was particularly strong amongst this group. Nurse 'P' who had recently had her first child and now worked at the time of interview on a part-time basis explained: "*Part-timers can't go anywhere; they can only progress to a certain level. You know that really makes it an easy choice.*" This was not an isolated opinion, as nurse 'U', another part-timer declared, "*The choice to put my husband first was easy, he was the main earner. In our department they tap only the full-timers on the shoulder for promotion. Whilst this is depressing it makes the choice straightforward.*" Nurse 'W' explained the rationale:

> *My husband's career with the police meant that I had to be flexible with mine as there was a lot less with his. Working full-time wasn't an option for me because of my husband's job as a policeman. Not working wasn't a financial option and with two shift workers in the family there were problems in getting everything to fit in terms of looking after the kids.*"

There was a strong emphasis on men's greater earning capacity as being the driver for these decisions. Nurse 'B' declared, "*My husband is extremely supportive but for me, his career is more important because he just earns more. I am not some Tammy Wynette character standing by my man, it's about pounds, shillings and pence.*" This was frequently repeated as Nurse 'S' stated, "*Right from the beginning we decided his career was more important. Our jobs didn't have the same earning potential opportunities, they weren't equivalent. Even if they were he wasn't going to have a break in his service.*" Great importance was attached to men's continuous employment as a decisive factor in women's decision making process. Nurse 'Y' observed, "*If you have a long maternity leave it affects your career. I had 8 months off in total - 3 months before and 5 months after the first one and I had 6 months - a month before and 5 months after with the second one. It most definitely affected my*

career." She stated, *"Men don't normally take paternity leave, if they did and saw the impact on their own careers – they wouldn't."* She added, *"Thank goodness that they don't, my God how would we ever pay the mortgage!"* The continuous employment of men combined with a belief in men's greater earning capacity appeared to be critical deciding factors for many of those women interviewed who had decided to make their careers subservient to their male partners/husbands.

Indeed, regardless of the job of the man the overwhelming majority of women interviewed still put their husband/partner's employment needs ahead of their own. While the majority of the women who elected to do so were either the partners /wives of 'professionals', doctors, lawyers, policemen or firemen with higher earning 'potential', there was a minority of women whose husbands/partners had lower earning 'potential' yet these women still elected to alter their hours and conditions. This seems to suggest that perceptions associated with gender roles related to the family still had considerable agency with this group of women. Certain 'career minded' nurses voiced this position as they expressed the view that women conformed to stereotypical perceptions related to their roles as wife and mother. Nurse 'R', a single nurse in her late-thirties without children, voiced this opinion, "*Nurses still buy into the stereotypes of what it means to be a good wife - caring for your children and supporting your husband's career is viewed as a wife's main priority.*"

Conversely the more traditional or socially conservative nurses were not ashamed, but proud of their unstinting support for their husband/partners. Nurse 'D' conveyed these sentiments, "*It is the quite normal, natural, and expected demarcation line and I don't think I thought twice about supporting my husband. It certainly was expected but it was also something that I wanted to do.*" She later added:

> *I'm a committed and practising Christian, I think that in life you have a range of choices open to you and it's up to you to make the very best of whatever those opportunities are. I might have made different decisions but I didn't think it was appropriate. I wasn't prepared to sacrifice the upbringing of the children or not support my husband for my career.*

These 'traditionalists' located personal 'choice' as a principal driver as nurse 'Q' stated, *"I think the key to everything is choice. My choice was to support my husband and his career. We're working towards something. We haven't totally achieved it yet, but it was my choice to support him."* This was not an isolated view. According to nurse 'N', *"I think there are a lot of women like me who at the end of it all think that their relationship in supporting their husbands is at least as important as what rung of the ladder they reached."* She added, *"You know, whatever rung of the ladder you've reached, there will always be some rungs higher and some rungs lower."* There was strong support for this view, particularly amongst nurses over the age of 45 years. Nurse 'V' encapsulated these sentiments, *"There was a time when I was so busy climbing every mountain and reaching every pinnacle that I didn't ponder how I was going to support the interests of the whole family."* She stated, *"I made a decision. It was my choice to put the needs of the family first in supporting my husband."* This group recognised the significance and uniqueness of their contribution. Nurse 'K' considered she had never been, *"reduced to the role of 'trailing spouse'"* but was *"central to everything her husband achieved"*. She added *"everything he has achieved could not have taken place without my support and the wider family's. The sacrifice I made was for the greater good."* When questioned concerning the use of the word sacrifice she acknowledged that women who made this 'commitment' found it harder to gain recognition of their abilities from senior managers and colleagues.

Regardless of this, the view that women had facilitated their husband/partner's enhanced career was strongly held amongst this group. Nurse 'V' stated, *"We are a partnership in every sense of the word, building a life for ourselves and our family. We couldn't have achieved anything in life without working to support each other."* This is not conclusive evidence that traditional gender roles are entrenched through the profession but amongst this particular cohort it did appear to have agency. Middle aged nurses had different views than the younger cohort but their views appeared to predominate. The 'profession' was evidently defined by this group as were new initiates into the profession.

However, although there were different rationales for supporting their husband/partner's careers, there was agreement amongst nearly all those women

interviewed that it had a particular negative consequence for their career progression. Nurse W stated, "*Couples don't generally move to promote the wife's career, I know we didn't.*" She added the consequences were detrimental, "*They were devastating I was following him. He was going to an established job and I was starting completely a fresh.*" She qualified this, "*employers assumed that my ambitions were limited because I accepted a position beneath my qualifications. Often it felt easier just to give up my career.*" Again, this experience was not isolated as nurse 'L' who, throughout her career, had worked on various hourly conditions stated, "*It was not through choice that I worked certain jobs. When my husband's job took us to Inverness there was a very limited availability in certain areas. I took the job I could get not what I was qualified for.*" She added:

> *I would follow. If I climbed one or two rungs of one ladder then I went down to the bottom and started again and in some ways, you pick the flowers within reach and I've always thought of nursing as an opportunity to offer something back to the world in which we live.*

She considered that this was not "*really a gender issue*" because the person moving would be faced by the same dilemma regardless of their sex. She stated, "*Trying to find two 'good' jobs at the one time was difficult, though it can be done usually you secured one at a time. This is faced by anyone that moves.*" Although this position is plausible, it seemed that women were the principal sufferers from the move in terms of career progression as they, in this instance, were usually the accompanying partner, e.g when they moved house they could not generally continue to work in the same hospital/ward. This did have an effect as Nurse 'V' acknowledged, "*it would be churlish of me to pretend that moving does not have a drastic effect, it quite simply does....(long pause) on every level.*" This supports the position of Ratcliffe (1999) who argues that men's greater geographical mobility compromises their female partners' access to enhanced career progression.

This prioritisation demonstrates the relevant worth prescribed by individuals to their own careers. Regardless of this amongst the majority of those interviewed, men's continuous employment was perceived to have greater impact on the earnings of the family unit. As indicated, financial factors appeared to have a considerable impact but these do not explain why women with greater earnings potential than their spouses

or partners reduced their career opportunities to support their partner or husband's career. There were no instances where the male husband or partner gave up his career for his wife's; these can be explained in part by gender perceptions and values having an influence within this group. There is an argument that 'free choice', as alluded to earlier, is an independent arbiter but to what degree this 'free choice' is 'free' or the imposition of gender values remains unclear but this 'free choice' bears a close relationship to Hakim 'preference' theory with the same pitfalls in relationship to wider social and economic circumstances. However, the importance subscribed to the role of 'housewife and mother' by those interviewed makes it not unreasonable to suggest that altering of work patterns by women to support their spouse or partner's employment is a manifestation of values associated with an ascribed gender. Indeed, amongst those interviewed there was strong belief that their role was to support their partner's careers which supports Heilman *et al.'s* (2004) observation in relation to the overarching power of gender and gender stereotypes. It is evident however that this is a complex area, with multiple factors at play. A consideration that is important within this context, but which has not so far been discussed, is the issue of childcare provision and this is the subject of the following section.

9.4 Childcare Provision

Childcare provision produced a clear split amongst those interviewed. On the one hand are the 'modernists' who represent a significant minority view about the need for increased childcare within the hospital.

These 'modernist' views were held generally by younger nurses and nurses without children of a school age. 'Modernists' held the opinion that nursing at an operational/managerial level was hesitant and resistant in relation to providing sufficient or expanded childcare provision. On the other hand are the 'traditionalists', usually older nurses who had had children or were grandparents. Nurse 'G' a 'modernist' reflected: *"There is no real empathy when it comes to childcare at the top. There is a awareness of needs but there are 'concerns' as to how it is provided, i.e. childcare within the confines of a hospital."* It was the experience of many of those nurses interviewed that this hesitancy and resistance at times manifested itself as open hostility as Nurse 'B' remembered:

I've often been told, 'it's up to each couple to work out childcare between them' but reminded that the service is the 'prime' consideration. Empathy and sympathy seemed to be exclusively reserved for patients. I never cease to be surprised that women can say this to other women but then that is what happens when you become institutionalised by a system. Remember, that's what nursing is a pervasive and all consuming system.

It appeared that nursing was professionally schizophrenic at times lacking in professional self-confidence. The profession's resistance to change is epitomised by nurses having to 'play along with' social cultures and 'work harder' to 'prove' themselves. This is contrasted with a professional standpoint that values the highest standards of professional and technical skills. Arguably, the existence of this anomaly exposes the static nature of the culture which persists and is common within the profession. Evidence of its impact is demonstrated by the lack of support to practitioners. Nurse 'C' comments reflected this view:

One of the problems we've got in nursing is that certain segments within the profession concentrate on the job to such a degree that it fails to consider the personal needs of the practitioners. Consequently, there really isn't enough meaningful or 'real' support for people with children of a school age. I don't just mean women, I mean men and women. There is no accommodation of a work life balance, there is a lot of rhetoric, policies for this and policies for that but they're like the Indian rope trick, an illusion with no substance.

This statement seemed to point to a belief that this was a product of a generation gap within the profession. When questioned specifically about who the 'segments' were that she had referred to, she stated, *"the bosses."* When further questioned what she meant by this remark she added, *"Look there are a group of senior nurses whose attitudes are stuck in the nineteenth century, I wish I could say they were older nurses but they encompass all ages."* This emerged consistently throughout the interviews with the 'modernist' nurses; however, there was a disagreement about the composition and age of this cohort. Nurse 'X' provided the nearest approximation in terms of age when she stated that this group was constituted by *"older nurses – late forties and upwards."*

These nurses in their replies noted the impact that a lack of childcare provision has upon individual nurses. Nurses 'Z' explained the stress and fatigue the additional travel to the childcare provider and the ward had upon her, "*It was difficult. In fact I ended up being more ill that year than I had for a very long time due to the stress of travelling and the stress of work. It put me under a tremendous physical pressure.*" This view was shared by nurse 'C' who reflected, "*Purely because I'm not very organised I couldn't get my act together at all - I totally lost it. I felt I couldn't even brush my own hair, there was just no support. I ended up going off sick.*" The lack of support and sense of isolation was a major determinant for many of these nurses leaving the profession as nurse 'H' confided:

> *In the end the lack of support meant I was forced to give up my job and devote myself full-time to my children. You know what shocked me most was many women were happy to see me go. Though they didn't say anything directly to me there was no doubt where my responsibilities lay.*

She highlighted the *'coldness and dispassion'* in which this was presented, "*If you want to work full-time and not have a child then that's fine. If you want to work full-time and have children and get somebody else to look after, well that was most definitely not alright and that was often made clear in the duty roster.*" These remarks suggested that gender perception at times crossed what seemed to be a fine line from values to active discrimination. The impact of this prejudice was not restricted to physical exhaustion and fatigue but was also evident in access to training as Nurse 'M', eluded, "*when I was younger I wanted to go on a three week training course. My mother couldn't watch the kids and Sister wouldn't alter the roster and this resulted in me being unable to go and do it.*" Single parents found the lack of childcare or organisational support in the workplace particularly difficult. Nurse 'G' stated, "*It is very hard as a single parent to combine a home and a career and I suppose it's one of the reasons that I've perhaps done the things I've done in my career.*" She explained, "*It's the major consideration which shapes all your decisions but when you have limited support from the profession, what you can and can't do in terms of your career goes beyond being limited to becoming impossibilities.*"

A major difference of view amongst 'modernists' and 'traditionalists' was the introduction of crèche facilities, this was the terrain in which different values and ethos was most evident as Nurse 'H' stated:

> *It's something that's ongoing during my ten years in nursing and is never really openly addressed. The old-school won't compromise on it and younger nurses see its whole-sale introduction as essential. The need to improve childcare provision, and formalise policy on job share and other initiatives is a long running problem.*

It was argued by 'modernists' that there was a great need for increased usage of family friendly initiatives to retain staff. They pointed out that as training was expensive and experienced nurses were vital to the profession, enhanced child care was critical. Nurse 'L' highlighted this:

> *There is a need for childcare provision so that people can come back - we can't afford to constantly lose our best qualified and highly trained nurses because we can't accommodate the fact that their personal circumstances have changed. We can't afford to go on training new entrants to leave because we can't provide sufficient childcare provision. People need to have a reasonable or at least an acceptable work-life balance. I'm not talking about great chunks of additional or paid maternity or paternity leave. I'm actually talking about a fairer split of responsibilities between parents and a greater understanding of the work-life balance by employers.*

However, 'traditionalist' opposition was vehement and vocal in relation to the introduction of crèche facilities which were viewed as compromising the professional integrity of the discipline. Nurse 'I' who had children over eighteen years of age she considered herself to be *"an arch-traditionalist"* argued, *"Scotland has substantial child-caring facilities – hospitals are for patients they are not and never should be day care centres for children. Nurses must never be distracted from the matters at hand – patients"* As indicated, these 'traditionalists' were overwhelmingly older women with adult children and young grandchildren but within this group there were nurses under-25, nurses who had just qualified professionally. The influence of this older cohort was significant with registered nursing despite disputed terrain within the

profession this group took a uniformly consistent view in relation to this and many other issues issue. Nurse 'Q''s opinion was indicative of this position, *"Some may scoff at my views but it is not ideal for nurses to bring their children into hospital. It would cause havoc – it would be a distraction which is just not on."* There were concerns that these facilities would have encompassed a range of children of various ages and would not been restricted to younger children. Those who held these concerns were worried about the operational consequences of this policy. Nurse 'T' stated:

> *We can't run a service with nurses working next to a crèche; it is too much of a distraction. There must be a divorce between work and family - having a crèche near a ward is not good enough, there must be 'clear blue water' between family needs and work.*

It is worth noting that the nature of nursing does not readily lend itself to this division in comparison to other professions, especially in certain disciplines, e.g. accident and emergency, surgery and oncology. It was apparent after interviewing all the staff that nursing requires in most circumstances a great degree of professional focus, emotionally detachment and in extreme cases a combination of these present a conflict for many practitioners.

The cost of providing childcare was a contentious issue particularly, amongst 'traditionalists'. Nurse 'F' argued, *"Why should I be subsidising another women's life style choice. Even if they are paying a small fee to a crèche, it will be part-subsided. In reality they would be receiving a pay increase – this is just not on."* This was not an isolated view as Nurse 'W' stated, *"If a woman doesn't want to be in a couple and wants to bring up children on her own well then that's up to her but they shouldn't be getting a pay award for having a kid"*. These concerns were linked to wider concerns that childcare provision prioritised one group over another. Nurse 'E' explained, "*I don't disagree with having provision for childcare but family provision must be consistent. Many nurses take care of elderly parents who need as much support as nurses with children of a school age, they probably need more."* She added, *"Care can't be focused only on children it must address the needs of all staff or it just builds resentment."* It was argued by nurses older than forty years of age that to create a better work-life balance for them that consideration was required of their

circumstance and how these factors underpin and affect their lives. Nurse 'Z' stated, *"There is need to break down the current split in support which divides nurses it requires new thinking to overcome this fiction that only women with children of a school age need support."*

Regardless of this, there was a strong expression amongst these nurses that the centre of sole responsibility for all care was the family. Nurse 'T' represented this opinion, *"Childcare is down to parents to organise. Domestic consideration lies only in the remit of family responsibilities."* She added, *"Crèches in-house would be an abrogation of parental responsibility. We shouldn't confuse personal needs with professional responsibilities."* Nurse 'A' was more overt in her criticism:

> *I know from experience that it's not always effortless juggling children, a house and nursing. I've heard enough about the supposed difficulties of combining work and motherhood to last a lifetime. So whenever another woman starts whining about juggling, or blaming her own abject failure to do the right thing on issues around the work-life balance, I simply want to scream 'get on with it' and then kick her up the backside.*

She added, *"In my day, we just got on with it."* These sentiments were frequently held amongst nurses over 45 years of age. Nurse 'D' believed, *"Having a proper family life is not a basic human right. Women, who bleat about the trials of combining a career with motherhood, just need to get a grip. They have never lived; I had just had to get on with it."* Although many acknowledged that having children and being in a stressful job in nursing was difficult, there was little sympathy from these nurses. Nurse 'A' comments were indicative of these sentiments, *"All the childcare talk is just an indulgence. When I and many other women of my generation entered nursing we quickly had young children we never made such a big deal of it – far less an excuse. We got on with it and simply made arrangements."* This lack of sympathy appeared to be generational and the older the nurse the less the sympathy.

However there was some disagreement with this view particularly, Nurse 'U' who commented, *"God, I've never had to balance great domestic responsibilities with a career and I have a great sympathy for nurses that are in that position. Some of my colleague's approach verges on the hysterical."* Adding, *"It's irrational and*

contradictory remember some people know the price of everything but the value of nothing." She considered the explanatory factors that facilitated these opinions were *'irrational'* and *'unadulterated prejudice'* that were linked to powerful perceptions *'undoubtedly'* linked to the role of women as mother and care provider. She expanded, *"Being able to be sure that you're going to have access to childcare if you need it is a primary consideration. However, many nurses are from the old-school they see the role of caring for children firmly in the confines of the home."* Nurse 'P' supported this position and considered nursing's failure to support *'family friendly'* provision a direct consequence of this belief:

> *For many nurses assistance with childcare needs are essential. There's no internal scheme for direct hospital childcare for many in nursing that would run against the grain - that's why it doesn't exist, this group are very influential. The service ought to ensure that there is sufficient childcare provision – nurses do a very difficult job. There should be greater efforts to help them, but that will be difficult to achieve with the lethargic attitudes towards change at the most senior levels.....Maybe what we need is regime change, I and many others would accept just a softening in attitude!*

Childcare provision generated considerable antagonism and exposed again the power, subtlety and paradoxically, the crudeness of underlying perceptions concerning the role of women as mother and the provider of care. Childcare was the metaphor for what at times appeared to be an open conflict between 'traditionalists' who defined themselves around their role as mother and matriarch of the family and 'modernists' who viewed childcare as a conduit to a greater work – life balance. In many ways it another example of what Heilman call 'attributional rationalisation' and which results in many women with dependent children being judged by a different set of standards in comparison not only to their male colleagues but female colleagues without dependent children. This research supports Heilman's observation that women judge women with dependent children on different and harsher standards that they would judge men or other women without dependent children. These gender stereotypic norms, dictate the ways in which women should behave, and the disapproval and approbation women experience for violating these "shoulds".

The dynamics underlying these process penalties women's career progression and outcomes being a woman within nursing makes women subject to gender stereotypic behaviours. It is notable that many of the most strident of those interviewed are not mothers but there was more to this than a simple dichotomy. Within both groups there were variations of views but these variations in general were minor and there appeared to be a deep and underlying prejudice by women against women centred upon the division between family and work. 'Traditionalists' were particularly dismissive of internal childcare provision and appeared unwilling or unable to recognise the 'modernist' position that the lack of comprehensive childcare provision was detrimental to the individual, the family and the service. This may well be the effect of a generational cohort effect as many of those nurses who made these pronouncements were middle age though this is a superficial analysis as these viewpoints were held by many nurses in their twenties and thirties. What it does suggest is that these viewpoints transcended age and reflects upon the power of gender perceptions and values to transcend societal changes. It did establish that these divisions were fuelled by perceptions associated with gender and gender stereotypes. The manner in which this active discrimination operated supported the observations of Heilman *et al.* (2004) that women discriminate against each other, particularly when they are in a position of authority. However, in many ways this highlighted what appeared to a resistance to change in nursing management and it is this that will be discussed in the following section.

9.5 Change and the nurse manager

The reflections of nurse managers in general exposed a difference between cultural values and corporate policy. These variances at times clashed with individual aspiration and the institution's policy intent.

Many of those interviewed considered they did not possess the authority to implement operational change resulting in some hesitancy amongst senior nurse managers to initiate change. This was particularly prevalent amongst nurses over 45 years of age and less amongst nurses under this age. Though many of those current and former managers interviewed notionally supported the introduction of family-friendly provision to provide a greater work-life balance they did not consider themselves *'empowered enough'* to initiate change. Nurse Manager 'A' argued, "*I would like to*

see childcare provision comprehensively settled but it's not for me to do it unilaterally, the centre of responsibility doesn't lie at the periphery. I can't or won't make precedent which advantages one group over another." This was not an isolated opinion and there was a belief that the division of responsibilities struggled, not merely with the concept of delegated responsibility, but upon on the notion of *'ownership'*. Nurse Manager 'B' stated:

> *There is very limited practical support for women with 'external responsibilities'. I think as a manager we are not really aware of how to provide it. What is ironic is there's a policy in place for just about everything, a stated commitment to this and a stated commitment to that, but these are imposed from above, they don't really meet grass root needs. There is nothing organic about them. They are imposed by a political body that is completely divorced from the workface. These policies don't understand workplace needs or really practical needs.*

This last sentence highlighted a powerful issue - *'professional needs'* and *'individual needs'*. The prioritisation of these 'needs' amongst those interviewed caused considerable debate and presented itself in the debate concerning individual needs/aspirations and corporate responsibilities.

Corporate responsibilities appeared to be driven by economics. The 'realities' of these responsibilities created a situation in which many became resistant to change for financial reasons. As Nurse manger 'D' illustrated, *"I am resistant to part-time working at a strategic level not because I have anything against the individuals who would fill the posts but having two people means twice as much training – double the costs for the exact same post."* For many of those interviewed these additional cost implications were a primary consideration which drove a decision making process which restricted access to more senior positions. Nurse Manager 'C' explained, *"I have to manage budgets, I have to consider every penny spent, the more spent on training two part-timers in financial terms unsurprisingly means it cannot be spent elsewhere."* She reflected, *"Unless there are more additional funds it makes financial sense to employ one full-timer."* This was considered a *"commonsense approach"* but it was acknowledged that it was detrimental in terms of women's career progression. Nurse Manager 'E' lamented, *"It's regrettable but being a manager on a ward*

nowadays is as much about balancing budgets as it ever was about professional standards." She added:

> *As a manager I must ensure a cost-effective, quality service; my job isn't about social justice as laudable as that would be. Full-time staff is an essential 'norm' because when they are upgrading or updating their skills base, the ward budget only has one additional cost. Sadly and unfairly this means part-time are priced out of the market. It's all down to economics.*

When pressed about the smaller costs of employing part-time nurses because of reduced national insurance contribution, she replied, *"Nurses salaries are paid centrally whilst training budget are allocated on a ward by ward basis. A ward receives no financial benefit from employing a part-timer, but all the negatives in terms of increased training costs."* However whilst this may in part provide a rationale for managers in areas with a need to provide on-going or a high degree of technical/practice training, it would not explain why this occurs in areas with limited training requirements.

Within the areas with less need for on-going training it appeared that deeper rooted perceptions had agency. Amongst the majority of nurse managers interviewed the concept of a work-life balance supportive of the individual as opposed to the profession was not readily embraced. Many of these managers had worked in these areas during their careers but considered that higher grade posts needed to be reserved for full-time staff for operational reasons. This was demonstrated in a resistance to creating management level jobs on a part-time basis. Nurse Manager 'L' comments were indicative of these sentiments, *"Whilst I am willing to consider requests from existing staff for job sharing I will not create part-time posts for senior grades."* When pressed on why, she explained, *"I prefer full-time workers because they offer the most effective and efficient means of service delivery with few outside distractions."* This appeared to be directly associated with perception and values concerning the suitability of part-time nurses occupying senior posts. As nurse manager 'F' admitted, *"The balance between part-time and full-time posts is quite rigid."* She added, *"Changes in the use of part-time and full-time staff are not driven by a desire to create a more balanced workforce so much as by reflections of some of the perceived disadvantages of part-time workers."*

There was evidence that the introduction of part-time posts at a senior level was frequently resisted by nurse managers. All of those interviewed superficially acknowledged the worth of part-time nurses for instance, but a vocal segment continually questioned the construction of these posts These managers valued their part-time staff as members of the *'team'* but they could not accept their occupation in higher graded posts. Nurse Manager 'E' highlighted this fissure, "*In nursing the task of providing care is the job, it's a career not a hobby.*" She added, *"The manager needs to be there. They need to be completely dedicated to the job. Nursing is a process and interruption to it must be kept to a minimum, everything even staff are subservient to it - Kids at times do have to come second.*" This position suggested that perceptions related to women with children of a school age had a powerful influence amongst this cohort and were pervasive within the profession as nurse manager 'D' explained, "*Part-time nurses are seen as less 'attached' to the ward, they usually have kids and cannot be expected to go that extra mile, or do extra shifts when people are sick etc.*"

However, there was a view amongst the most recently promoted senior nurse managers which rejected this position. Nurse Manager 'A' stated, "*There is a view in nursing that part-time working is OK but it's only for lower graded post. Part-time nurses are seen as replaceable and their skills are substantively undervalued.*" She declared, *"I don't believe it, have and never will apply it. I think many older managers are fairly closed to new ways of doing things. Maybe they can't see the opportunities for staff and the service".* When questioned on what these *"opportunities"* were she stated:

> *An end to the long hour's culture doesn't just improve the family life of staff, it will improve the quality of care for the patients. Staff will be fresher, less stressed and anxious. By striking a balance and offering support we remove at a stroke a major impediment to our own staff well-being and the quality of care we provide.*

There was a positive view amongst these managers concerning change but a clear acknowledgement that meaningful change was at the early stages of conception and had to overcome *'entrenched resistance'* from within nursing and nursing

management in particular. Nurse Manager 'B' noted that within the nursing workplace there were clear policies to promote a greater work-life balance. She conceded that regardless of the sentiments of these policies they were not being applied consistency throughout the discipline because of a lack of support by key agents of influence. She claimed that "*Though all of our HR strategy hasn't been finalised most of it is in place ...what it has to overcome, and this will be difficult, is a real anti-change approach from key senior managers within the profession.*" Women's career progression appears to be intimately linked to 'traditional' perceptions concerning the role of women. Though there are other factors, what is evident from this thesis is that once women nurses enter lower status posts, they in general become restricted to lower grades. The opportunity to address this situation by training or updating their educational qualifications in order to re-establish their position within the profession was restricted by perspectives concerning the worth of certain posts and the cost implication of providing training in terms of skills lost. This is important in relation to the perceived nature of registered nursing, the importance it subscribes to full-time working, preferences given to training issues and career progression.

This facilitated a situation where corporate policies were notionally rather than substantively applied. This was exacerbated by hesitancy and a lack of confidence by certain managers in applying policy. This reluctance appeared to be pervasive particularly amongst nurses with a more 'traditional' viewpoint in respect to the role of women. This considerably larger faction was reluctant to consider new approaches even when legislation was in place to promote it. The impression was given that this reluctance was fuelled in-part by the perceived disadvantages of female nurses, particularly those nurses with children of a school age. This faction considered that there was a range of disadvantages with part-time staff. Part-time registered nurses were regarded as inflexible in terms of working hours because of their other commitments. They believed there were professional disadvantages in providing childcare provision and had difficulties in embracing the notion of work-life balance. These managers were generally very resistant to altering the conditions of management level posts. This supports the position of Griffiths (2003) view that policy announcements within nursing often differ from the entrenched, private views of senior managers. The second group, the 'modernists', were more supportive of

change to an enhanced work/life balance within the profession. They were willing to consider requests from existing staff for job sharing at a senior level and accepted that management roles need not necessarily be completed on a full-time basis. However, possibly due to its relatively small numerical size, its influence and power was restricted. This generally supports Heilman& Welle's (2005) observation in regards to the on-going influence of gender perceptions as the agent of gender inequality within the workplace.

9.6 Discussion

There were a host of aggravating circumstances which led to many registered nurses having relatively restricted career progression and accordingly restricted outcomes.

In the end, it is a job and nurses like other waged workers aim to maximise income and make it fit with the rest of their life – if this means working below qualification, this may be a rational response to the straightjacket of 'professionalism'. The importance of working flexibility as outlined in chapter 8 and in this chapter linked the economic benefits of part-time working had for the organisation with the contradictory position in relation to the additional cost of part-time workers. Many women within registered nursing voluntarily work below their career potential for a variety of reasons ranging from the social, personal and financial. The phenomenon of many women electing to work at a lower grade or reduced working hours was linked to the need to achieve a practical work-life balance whilst reconciling their financial requirements.

Those nurses interviewed confirmed that once women worked in a lower graded post or in part-time post for a significant length of time, they found it difficult to move to higher graded posts because of the lack of opportunity to gain the *'necessary and appropriate'* skills and training a point Griffiths (2007) makes frequently and which apparently has considerable merit. Those seeking to re-train or to update their educational qualifications in order to re-establish their careers in registered nursing encountered were encumbered by this restricted access and receipt to training. The access to and receipt of training had significant impacts for women with children of a school age or those of a child-bearing age the denial of the access and receipt amongst those interviewed was influenced by the gender perceptions and stereotypes related to

women's role in the family. This was exacerbated by a belief which esteemed full-time working against any alternative or variation. This chimes with Legault and Chasserio (2003) previous findings but it refines it by weaving the complex threads of these phenomena together they are not distinct or separate but work in tandem, seamlessly with powerfully gender perceptions. The cumulative effect in relation to a women's human capital is detrimental. Training provides knowledge and skills that have a direct influence on the career progression. Becker (1962, 1964) position that employees with higher level of qualifications enhance their human capital and their worth as employee is evidenced within the research. When the access and receipt to training is restricted the human capital of a nurse and their ability to progress is reduced. Career progression in nursing are directly linked to the access and receipt of training and the attainment of qualifications.

Many of these women made a conscious choice to work at a lower grade or varied hours, but they did not 'choose' to reduce their skills or career outcomes. It appeared that for many female nurses there was no meaningful choice. Many of those women interviewed did not have an independent choice; their choice was limited by powerful social arbiters and stereotypes associated with women. While Hakim's preference theory (2000) locates choice as a critical factor in relation to women's career outcomes and progression its disjuncture from economics and gender stereotypic norms is a fundamental weakness. While the economic argument is clear the potency in gender stereotypes in reducing meaningful choice is equally significant. The expectation that women look after children and adjust their careers to the needs of the family still has significant influence in exposing preference as an illusion. Preference might have validity in relation to certain groups – families with high earning but its critical weakness lies in not factoring in the potency of gender perceptions and values as inhibitors upon career outcomes and progression. Its failure to recognise the power of the distinct and separate manifestations by which gender stereotypes influence women is vital in underlying the influence of these values and the relative insignificance of preference theory in terms of career progression and outcomes. The hostility of those women interviewed to other women support Heilman *et al.'s* (2004) view that is it not just for many women, particularly those with children of a school age. It is these norms that mean many nurses have no 'free' choice in relation to their career decisions.

Childcare provision for many of the women had an apparent but unintended consequence. That is, women who utilised this provision to allow them more flexible working arrangements to address the demands of families reduced their career prospects. Being 'family friendly' in nursing was seen as the opposite to being 'career-friendly'. Amongst those interviewed 'norms' were constructed; the greatest of which was the paramount role of women in relation to the family and children. Many of the women interviewed encouraged the propagation of these values within the workplace again an example of the power of the gender norm (Heilman *et al.* 2004). It was apparent that gender perceptions, in particular those associated with parenthood had considerable power within nursing in relation to career development. This would support Wajcman's (1998) position that gender values and their materialisation within the workplace still affect women's career progression and outcomes, and suggests that the practicalities of combining career and family responsibilities materially prevented women from comprehensively accessing enhanced unrestricted career outcomes it is important to note that the above affects a wide range of women not only women who are mothers but at times those considered likely to be mothers in the near term. It must be acknowledged that it affects certain women more than others but it has a clear and present effect to those it does affect and on the strength of this research this would appear to be a significant number of staff.

The debate in relation to traditionalists and modernists is interesting. It exposes that the age of the' traditionalists' is not important as there were many 'modernists' near retirement and traditionalists who had just left school. It is apparent that the social conditioning of nurses in relation to values, particularly 'flexibility', the ability to work flexibly and professional knowledge was the process in which people accepted 'traditional' values. The values were deeply rooted in a model which prioritises the patient and their needs. The mantra that the *'patient comes first'* is part of this process a process through which training nurses to respond in a manner generally approved by the profession. The concept is stronger than that of socialisation; it goes beyond the process of inherited norms, customs and ideologies. The social structure in which nurses finds them-selves influences and determines their social actions and responses. As nursing is organised on a hierarchy defined by its attitudes, beliefs, behavioural norms and values the consequence are an accentuation of these values. Adherents are judged positively and the non-adherents are judged. As the social categories in which

nurses' find themselves are highly structured and exist only in relation to other contrasting categories this relationship with professional values is a powerful agent in terms of power, prestige, status, and career. Through this traditionalists normally become senior managers with those unsympathetic or hostile either sidelined or silenced. It is conformity to these values which produces senior managers in nursing. This is the paradox of nursing a profession as the cutting edge of innovation yet restrictive within its own culture.

By maintaining the meanings and expectations associated with a role, nurses maintain the complex interrelatedness of social structures. Nurses are tied to their profession; they are tied mechanically through their role within the discipline. The meanings and expectations are tied to each of these roles, regarding performance and the relationships with the profession's values principally commitment, the ability to work flexibly and professional knowledge. It is the prioritisation of these which creates a situation where the adherents to the values progress within the profession. It is the prioritisation of the established pattern of relationships within the organisation which allows for the promotion of traditionalists but this bears no relationship to their age or background. It is built upon adherence to these values. This aspect of the research was evidence of the complex relationship which the profession negotiates in ordering the sphere of interaction between organisational values and gender perceptions. This relationship acted both as an inhibitor and arbiter upon the careers of many women in registered nursing. This was propagated by the prioritisation of operational values at the expense of individual requirements. Environmental factors necessitate the need for organisational certainties but they are influenced by extraneous social factors. Operational requirements and professional values are mutually related, they appeared to define normative rights despite complex and diffuse social interactions. There is an irony here that in a profession so dominated by females numerically, that it has developed a set of professional values so far in conflict with the needs of working women. With no alteration in organisational culture or prioritisation there will be no change, these values will continue to be propagated as there is nothing to counter it or mediate against it. As these values are deeply embedded within nursing it is not an issue of seniority or of modernists and traditionalist but one of culture.

The differences might be a result of crude gender-perceptions, for example, employers and employees may consider that men are more 'naturally' capable of dealing with the security-related problems that may be present for those caring for the mentally ill. If this was the case, women's and men's careers would be directly and indirectly affected by gender perceptions.

9.7 Summary

It would appear that gender perceptions and values amongst many of those interviewed appeared to have an effect on women's career progression and outcomes. It would suggest that that:

- Perceptions concerning work-life balance, flexible working and childcare provision are the products of gender perspectives about the appropriateness of women, particularly women with young children working in nursing at the 'expense' of the child. Childcare provision for many of the women had an apparent but unintended consequence. That is, women who utilised this provision to allow them more flexible working arrangements to address the demands of families reduced their career prospects. Being 'family friendly' in nursing was seen as the opposite to being 'career-friendly'. Gender perceptions and the expectations result in the devaluation of women, a denial of opportunity in relation to the access and receipt of training and a penalisation in respect to career progression and outcomes.

- The access to and receipt of training had a significant impact on career progression it is the medium of transfer for women's relative career disadvantage in comparison to men. The restricted access to training plays a key role in disadvantaging women with children of a school age in registered nursing in relation to men and women without dependent children of a school age. Many women with dependent children had difficulties in reconciling family commitments with receiving training. Training was provided in a format which frequently did not accommodate their needs. Training within the NHS was usually provided on a full-time basis and this presented staff with child care responsibilities, or who worked on a part-time basis, with major

problem in attaining this training and in both sustaining and developing their skills base.

- Nursing has developed a set of professional values defined by 'commitment', the ability to work flexibly and professional knowledge which when combined with gender perceptions creates a tension which are in conflict with the individual needs of many working women, particularly those with dependent children.

- Part-time working was a negative determinant of a practitioner's career regardless of circumstances. This is apparently exacerbated by the profession's apparent preference for full-time working. There is also, for whatever reason, a dearth of part-time posts in more senior positions within registered nursing and, consequently, this leads to those nurses who are predominately women with major childcare responsibilities, experiencing difficulties reconciling career progression with the need or desire to work on a part-time basis. There is a perception that part-time nurses lack the skills, knowledge and commitment of their full-time colleagues.

The following chapter summary will outline proposals to challenge the impact of these values and the very perceptions themselves.

Chapter Ten Conclusion and Recommendations

Change doesn't happen because of time. We have to do things to make society change. Trevor Phillips, *The Guardian*, July 23rd 2009

10.1 Introduction

This chapter is intended to pull the various threads of the discussions undertaken throughout this thesis into a cohesive whole. It will commence with an overview of the significant findings. Included is a critical review of the research limitations, a statement of significance, policy recommendations and reflections on the research process. It will conclude with closing comments.

10.2 Findings

The aim of this research was to investigate the impact of gender and gender perceptions on career progression in registered nursing in Scotland. This section outlines the key findings in relation to the three identified objectives.

Objective one established the scale and pattern of gender difference in registered nursing in Scotland. The following was found:

- The percentage representation of women decreases the higher the grade in registered nursing in comparison to their male colleagues. Male registered nurses have a greater likelihood of progressing into a senior post than their female colleagues (see chapter 6, pages 102-105)

Objective two analysed the impact of key factors - dependent children, age of the children, career breaks, part-time working along with access and receipt of training on career progression in registered nursing. The following was found:

- The career progression of female registered nurses with dependent children of a school age was limited in comparison to male registered nurses with or without children of a school age and female registered nurses without children of a school age. The likelihood of female registered nurses with children of a school age achieving higher graded posts was directly associated to the age of the dependent child. There is a casual factor: the age of the dependent school aged child had a significant negative impact on women's career progression.

For this group of women their career progression incrementally reduces relative to the age of the child - the younger the child the lower the likelihood that a woman with a dependent child would progress to a higher grade at that stage in her career. (see Chapter 7, Pages 115-119)

- Career breaks, and their length, had a particularly debilitating impact on women's career progression. Career breaks are mostly linked to children. Women take career breaks to have children or to take care of children; men rarely take career breaks for this reason. With a career break of greater than two years, the human capital of the nurses acquired prior to the break becomes diminished (see Chapter, 7 Pages 120-123).

- The length of career breaks creates a *"snakes and ladders"* effect which detrimentally affected women's careers. Upon return from this length of break, women frequently returned on a part-time basis, in a lower graded post than their experience merited, or both (see Chapter 8 pages 146-151).

- The access to, and receipt of, training had a significant impact on career progression. It is the medium of transfer for women's relative career disadvantage in comparison to men. The restricted access to training plays a key role in disadvantaging nurses who work on a part-time basis. Specialist training within the NHS was usually provided on a full-time basis and those nurses who worked on a part-time basis were normally prevented by this circumstance from accessing it.

- Part-time working had a negative impact on nurses' careers regardless of circumstances. This is exacerbated by the profession's preference for full-time working. There is a dearth of part-time posts in more senior positions within registered nursing and, consequently this limits women's progression opportunities.

Dependent children affect the career progression, at least in the short-term; this effect is greatly influenced by the age of the child. The degree of impact of this is directly linked to the age of the child: the younger the child, the greater the negative impact. The age of the child is an inhibitor to women's career as it reduces the likelihood of

career progression. This enhances the research of Waldfogel *et al.* (2004) by showing the career impact of dependent children on women's careers. There is a career penalty for mothers with the agent of this being the age of the child. Waldfogel is correct in that employment continuity is crucial to career progression but there is a gender effect. Women who have multiple career breaks are disproportionally and negatively impacted in terms of their careers in comparison to men. Those who take a career break are perceived to diminish their human capital by suffering a loss of skills but again, this appears to have a gender bias. However, for women this is exacerbated by two issues. The *"Snakes and ladder"* effect upon women's careers as outlined previously and by the restricted access to the receipt of training. In isolation, one of these effects would be detrimental but when they occur in tandem, the effects are manifest.

Objective three explored the relationship between nursing values and gender perceptions on career progression. The following was found:

Gender perceptions directly affect career progression. The loci of these are firmly rooted in perceptions associated with dependent children and women's role as primary carer - *"the family comes first"* syndrome. These perceptions had considerable power amongst many of the women interviewed. At a certain level; women who had children, notably of a pre-school age, were overtly and implicitly expected to prioritise their children, and variations from this were met by, at times open hostility. This was a 'norm' within nursing which centred on the role of women in relation to the family and children. Those nurses who challenged these perceptions were marginalised and their careers restricted. In relation to these, Heilman *et al.'s* (2004) argument has value: gender perceptions and the expectations they produce result in the devaluation of women's abilities, a denial of opportunity and a penalisation in respect to careers. Organisational fit expectations, whether positive or negative, profoundly affect evaluation processes. Wajcman's (1998) position that gender values and their materialisation within the workplace affect women's career progression is as valid in the twenty-first century as it was in the twentieth. Within this lies a central mechanism of the transfer of gender disadvantage; working women with children, particularly dependent children of a pre-school age are disadvantaged

by these norms. They are presented by perceptual barriers which place restrictions on their careers.

This interaction between organisational values and gender perceptions, acts both as an inhibitor and arbiter upon the career progressions of women in registered nursing. Professional prioritisations, particularly 'commitment' to the profession, working flexibility and professional knowledge are potent within registered nursing. Traditionalists within nursing expected two things. The role of the nurse was to prioritise patient care at the expense of any other consideration. Operational requirements inform values concerning 'acceptable' practices. This operational prioritisation existed in tandem with a belief that women should personally prioritise their family, particularly dependent children. While operational values are not a product of gender perception, there appears to be a symmetrical relationship between them. Operational requirements and gender values within nursing are mutually related. The core of this relationship revolved around perceptions that commitment, flexibility and professional knowledge were best provided by nurses removed from family considerations. There is a contradictory aspect to this relationship as nurses who work on a part-time basis are relatively undervalued but their ability to work flexibility is highly valued. Perceptions are frequently illogical and this is one instance but what this exposes is the value ascribed to a full-time member of staff who is at the disposal of the profession as opposed to a part-time member of staff who may potentially work in their own individual interest.

There were instances of crude gender discrimination but the impact of gender perceptions was more sophisticated. It is the relationship between nursing values with their emphasis on commitment and full-time working, and a belief that as a nurse they are subservient to the needs of the discipline as opposed to their individual needs. This creates a tension that is detrimental to the short and long-term career ambitions of women. Nursing values prioritised the profession at the expense of the individual. Nursing with its emphasis on commitment to the profession and full-time working has a philosophy of subservience to patient care which encourages a situation in which these imbalances can exist. This supports Griffiths (2009) previous research in relation to conforming to values. The disjuncture between operational requirements and the individual nurse results in women in general conforming to professional

values as opposed to nursing adapting to the needs of the individual. It does support Legault and Chasserio (2003) that the potency and power of these values, when combined with gender perceptions facilitates compliance and adherence which leads to their propagation. In these circumstances and it is understandably difficult for women to disassociate themselves from these values, particularly in a profession which places an emphasis on them behaving according to certain expectations. Altering these dynamics is difficult when the dominance of acceptable values, both in gender and professional terms is complete and results in non-adherents to 'orthodoxy' becoming excluded and marginalised. Gender perceptions within nursing are highly resilient and appear at times invulnerable to change; it is the strength of this relationship which propagates them. The relationships between perceptual and operational distinctions, particularly commitment, the ability to work flexibly and professional experience are important because they directly affect and define career progressions.

There are several reasons for women working below their qualification. One is personal choice and there is evidence to suggest that this does occur. However, the more common reason is that when women wish to work on a part-time basis there is a lack of posts commensurate with the experience of the practitioner. Through economic circumstances nurses work in the posts that are available. Though, Hakim's (2000, 2002, 2004) preference position that some women voluntarily decided to restrict their career outcomes was supported. However, there is a caveat to this, the research suggests that this was a relatively rare phenomena. Within the group of women interviewed who elected to work below their experience they did so to accommodate childcare needs rather than through 'personal' choice. Personal choice is a highly subjective notion, it does have a form of validity for groups on the highest incomes but choice is constrained by economic circumstances. For those on the lowest incomes, there was no substantive validity for the argument in favour of free choice. Personal choice ultimately appeared to be determined by economic factors rather than any philosophical positioning.

Given the gendered nature of nursing, both in terms of workforce composition, philosophy and its institutional nature, women's relatively restricted career progression is still surprising. Women's careers in nursing are socially constrained by

gender and exacerbated by a symbiosis between gender perceptions and nursing values. This relationship between professional values, particularly flexibility and commitment and gender perceptions are detrimental to career progression for women. This has profound implications for women, particularly those with dependent children, notably those with children of a pre-school age. The gendered nature of careers and the relationship with 'motherhood' is apparent - being a woman restricts or reduces women's careers. These findings require to be framed within the limitations of the research and these will be discussed in the following section.

10.3 Limitations of the Research

As with most research, there are limitations to the current research. This section will discuss the limitation of the research, including the limitations imposed upon the quantitative and qualitative research by time restrictions and resources.

A limitation of the quantitative findings concerned certain aspects of the data related to career progression and gender. This limitation was related to the quality of the material; the most accurate data in relation to length of service was not accessed by the researcher. This data, the superannuation records, was complicated by its structural complexity and practical accessibility. The complexities of the material, particularly whole-time equivalencies and length of service data in comparison to re-entry dates of returning nurses after a career break made accessing the data extremely difficult within the time available. There was also a limitation imposed due to the variety and differences within the disciplines/types of nursing, and the concentration of men in only a few areas, particularly Mental Health. Not accessing the data related to the ethnic composition of the workforce was a limitation which could have provided another dimension to the findings, even though the ethnic minority population is very small in Scotland (relative, for instance, to England). It would have been appropriate to assess dependents such as grandchildren and older relatives to facilitate a more complete and accurate assessment of career progression. However, this data is unavailable.

In order to evaluate the relationship between experience and seniority; one alternative considered was to equate experience to 'length of service' which could have been attained by subtracting time worked out with nursing or on a part-time basis from the

period since registration. There is a significant failing with this approach - it does not consider the distinct possibility that applicable experience appropriate to nursing e.g. nursery work, could be accrued outwith the nursing environment. Utilising superannuable service as an indicator of experience was arguably a more accurate record of length of service, but this was an inexact measurement as this data included non-nursing and non-registered superannuable service. For older employees, this means of ascertaining experience was further compromised by historical regulations, which left membership of the superannuation scheme optional. However, the surrogate determinants applied were extremely accurate and were not restrictive in terms of time or human resources.

The limitation of the qualitative research is principally that it is specific to time, location and organisation. The outcome measures used are selective, and in certain instances, the analysis is based on individual reflections. This has inherent limitations - the possibility of misinterpretation and bias. The limitation of exploring a relatively small group with specific experiences limits the ability to generalise the findings to other sectors or people, although generalisation was not the purpose of this phase of the research. Another limitation was not examining the issue of childcare access on a larger scale, its economic and social consequences, opportunity costs and its shadow effects in terms of career progression. The data related to the percentage of gross spending on childcare per household relative to net income and gross incomes of the household were available. However, there were insurmountable legal considerations which resulted in this avenue remaining unexplored. The data provider, the Benefit Agency, was prevented from providing this material by the Data Protection Act.

Within this research, it was clear that career progression and gender are not mono-dimensional but complex and this complexity resulted in several limitations. However, this did not compromise or diminish the research; the research was significant as the following statement outlines.

10.4 Statement of Significance

The significance of the research is built upon the unique quality and quantity of the national workforce data - 65,781 employees and multiple variables which included; employment grades, qualifications, number and length of career breaks, lengths of

service, age, working patterns, the number and age of children and the practitioners marital status. This is the only example internationally, of a national workforce being examined on this scale and to this extent the findings generated are significant. It questions, confirms and enhances theory and adds to knowledge. The findings include:

- Confirms that the sex of a nurse directly informed their career opportunities and progression.

- Defines the degree of impact which dependent children of a school age have upon men's and women's career progression. For women with dependent children, the degree of disadvantage is directly related to the age of the child, the younger the child the greater the detrimental impact – there is less likelihood of career progression. The degree of impact is directly proportional to the age of the child. It substantively develops Waldfogel's position that there is penalty in relation to motherhood for women. There has not been any literature or research that defines the impact of dependent children on career progression. This has furthered the understanding of that issue.

- Defines the detrimental impact of career breaks upon women's careers. Women who take a career break of greater than two years see their careers depressed and restricted. The impact is not gender neutral as men's careers do not suffer to the same degree. There has been literature and research in this area but this research defines the impact of career breaks. This has furthered the understanding of issue.

- Confirms the negative degree of impact that working on a part-time basis has upon a nurse's career. This is related to gender and children, part-time working are 97.49% female and those who work in this area have a disproportionate amount of children in comparison to their full-time colleagues.

- Confirms that nurses who work on a part-time basis and/or have dependent children of a school age have restricted access to the receipt of training. This

restricted access to training is a principal mechanism of transfer for career disadvantage in registered nursing.

- Confirms the existence of the 'Snakes and ladders' effect. This being that prior to a career break, women rise through the grades until they take a career break. Upon return, they start on a lower grade or reduced hours or both and have to effectively recommence the careers. This is the *"Snakes and ladder"* effect in action and its effect has a direct impact upon their career progression. This is a new contribution to knowledge.

- Observes that coarse discrimination is not restricted to men and women but is prevalent between women with children and women without children to a higher degree than previously considered or acknowledged. Nursing has an apparent preference for full-time nurses occupying senior posts than part-time nurses.

- Observes the relationship between gender, gender perceptions and operational values, particularly commitment, working flexibility and professional values are central to defining career outcomes for men and women. This not only has important implications for women in employment, but also for women in management and leadership roles.

The findings are relevant for other employment sectors, both nationally and internationally. They are significant in relation to broadening the debate in relation to equality of opportunity for women. The recommendations that can address these issues require to be reviewed and these will be discussed in the following section.

10.5 Policy Recommendations

The NHS is facing choices in relation to how it will address significant financial restraints presented by the demands of an ageing population, an ageing workforce and governments requiring economic efficiency savings. In the near future, the NHS will need to make real term cost savings whilst maintaining and, where possible, enhancing the quality of essential services. The requirement for efficiency savings to enable reinvestment in quality is apparent. This requires the NHS to increase productivity, as productivity is highly variable within it and even within trusts

(Appleby *et al.* 2009). Given these pressures, the productivity of nursing is an extremely salient topic. These decisions in general are out of the organisation's control; however, it does have a prerogative. Nursing as a profession has a choice - to maximise the skills of all its practitioners or to restrict contributions of many of its members. This section will make recommendations, based upon the findings in this thesis, related to human resource management, the support framework in relation to training, flexible working and childcare provision:

- Nurses, while absent on a career break should be offered on-going training to maintain their skills.

- The skills base of nurses who return from a career break should be evaluated and training provided.

- All grades of nurses should be afforded support in accessing and receiving training, the time-length of courses should be altered if needed to accommodate part-time practitioners.

- Accessible training and learning pathways at a national, regional and local level and unequivocal statement of recognition of prior learning. Enhanced learning frameworks are needed to support access to education and training so that all nursing practitioners, particularly those returning and part-time practitioners can be more easily realised.

- There needs to be a greater emphasis on the career development of all nurses, particularly part-time nurses and nurses returning from career breaks.

- Alternative working arrangements to foster gender equality, both at home and in the workplace

- Enhanced child care provision provided directly by the NHS within the workplace would support a greater work-life balance and better enable women, particularly women with pre-school children.

- The Royal Colleges of Nursing and Midwifery needs to be involved in engaging and reviewing nursing's values, their appropriateness and applicability in relation to practice and the individual.

In summary, the impact of the choices which have been discussed can directly benefit the financial and operational efficiency of the NHS. The retention and return of experienced registered nurses can reduce the on-going expenditure on the training of 'new' staff. Re-engaging and retaining experienced nurses would further enhance the quality of care provided by the service. This notwithstanding, it is a necessity for the NHS if shortages in registered nursing are not to become chronic in the near future.

For nurses, these proposals can enhance the work-life balance and positively confront the choice many women are presented: between their career and family. It represents an opportunity to enhance all women's career outcomes, particularly those with dependent children, while preventing the permanent loss or curtailed career development of the most highly trained and skilled members of staff, which is neither advantageous nor desirable for the NHS or the nursing profession. These recommendations would support the possibility that woman, particularly those working part-time, those returning from career breaks and those with dependent children of all ages, could meaningfully develop their career. These policy recommendations were dependent upon reflection and it is these that will be discussed in the following section.

10.6 Reflections

This section will discuss the successes, frustrations, surprises, failures and regrets concerning this research. It will discuss what would have, in hindsight, been attempted differently, why it would have been done differently and how it would have been completed.

There were many successes and frustrations during the process of completing this research. The greatest research success was attaining access to both quantitative and qualitative data while the greatest frustration was awaiting ethical approval. This I believe was a good example of the worth of forwarding planning and an inappropriate approach to research. However, there was regret in relation to this request; this was in not asking for certain data, particularly data relating to ethnic minority groupings. This was an error which possibly occurred because the ease of access and the level of support provided by the NHS overcame the researcher.

The importance of building positive relations with key actors and agents and maintaining them, even when the initial engagement has ceased was critical. The time spent on updating them with abridged summary reports was important in maintaining their on-going support. Summary documents were a great success, after every supervisory meeting a summary report was prepared and circulated to the supervisory team. This was critical in focussing the researcher and keeping the research aligned to the research focus. Literature grids were a highly effective and efficient research tool

which reduced complex material into a concise format. It was particularly useful in relation to the preparation of the literature review. The research timetables reinforced the need for a clear focus and the aims and objectives of the research project. These were simple but highly effective research tools.

The heavy involvement of the supervisory team paid direct dividends in terms of the attaining of the research data, they encouraged that the data request be comprehensive. The development of cordial relations with data provider was highly beneficial to the accessing of the data and was instrumental to achieving the quantity and quality of data provided. On reflection, the greatest success was developing this relationship prior to the commencement of the research at the proposal stage. This was part of a strategic planning process which engaged with issues such as access, validity and ethical considerations - this I believe was a forte of the research. It reduced the inhibiting impact of practical problems, principally time and resource restrictions to a minimum.

The steepest learning curve took place during the qualitative pilots where six interviews had to take place before the researcher's voice was reduced and the interviewee's 'voice' was more fully heard. However, being physically based at the location of the interviews was a successful aid to understanding the internal and external dialogue within registered nursing - it allowed a greater ease of exchange between the interviewer and the interviewee. This approach made the nurses involved more amenable to participate and sympathetic to the research aims and objectives. This embedded approach gained the trust and confidence of the nurses involved and paid a dividend in the quality of the research.

There are things that could have been done more efficiently and differently, principally the use of time in continually rewriting the thesis in the early stage. This emanated from a lack of confidence which manifested itself in an adherence to all suggestions from the supervisory team. The confidence that developed from dealing constantly with the material assisted the development of critical thinking, but it was regrettable that this did not happen earlier as it would have facilitated a more efficient use of resources. In light of these experiences, I would approach this differently. I would on reflection, attempt to be more patient and less anxious. I have no doubt that

every researcher has these experiences but in the final analysis these minor issues did not impinge upon the quality of the research – rather they added to it and on this note the following section will address my closing comments.

10.7 Closing Comments

There are significant issues which affect women's career progression in nursing. Gender and gender perceptions affect the ability to access and receive training. Gender perceptions have agency in creating and maintaining barriers which directly affect women's career progression. It should be borne in mind that in each discipline of nursing there are unique conditions. This distinctiveness places them within a context which is central to understanding the factors which reduce career progression of women and cast a shadow on their career outcomes. The NHS and the nursing profession have a choice in relation to these issues. In easing restrictions and increasing access, particularly for part-time professionals, practice and career outcomes can be improved.

This analysis opens up a wider research agenda, greater research is needed which can explore women's careers relative to the age of the dependent child, posts within a wider range of occupations and industries from the points of view of both employers and employees. As this study was located in nursing, replication in other occupations would determine whether the results are applicable in occupations that are not numerically dominated by women. Further research is needed to explore the contribution which women with children of a school age, notably pre-school children, make to their communities and to their families and the degree that the age of the child has upon their life and work. The impact both short and long terms on career progression and the care of older dependents has on women's career outcomes is an area suitable for examination. As is the degrees of dependency within its social and economic context. In relation to academia, further research is required that discusses the relationship between professional values and gender perceptions in a theoretical and analytical framework explicitly dealing with issues of career progression. Such a discussion can deepen our understanding of this issue, employment and in the domestic realm. It throws light on the ways in which gender perceptions are related to the implicit and explicit view of the 'proper' roles for men and women in employments. As knowledge is the key to change, research into the wider social

conditions of women's and men's lives is therefore vital when developing strategies aimed at creating a more equal society. All of these areas still remain relatively under-examined; a fuller understanding of this aspect of women's lives could help to ensure that the contribution women make to their families, to their communities and to the labour market are understood and rewarded.

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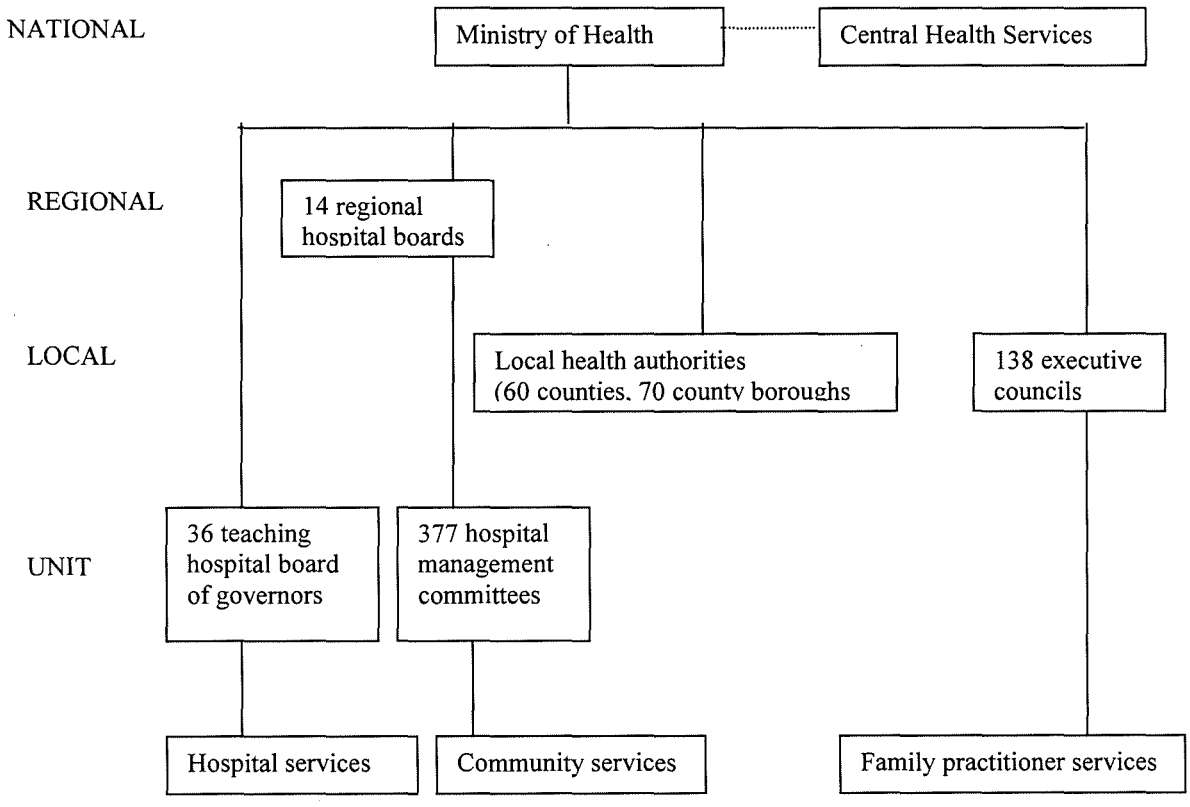
Appendices

Appendix 1 The Strategic Organisation of the NHS

Butler and Butler (2000) stated that the Labour government in 1948 elected, for operational and political reasons, to maintain a local framework placed within a centralised structure. To facilitate the introduction of the NHS a tripartite structure was created between hospitals, primary care and local authority health services. This organisational framework did not alter accepted practices, operational relationships or management structures and it resulted in a structure driven by a patrician ethos (Johnson, 1987). Klein (1995) noted this tripartite structure gave considerable autonomy to regional boards and hospital management committees within the limits of a fixed budget set by national government. The autonomy of the medical professional was unchallenged: *"While central government controlled the budget, doctors controlled what happened within that budget"* (Klein, 1995: 75). The structure was as follows:

Diagram A1: The National Health Service - 1948



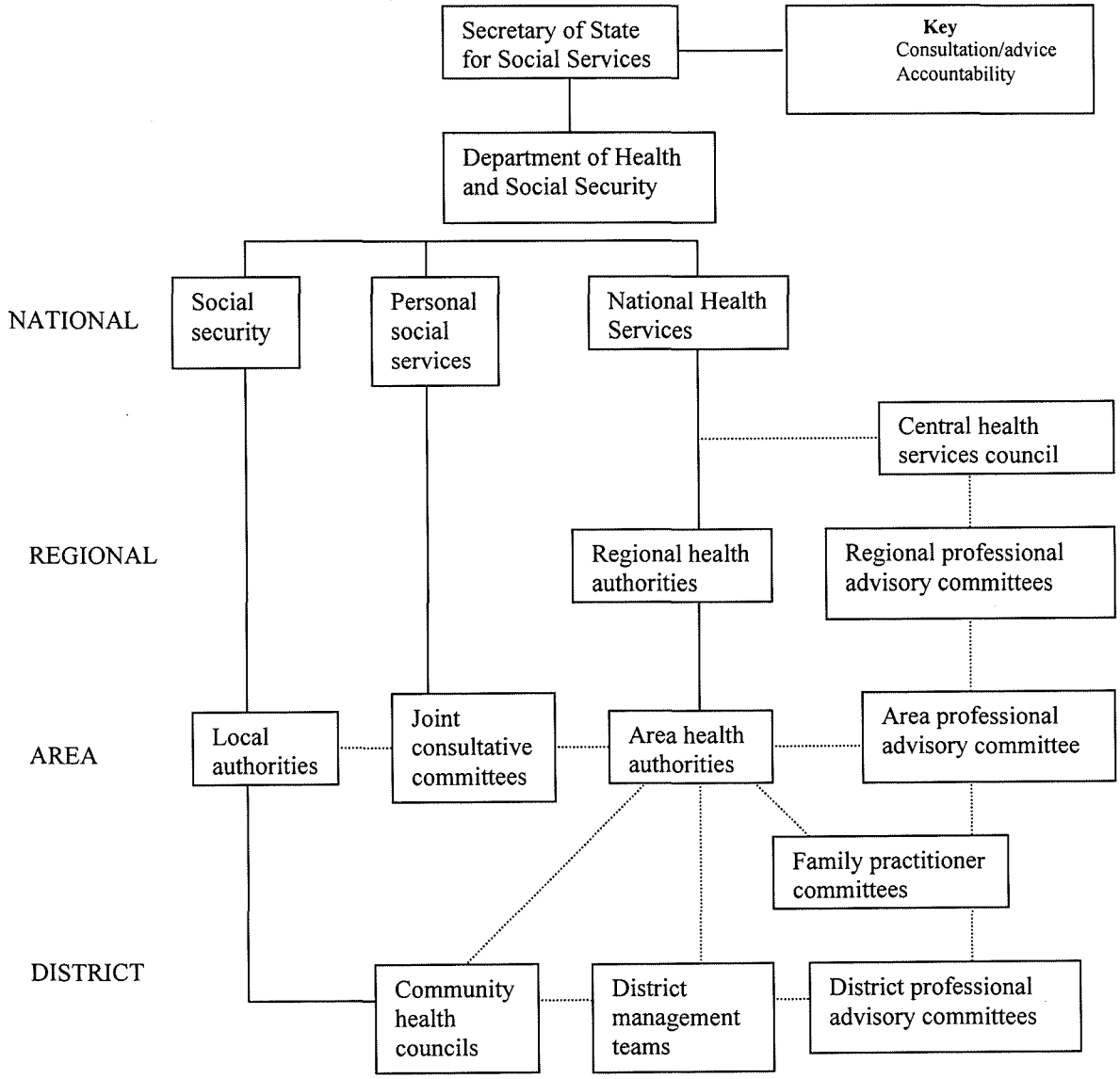
Jewkes and Jewkes (1961: 167)

Contrary to expectations of steady or reducing costs, the cost of the NHS became a political issue, as expenditure began to outstrip estimates. Concern over rising costs led to the appointment of the Guillebaud Committee of Enquiry in 1953 with a remit to review the containment of health expenditure. It found no evidence of extravagance or inefficiency. Reflecting on the review Churchill's Conservative government believed that government had the duty to plan services within the NHS to achieve greater efficiency and rationality in the use of NHS resources. This emphasis reflected the pressures on resources exerted by the rising costs of care. This occurred due to developments in medical technology and medical pressure to keep pace with such developments; rising expectations on the part of the population; pressures for higher wages and salaries within the service; and the demographic changes caused by an ageing population. Yet the Guillebaud Committee did record a concern that the tripartite organisation of the NHS emphasised the importance of the hospitals at the expense of the other two branches of the service. It suggested that the divisions be reduced by the creation of a more unified management structure (HMSO, 1962). In 1967 the Joint Working Party on the 'Organisation of Medical Work in Hospitals' issued the 'Cogwheel' Report. It recommended a corporate approach to medical administration and the creation within hospitals of clinical divisions of linked specialities, thus ensuring efficient deployment of resources and management issues within clinical fields. It was argued that the sharing of information produced by such links would improve the use of resources. (Harding, 1994)

During this period securing co-ordination and integration between the three wings of the NHS became increasing problematic. A consensus developed that the tripartite structure of the NHS was a source of problems (Rawnsley, 2001). The 'National Health Service Reorganisation Act 1973' proposed a more integrated system of management. The reorganisation coincided with the reorganisation of local government under the Local Government Act 1972 which produced a more theoretically unified structure: three main levels of management - regional, area and district and two in Scotland – regional and district. The reorganisation aimed to unify health services by bringing under one authority all the services which had previously been administered by regional hospital boards, hospital management committees, executive councils and local health authorities. It was intended that this reorganisation would bring about better co-ordination between the health authorities and local

authorities (Corby & Higham, 1996). To facilitate this, the boundaries of the area health authorities were designed to match those of the local authorities providing social services through regional health authorities (RHAs). These were responsible for planning local health services. Areas were expected to liaise with local authorities. Most areas were further divided into health districts administered by district management teams (Rayner, 1994). The structure is set out in the following:

Diagram A2: The Reorganised National Health Service - 1974

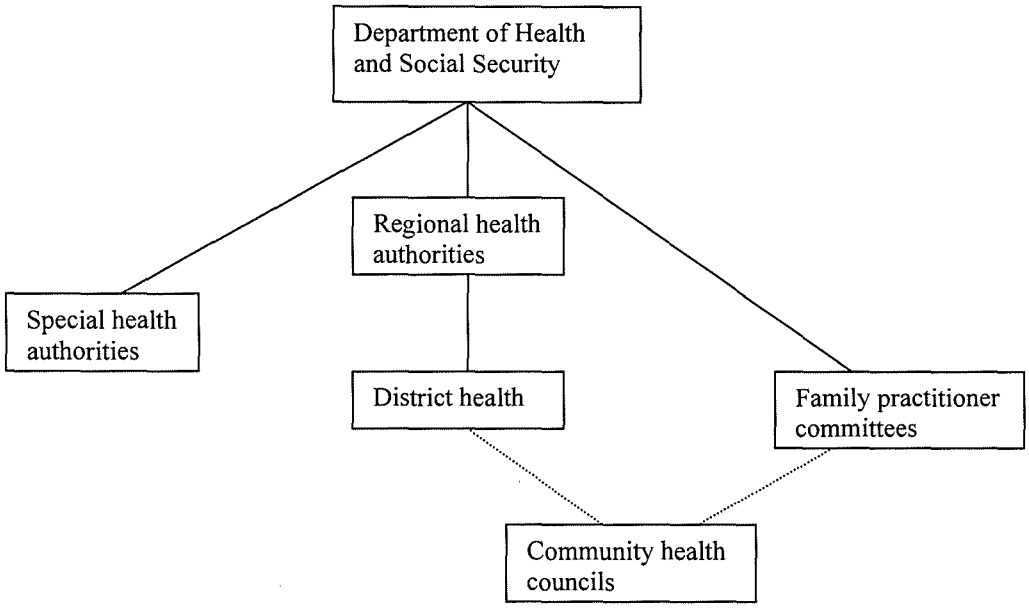


Levitt *et al.* (1999: 39)

The reorganised structure did not meet with widespread approval, it was rapidly criticised for containing too many tiers of administrative decision-making which led to bureaucracy and delays - too many tiers; too many administrators: financial

inefficiency and a failure to make decisions (Winchester & Bach, 1995). The 1976 Royal Commission in response to these accusations considered the best use and management of the financial and personnel resources of the NHS. It recommended in 1979 that there should be only one level of administrative authority below the level of the regional health authority. It proposed a strengthening of management at a local level, with greater delegation of responsibility to hospital and community levels, and removing the area tier and establishing district health authorities to combine the functions of areas and the existing districts. It emphasised devolving management down to smaller units of management (Kessler & Purcell, 1996). The changes made in the structure of the NHS resulted in the following:

Diagram A3: The structure of the NHS – 1982



Ham (1999: 40)

The attempts to increase delegation to the periphery and to decrease central prescription as the 1982 reforms attempted did not endure. Central scrutiny and direction intensified as the government sought to wrest greater efficiency or higher outputs from the NHS. The Thatcher government commissioned Sir Roy Griffith to comprehensively review the NHS. Griffith argued that there was a lack of a clearly defined general management function and consequently the NHS was weakened as an effective organisation. He noted that at each level of management there was no one person ultimately accountable for management and organisational actions. Griffith

recommended that all levels within the NHS should operate under the control of a single general manager or chief executive. The report proposed the introduction of a management culture which gave managers more prominence (Davidmann, 1985). Klein (1995) noted within the report the coloration between clinical freedom, management responsibility and monetarist market philosophy:

> *One of the report's central arguments was that the management task revolved around delivering a good product to the consumer: 'Businessmen have a keen sense of how they are looking after their customers. Whether the NHS is meeting the needs of the patient and the community, and can prove that it is doing so, is open to question.' Thus Griffith put two new questions on the NHS agenda, which became increasingly salient over the following decade. First, was the NHS producing the right kind of goods? Second, was the quality of the goods being produced adequate?* (1995: 151)

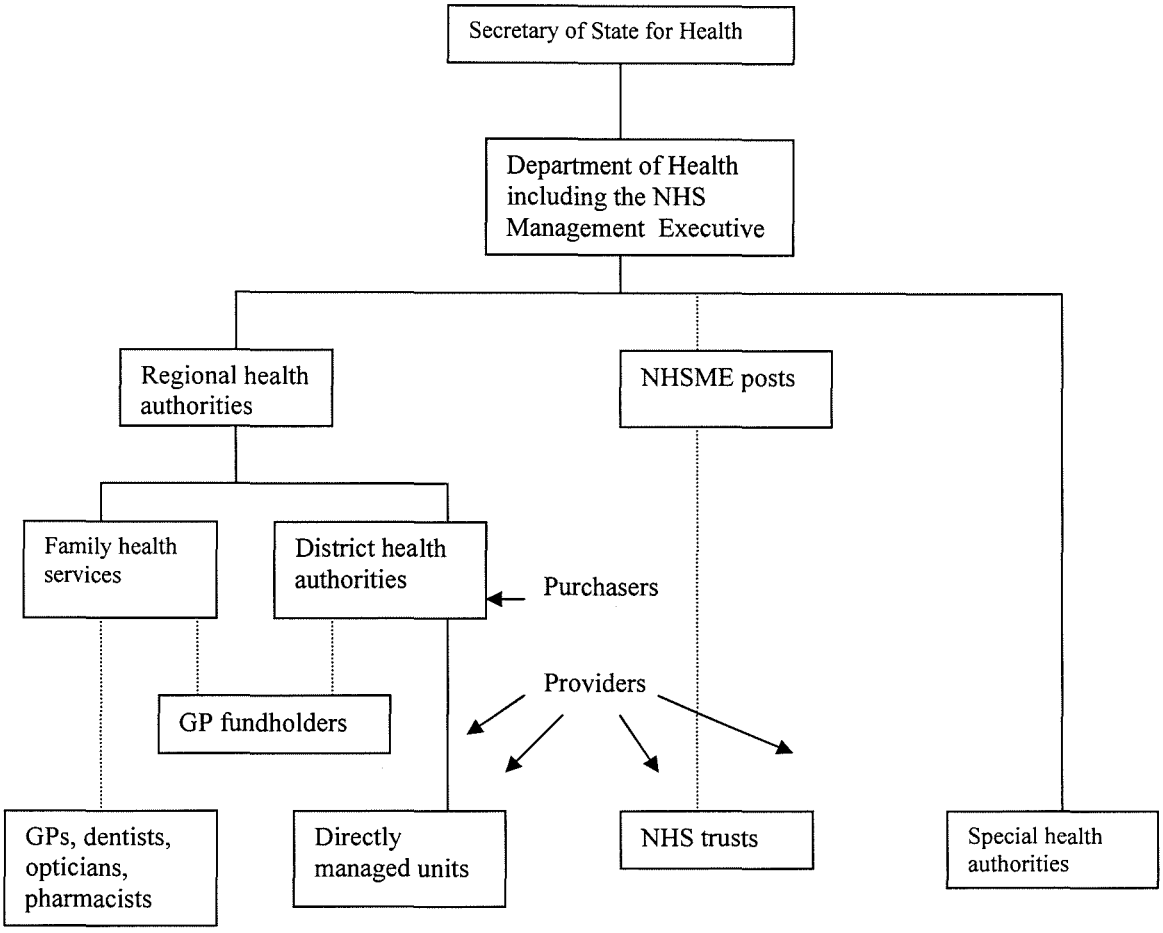
Jenkins (1995) argued that the Griffith review generated the most fundamental series of changes to affect the NHS at a strategic level. Jenkins argued these 'reforms' were not concerned about care ethos or philosophy but purely with the financial operation. The introduction of general managers into the NHS altered the strategic relationship. Power and responsibility within the NHS became centralised post-Griffith. This 'new managerialism' rejected the prevailing consensus management style which had been successful in the Pacific Rim economies. These changes were concerned with financial efficiency and were the products of a monetarist agenda. They introduced and encouraged private practice to public services and imposed a top down management structure to minimise financial expenditure (Horner, 2000). This led to the introduction of Compulsory Competitive Tendering (CCT) which attempted to bring this efficiency to health services through the use of competition. The Conservative government argued that improvement could only be achieved through subjecting internal NHS services to external competition. They argued that this was needed to stimulate efficiency: they believed that the economics of the market would improve the NHS. The relative failure of CCT was arguably caused by an immature market and poorly conducted procurements procedures that focused on price at the expense of quality. It ensured staff resistance and enmity as employment conditions were attacked.

The introduction of the 'internal market' set up a mechanism of internal purchase of services between hospital and NHS Trusts. NHS Trusts would provide services and would derive their income from contracts with purchasers, notably local health authorities and general practitioner fund-holders (Bryson *et al.* 1996). Health authorities would purchase services from independent NHS trusts, after assessing local needs and developing a strategic assessment of, or plan for, those needs. They would also monitor the delivery of the services that they had agreed to commission. GPs were offered the option of becoming 'fund-holders', able to purchase most services on behalf of their patients. Ham (1999) observed: *"Whatever the preferred approach, the outcome was the same: the internal market became a managed market in which competition and planning went hand in hand"* (1999: 43). Under these reforms NHS managers were delegated greater powers than they had assumed under Griffith, but this exacerbated tensions between them and their clinical colleagues (Klein, 2006). The Conservative government argued that this system would create an incentive towards the more efficient use of resources with more attention paid to the services that patients/consumers wanted (Bach, 1995). These reforms centralised administration but arguably the NHS lost any sense of integration of services and co-ordination.

Due to its very complexity unsurprisingly the 'internal market' was slow to develop. Initially achieving a 'steady-state' rather than risking disruption of existing services was considered to be particularly important. Change was slow or limited for a number of reasons. Firstly, the information needed to compare services and their costs often did not exist. If it did, it tended to lie in the hands of the providers rather than the purchasers. Secondly, many services were not readily amenable to 'competition' from alternative providers. When factors such as access (or travel costs) by the local population were taken into account, many local trusts were natural monopoly providers of many services. Block contracts for services tended to be used, sometimes differing little from the global budget allocations they had replaced. Patients might then follow contracts, rather than vice versa. Thus limited progress was made towards developing an 'internal market' and co-operation and partnership in service development between purchasers and large local providers was a common approach (Ashburner *et al.*1996). This was to shape the structure and organisation of health

provision until the election of the Labour party in 1997. These 'reforms' created the following structure:

Diagram A4: The structure of the NHS - 1990



Klein (2006: 44)

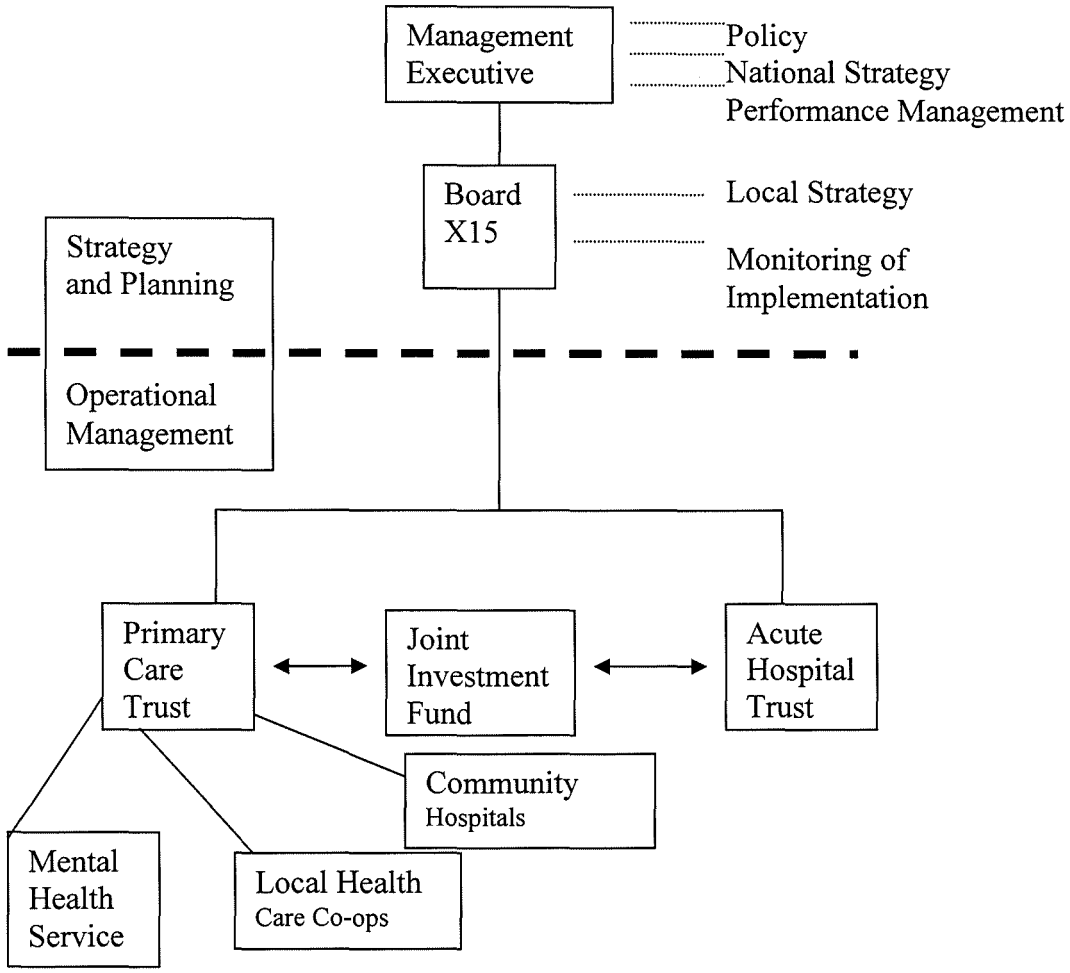
The advent of the Labour government in 1997 reinvigorated organisational change. Rentoul (2001) noted that these free market managerial concepts, especially 'fund holders', were opposed by the Labour party when in opposition but after their election, Tony Blair's government reversed its manifesto commitment to remove the 'internal market' and abolish fund holding. Pollock (2004) stated that this reversal was due to the circumstances they faced in office. The rising costs of medical technology and medicines, the desire to increase standards and 'patient choice', an ageing population and the Exchequer's desire to contain government expenditure were pivotal in forming this policy reversal. Labour considered a reorganised 'internal market' and a modified fund holding process was seen as critical to the modernisation of the NHS (Jones, 2002). Labour believed the mechanism to deliver improved

services lay in detailed service standards and strict financial budgeting. The subject of 'practice-based commissioning' was ever more controversial, Beethan *et al.* (2002) considered these reforms to be de-facto 'fundholding' and the primary reason for the weaknesses within clinical and corporate governance: due to its compromising coherent management structures. Newman (2001) argued that this was exacerbated by the de-facto outsourcing of services through the Private Finance Initiative (PFI). The Private Finance Initiative was developed to provide financial support for Public-Private Partnerships between the public and private sectors. These projects aimed to deliver for the public sector material facilities and the provision of associated operational services. The private sector received payment, above the price that the public sector would have achieved the work and these payments were linked to its performance in meeting agreed standard of provision (Rawnsley, 2001). This increased utilisation of private sector consortia. Unison (2006) argued seriously affected the structural effectiveness and organisational accountability of the NHS by removing direct accountability. This compromised control was equalled by the unbalanced financial arrangement which favoured the private sector. Froud & Shoul (2001) noted that the cumulative consequence of this for the management structure of the NHS was considerable.

Arguably these continual changes resulted in a dislocated operational management. Augley (2001) observed that in Scotland the situation had on one level become more complicated but on another more simplified with the introduction of political devolution in 1999. The complications arose from Scottish Labour's desire for 'democratic accountability' whilst maintaining a coherent strategic management organisational structure. The devolution settlement led to a structure where healthcare policy and funding were the responsibility of the Scottish Executive. Devolution resulted in the removal of the 'internal market' and the unification of Trusts and Health Boards. This centralised strategic organisation was different from the increasingly decentralised model in England. Freeman and Wood (2002) observed that this required a new structure in order to take cogniscence of devolution and provide a structure that was efficient and effective. It resulted in healthcare provision becoming the responsibility of 14 geographically-based local NHS Boards and a number of Special Health Boards. The NHS Trusts in Scotland were abolished with effect from 31st March 2004 These NHS Health Boards were and are Ayrshire and

Arran; Borders; Dumfries & Galloway; Westerns Isles; Fife; Forth Valley; Grampian; Greater Glasgow and Clyde; Highland; Lanarkshire; Lothian; Orkney; Shetland and Tayside (www.scotland.gov.uk). The NHS management structure was as follows:

Diagram A5: Scottish NHS organisational structure - 1999



(www.scotland.gov.uk/library/documents1/care-03htm)

This strategic organisation of management had clearly changed since its inception but there was no suggestion that the core values had changed until the Thatcher government's reforms. These and subsequent reforms changed the emphasis from a 'person centred' approach to an 'economic based' ideology. The objective was to create an efficient health service. Reorganisations, however, predominately occurred for economic and financial reasons.

Appendix 2 **Letter of Invitation**

Participation in Research

Subject: Gender stereotyping and career opportunities in registered nursing

Dear ___,

My name is Bryan McIntosh and I am a research student in the Business School at Napier University. I am conducting research as part of the requirements of my PhD, and I would like to invite you to participate in my research. If you decide to participate, we will meet to discuss your career experiences in registered nursing. The meeting will take place at a mutually agreed time and place, and should last about 60 minutes. If you agree the interview will be audio recorded so that I can accurately reflect on what is discussed. The tapes will be transcribed and then destroyed.

Participation is voluntary and I can assure you that our discussions will remain completely confidential. You do not have to answer any questions that you do not wish to and whilst taking part in this research you may choose to withdraw at any time. All data will be kept in a secure location at Napier University. The results of the study may be published and presented at conferences, but your identity will remain anonymous as it will throughout and after the completion of the research. There may not be a direct benefit from participating in this study but I hope that society in general will benefit from the research.

If you wish to discuss any aspect of the project with my supervisor please contact Professor Anne Munro on 0131 455 4342 or am.munro@napier.ac.uk.

Thank you for your consideration.

With best regards,

Mr Bryan McIntosh

Version Two - 15/09/2008

Appendix 3 **Consent Form**

CONSENT FORM FOR PARTICIPATION IN RESEARCH BY INTERVIEW

Title of Project: Gender stereotypes and Career outcomes in registered nursing

1. I confirm that I have read and understand the information pack for the above study. I have the opportunity to consider the information, ask questions and have them answered satisfactorily.

2. I understand that my participation is voluntary and that I am free to decline to answer particular questions and withdraw at any time, without giving a reason.

3. I agree to audio recording of my information and participation.

4. I am aware that the recording/observation be stopped at any time, and may withdraw at any time from the session or the research without disadvantage.

5. I agree to take part in the above study:

Participant's name.....

Participant's signature.....**Date**.....

Researcher's name.....

Researcher's signature.....**Date**.....

Version Two - 12/12/2008

Appendix 4 Interview questions – 12/12/2008

Q1 I'm interested in understanding how people come to be in their present jobs. Could you start off by telling me about your career history?

Prompts:

- Grade; area; job (specialty and geography)- How did you end up working in this area of nursing?
- Life choice - How have you balanced your working and personal life i.e. in relation to your family?
- Children - Have children impacted on your career?
- Training - What major training opportunities have you had or not had during your career? Why did you think this happened?
- Working patterns – What hours and patterns of working have you worked? Why?

Q2 Have household circumstances, such as a partner or children, influenced their career and job choices during their working life?

Prompts:

- Family – What jobs does your partner do? Did it impact on your career decisions
- Working patterns – How were your hours or your colleagues affected by these personal circumstances?
- Jobs - What job did you occupy and why?
- Area (specialty and geography – Why did you choose to these areas?
- Training – What were the consequences for your training opportunities? Why do you think this happened?

Q3 I'm interested in career breaks, what effect do you think career breaks have on nursing careers? Can you give any examples from your own experience?

Prompts:

- Working patterns - How were your hours or your colleagues affected upon re-entry after a break? Why do you think this happened?
- Grades – What job and grade did you return on? Why?
- Area (geographical or nursing specialty) - Why did you choose to return to that area and job?
- Training - What were the consequences for your training opportunities? Why do you think this happened?

Q4 Do the number and length of career breaks have any impact on nursing careers?

Prompts:

- Grades – What effect do they have on grade and jobs occupied? Why?
- Personal choice - Did you choose to return at this grade?
- Area – Do the number and length of career breaks affect the areas and jobs that returning nurses can work in?
- Training – What is the impact on training?

Q5 I am interested in working patterns and working hours - What hours have you worked during your career? Has it affected your career (positively or negatively)?

Prompts:

- Career – what impact did this have on your career?
- Training - Do the amount of hours worked impact on training received and offered?
- Children – What is the relationship between your selection of hours worked and children and the family, if any?
- Personal – Do nurses who work full-time have more career outcomes, if so can you tell me why you think this happens and how this takes place?

Q6 I am interested in the values of the profession, what do you think they are?

Prompts:

- Career – What do you think are the predominant values in registered nursing?
- Working patterns – Are full-time workers preferred to part-time workers? – Why do you think this happens?
- Do you think having children has an impact on careers? Why?
- Gender – Does being a woman have an impact on women's careers? Why?

Q7 General closing questions

- What have been the greatest challenges/achievements so far for you in your career?
- Why?
- Where do you hope to be in the future in terms of your career?
- How do you think nursing is going to change in the future?
- If there was one aspect of nursing you could change what would it be?
- Is there anything else would you like to say?

Appendix 5 Interviewee Profile

Name of Interviewee:
Date of Interview:
Grades, qualifications, length of service and posts held during employment:
key factors affecting why interviewee worked on whole time and part-time basis:
Age, number of children, age of children, and other personal circumstances:
Partner's Employment (If applicable), Social network - family and friends:
Interviewees biography e.g., parents, school, work, etc. – key factors affecting them moving into or out of work or staying out of work e.g. career breaks:
Key or critical incidents (surprising) points raised in interview:

Appendix 6 Interview transcript: 31/01/09 - AA

BM: I'm interested in understanding how people come to be in their present jobs. Could you start off by telling me about your career history?

I started off working in an office for an offshore company. I was a secretary. I had turned down a guaranteed place at Gray's School of Art in Aberdeen. I turned this down for 2 reasons – 1) My family wanted me to start earning money as soon as possible so I could contribute to the household and 2) At the time I couldn't handle the thought of doing the mandatory life drawing that was required. I felt sick and embarrassed at the thought although didn't understand why at the time.

I stayed at this job for about a year before working as a sign-writer. I got taken advantage of (in terms of money and workload) by the guy I worked for so left and went back to office work. Did that for a year then worked as a junior draughtsperson in a drawing office for an offshore company. I was only there 6 months when I became pregnant. They wanted me to go back to the job after the baby was born but pressure from my then boyfriend made me leave. I had some jobs of no consequence in between. Had another baby 2 years later. Went back to take Highers at the local school at night. I wanted to go to university and take a Social Anthropology degree but family refused to look after the kids. At the time there were no crèche facilities. So again from pressure from family, I took a job offshore in the catering industry. I spent 8½ years there.

During this time several things happened. My sister in law became ill with breast cancer. It was aggressive and she had a mastectomy. Her husband and young kids were devastated and couldn't face the thought that the prognosis wasn't good. I was the only person she could talk to, so I spent all my free time allowing her to talk and discuss matters which nobody else wanted to talk about. This included dying. She began looking back at her life; the highs and lows and regrets. Effectively, she needed somebody to listen to her life story, to validate her existence (I thought), and to face her fears of what happens next if the chemotherapy didn't work. In the space of 6 months I suppose I became her counsellor, confidante, best friend, and confessor. The day she died I saw her in the hospital in the morning. She held my hand and wanted me to tell her that her husband and kids would be ok. I assured her they would. She said she was tired of it all and wanted to go but was scared and didn't know how. There was a special moment there when we looked at each other and it was like she was asking permission to die and we completely understood each other. So I told her that she'd already sorted everything out, everyone would be okay and all she had to do was allow herself to sleep and let go. She smiled, said thank you said she'd see me on the "other side". She died a couple of hours later.

About a few months after my friend was also diagnosed with breast cancer. She also had 2 small children but no husband or family to speak of. She also needed a mastectomy but in hospital at the last minute got hysterical and refused. The doctors told her she'd die without it. This marked a change of attitude for Diane in many ways. Before her diagnosis she was very vain, money and status was everything and she was very self-centred. Now with the possibility of her children becoming orphans and also of death, she did a radical re-evaluation of her priorities. Where she used to complain about aches and pains and things of no consequence, now she had

something real and tangible to worry about and it transformed her. She came out fighting and found an inner strength she (or anyone else) didn't know she possessed. She had 2 rounds of chemo, lost all her hair, had a hysterectomy and found a sense of humour. She should have died but didn't and still survives, her new attitude intact. She confessed one day that she was convinced she "willed" herself to have cancer because in the months previous to diagnosis she's spent a lot of time praying to die, to contract a disease where she'd be able to get out of her miserable life. So we talked about the rationality of this perception. She wouldn't be swayed though, and is still convinced her own mind created the cancer. I found the mental processes of these two women fascinating.

Also during these years offshore I decided to go and seek hypnotherapy. I had holes in my childhood memory that bothered me and I wanted to know why. I found a reputable practitioner who had over 20 years experience. I went there a couple of time and the poor man had a bucket load of patience but after 3 solid hours of trying again the second time, he told me that whatever was in my subconscious didn't want to be tampered with yet, and that it would find its way out in its own time. Very frustrating! So I started reading up some stuff on memory; Freud etc and began meditating to see if I couldn't tap through whatever steel wall I'd created in my head.

Offshore I seemed to be plagued by people telling me their problems, wanting a non-judgemental listening ear. This was sometimes accompanied by guys "trying it on", but in the main, there seemed to be quite a lot of stress and depression around, especially about the possibility of their wives playing around while they were working. That was also true the other way around of course. One guy committed suicide and one had a nervous breakdown on the rig I was on. I knew them both quite well and it was an eye opener as to just how fragile human beings really are and how little we know ourselves. Men of course are notorious for keeping stress to themselves in terms of talking, so there were a lot of problems with alcohol and drugs outside work. I became interested in how people cope with stress.

My friend from school, Angela, had finally opened up once we left school about her strange family. Her older brother had been abusing her from an early age, but her family were part of some strange religion (Plymouth Brethren I think) and so wouldn't acknowledge the possibility that this could happen and she was labelled as a liar and mentally unstable. This went on for years until she did end up with mental health problems and ended up in a psychiatric hospital in Aberdeen. Without the support and help from her family (I didn't seem to count, I wasn't enough), she finally committed suicide 2 ½ years ago. She slit her wrists, lay in the bath, and left her 6 year old son and 3 year old daughter to find her in the morning.

So all that, coupled with the fact that I found out my own kids had been abused during the time I worked offshore – eventually led me into the realms of nursing.....more towards the psychological aspects than practical clinical work.

BM: Have household circumstances, such as a partner or children, influenced their career and job choices during their working life?

Haven't had a partner since I was 21. He left for a much older woman when I was 7 months pregnant so I was a single parent the entire time the kids were growing up.

Yes this did affect my career choices. A compromise was reached with my mother – I'd give her half my wages and she'd look after the kids when I was offshore. Since I was the main bread winner in my own family it seemed a logical step. I could support the kids as well as help my parents. At the time my Dad had bowel cancer and couldn't work. I worked 2 on-2 off and mostly nightshift which suited me. I was in charge of an area and left to my own devices. Nightshift was quiet with plenty of time to think, and since I liked to read a lot and am naturally introspective, this was ideal for me. However, the stress of being offshore was a definite down-side.

BM: I'm interested in career breaks, what effect do you think career breaks have on nursing careers? Can you give any examples from your own experience?

I moved to Edinburgh to take a place at Edinburgh College of Art but took an HND in Illustration and Media design instead. Once qualified I got offered a fantastic job in South Africa with lots of benefits but it came at the same time that I found out about my kids being abused, so I stayed as there was a 2 year police investigation that followed. This caused a lot of stress which again got me thinking about how people cope, why some people get unwell and some don't. So I took a job as a care assistant working with people with MS. I did this for over a year, then worked in a Day Centre for adults with learning difficulties. It was here that somebody suggested I go and take a nursing degree. I hadn't thought of that possibility but decided to go for it anyway. That was 3 years ago.

In terms of working patterns when I went back to work. Initially I was again working nightshift. I found this difficult as I had been used to 2 weeks of straight nightshift, not 2 nights, 1 off, then back to nights. Psychologically and physically this was very demanding and more stressful than I would have thought.

Going to do a degree in nursing seemed the next logical step, even though I knew I didn't want to simply just work as a staff nurse at the end of it. In terms of balancing home life, study, work and children – this worked out fine as they were old enough not to worry about. Balancing almost full-time hours as a support worker with LD as well as full-time nursing degree – I didn't give it much thought. It was just something I knew I had to do so got on with it. Other people on my course however, with smaller children, found the balance difficult, stressful and a couple of them dropped out. Towards the end of my training I had the opportunity to take small courses like the ASIST course for suicide prevention. That wouldn't have happened unless I was on the course.

BM: Do the number and length of career breaks have any impact on nursing careers?

I know of a transgender person who has returned as a staff nurse after 10 years. Before that "she" was a charge nurse. In the 10 years she had suffered depression. So in some circumstances it does make a difference, she is having to work her way back up again. She chose to return at that grade as that was the only choice she was offered. She is also being given training to help her catch up on new policies and practices.

BM: I am interested in working patterns and working hours - What hours have you worked during your career? Has it affected your career (positively or negatively)?

When I worked offshore I could have been promoted to head steward or camp boss, but being on nightshift made this difficult. Only those on dayshift with the extra responsibilities were chosen for promotion.

When I worked at Leuchie House with MS – I was offered training but missed a lot of it due to being on nightshift and would be sleeping when the training was on. It was difficult to find suitable dates so I missed out on a lot. Also, it was only those on full time hours that were offered training. Part-time workers were only offered mandatory training.

I chose working hours to suit my responsibilities with the children. When they were older I still did that, especially since the youngest one had mental health difficulties. I would ensure that I was there as much as possible, so could have worked more hours, but chose not to.

BM: I am interested in the values of the profession, what do you think they are?

I think there is a conflict between what the values of nursing should be and what they actually are in practice. They should be about non-judgement, recovery, promoting autonomy, working in partnership and in a holistic manner. In truth and on the wards, nursing in still rooted in the medical model with outdated attitudes and a reluctance to change. For example, the govt's policy on providing spiritual care for patients is viewed with uncertainty, fear and scepticism at least in Scotland. The view that patients are experts in their own care is also viewed with scorn. For newly qualified nurses who are still unsure of their capabilities and perhaps lacking in some experience, there is a need to make a good impression and "fit in". Observation has shown that these newly qualified nurses allow themselves to be changed by the culture of the ward and nursing as it is, rather than endeavouring to evoke the changes learned during the 3 years training. Effectively, these newly qualified nurses are up to date on policy, procedures, trends and govt legislation, which ***should*** *be of interest to staff on the ward who could learn something, and which* ***should*** *be utilised by the charge nurse(s) in order to help change attitudes on the ward. However, this does not happen. Instead of using their enthusiasm to help promote positive change, the need to be accepted overrides this and they allow themselves to be "sucked in" to the ward politics and outdated attitudes. I've found that nurses who have been a long time on the job and who are just biding their time until retirement, are not really interested in change and it frightens them. Therefore, they underhandedly or subconsciously work towards keeping the status quo. I've seen newly qualified nurses being bullied into submission and told to keep their new ideas to themselves. Or, they argue for keeping their old ways and then make life difficult for the newly qualified nurse. In the end, beaten down or fed up fighting against the river, the newly qualified nurse falls into line and the ward stays at is always has been. So instead of affecting the culture, the culture affects them. On paper the nursing profession looks great and is making great strides towards change for the better. In practice it is a different story. Also, there has been talk over the last couple of years of the fear that nursing will end up like the USA and patients will start suing nurses. Based on that, it seems that there is a*

reluctance to do anything that a nurse could potentially get blamed for. I've heard it said many times, "it's not my job and just not worth it if it goes wrong.....". Some nurse's would also rather do paperwork than sit and talk to patients. This is because if a patient tries to blame a nurse for something, or said the nurse gave them info or told them to do something when they didn't, then it could affect the nurse's career. I've heard of a couple of nurse's suspended pending investigation for this very thing. So again, the fear that we are going the same way as the USA is a real and tangible thing. Overall I think the nursing profession is quite conservative, reluctant to change, frightened of change and any change is a long and slow process. It needs a major shake-up and not just on paper.

I think full-time workers are preferred because it offers continuity of care, and practically, it means that less time is spent bringing them up to speed on the days they have been absent from the ward. Effectively, they can start the shift already aware of what has been happening first hand. Also possibly, people on part-time work may be seen as less "attached" to the ward, therefore less likely to go that extra mile, or do extra shifts when people are sick etc.

Yes, children do have impact on careers. It affects choice of hours and days worked. From the employers point of view there is more chance of workers taking time off due to sick children or problems at school or school holidays etc. Also, young nurses at some point will go on maternity leave, impacting on staffing levels etc. This also affects the budget.

On being a woman – yes I think it does make a difference. I think there are more opportunities for men which it comes to promotion. Having had a discussion with several charge nurses, they admitted that men are seen as more authoritative and especially in acute wards, seen as better equipped to deal with aggression and violence.

BM: General closing questions

What have been the greatest challenges/achievements so far for you in your career?

Greatest challenges – in being a single parent and still having a full-time job, you have to learn to be well-organised, focused and strong minded. Also, being a single parent I've encountered certain prejudices from employers when going for interviews. The fear that with no support I'd be running off to sort things out, or assuming that because I'm a single parent I am educationally below par, etc.

Greatest achievements – gaining my degree I suppose. Although the experienced gained in working on the wards and in various other jobs has been equally, if not more valuable for me. At the end of the day a piece of paper is just that. It's frightening to know some of my fellow students who have gained their nursing diploma/degree and are still not competent enough to practice due to their attitude. There is no substitute for experience. I've learned that I am more capable than I thought I was and am a far stronger person that I gave myself credit for. You need that in dealing with some of the staff, never mind the patients!

BM: Why?

Because up to a point, we live in a culture where we are measured by our qualifications and material worth rather than the strength of our character, so gaining my degree is an achievement, as it is a physical thing to verify that I've reached a certain level of competence and dedication.

BM: Where do you hope to be in the future in terms of your career?

PhD next so I can get my teeth into something I really want to investigate and immerse myself in. After that I want to be able to influence how health professionals think about their practice. I also want to help people understand the mental processes people who have experienced CSA go through, and how they can help them overcome and progress forward into a meaningful life. I'd like to do some more research and writing and possibly some teaching. Teaching will mean overcoming a personal hurdle, but determination and will, will prevail.

BM: How do you think nursing is going to change in the future?

That will depend on the culture. Hopefully nursing will change in terms of attitude. I think nursing will also change in terms of educational requirements: entry level degree rather than diploma, but probably that will also change to a Masters degree for staff nurse. That's already being talked about. Nurse prescribing capabilities will also come into force as it is already heading that way. I think nurses will end up working pretty much as junior doctors do at the moment. However, there needs to be a balance between the academia side and the caring side. One can't override the other. In terms of mental health nursing, I think the introduction of better clinical skills is required as at the moment the physical health of patients on psychiatric wards is less than adequate. Even though there was a paper drafted in Feb 08 by the Govt and NHS stating that everyone with mental health difficulties will get a physical health screening every 15 months, this is still not enough and it will depend on funding and geographical location. If mental health nurses are trained to recognise physical signs and symptoms of physical illnesses, patients with mental health difficulties will remain healthier, problems will be caught at an earlier stage, mortality rates will change for the better and this will impact on the level of government funding being spent.

BM: If there was one aspect of nursing you could change what would it be?

Attitude

Appendix 7 Calculation of progression from adjacent grades adjusting for sex, contract type and age

	logOR	SElogOR	z-value	Odds Ratio	LCL-OR	UCL-OR	p-value
Log odds of progressing from Grade D to Grade E							
(Intercept)	-0.864	0.049	-17.722	0.422	0.383	0.464	2.83E-70
SexMale	0.092	0.045	2.059	1.096	1.004	1.196	3.95E-02
Contract.TypePart	-0.246	0.023	-10.92	0.782	0.748	0.817	9.24E-28
Age.mid	0.024	0.001	20.93	1.025	1.022	1.027	2.86E-97
Log odds of progressing from Grade E to Grade F							
(Intercept)	-4.126	0.155	-26.61	0.016	0.012	0.022	5.27E-156
SexMale	-0.25	0.139	-1.794	0.779	0.593	1.023	7.27E-02
Contract.TypePart	-0.041	0.063	-0.639	0.96	0.848	1.087	5.23E-01
Age.mid	0.035	0.003	10.005	1.035	1.028	1.043	1.46E-23
Log odds of progressing from Grade F to Grade G							
(Intercept)	2.495	0.195	12.786	12.124	8.271	17.773	1.95E-37
SexMale	0.781	0.139	5.611	2.184	1.662	2.869	2.01E-08
Contract.TypePart	-1.185	0.068	-17.558	0.306	0.268	0.349	5.13E-69
Age.mid	-0.006	0.004	-1.273	0.994	0.986	1.003	2.03E-01
Log odds of progressing from Grade G to Grade H							
(Intercept)	-2.075	0.13	-15.957	0.126	0.097	0.162	2.54E-57
SexMale	0.064	0.057	1.111	1.066	0.952	1.193	2.66E-01
Contract.TypePart	-1.625	0.087	-18.666	0.197	0.166	0.234	9.40E-78
Age.mid	0.031	0.003	10.722	1.032	1.026	1.038	8.01E-27
Log odds of progressing from Grade H to Grade I							
(Intercept)	-2.443	0.238	-10.277	0.087	0.055	0.138	8.93E-25
SexMale	0.61	0.092	6.624	1.84	1.536	2.204	3.50E-11
Contract.TypePart	0.125	0.174	0.718	1.133	0.805	1.596	4.73E-01
Age.mid	0.022	0.005	4.331	1.022	1.012	1.033	1.49E-05

Appendix 8 Calculation of Progression from adjacent grades adjusting for sex, contract type and presence of dependent children

	logOR	SElogOR	z-value	Odds Ratio	LCL-OR	UCL-OR	p-value
Log odds of progressing from Grade D to Grade E							
(Intercept)	0.089	0.018	4.828	1.093	1.054	1.133	1.38E-06
SexMale	0.053	0.044	1.192	1.054	0.966	1.15	2.33E-01
Contract.TypePart	-0.247	0.023	-10.758	0.781	0.746	0.817	5.46E-27
ChildrenYes	0.026	0.023	1.171	1.027	0.982	1.073	2.42E-01
Log odds of progressing from Grade E to Grade F							
(Intercept)	-2.679	0.051	-52.569	0.069	0.062	0.076	0.00E+00
SexMale	-0.318	0.139	-2.291	0.728	0.554	0.955	2.20E-02
Contract.TypePart	0.029	0.064	0.444	1.029	0.907	1.168	6.57E-01
ChildrenYes	-0.014	0.063	-0.216	0.986	0.872	1.116	8.29E-01
Log odds of progressing from Grade F to Grade G							
(Intercept)	2.302	0.052	44.381	9.991	9.025	11.06	0.00E+00
SexMale	0.788	0.139	5.667	2.199	1.675	2.889	1.46E-08
Contract.TypePart	-1.172	0.069	-16.974	0.31	0.27	0.355	1.28E-64
ChildrenYes	-0.131	0.067	-1.946	0.877	0.768	1.001	5.16E-02
Log odds of progressing from Grade G to Grade H							
(Intercept)	-0.593	0.028	-21.482	0.553	0.524	0.583	2.30E-102
SexMale	0.328	0.053	6.206	1.389	1.252	1.54	5.44E-10
Contract.TypePart	-1.472	0.088	-16.802	0.23	0.193	0.273	2.35E-63
ChildrenYes	-0.417	0.046	-9.003	0.659	0.602	0.722	2.20E-19
Log odds of progressing from Grade H to Grade I							
(Intercept)	-1.407	0.05	-28.418	0.245	0.222	0.27	1.22E-177
SexMale	0.269	0.089	3.024	1.308	1.099	1.557	2.50E-03
Contract.TypePart	0.217	0.176	1.233	1.242	0.88	1.753	2.18E-01
ChildrenYes	-0.168	0.089	-1.894	0.845	0.71	1.006	5.82E-02

Appendix 9 Calculation of progression from adjacent grades adjusting for contract type and the amalgamated sex and presence of children categories

	logOR	SElogOR	z-value	Odds Ratio	LCL OR	UCL OR	p-value
Log odds of progressing from Grade D to Grade E							
(Intercept)	0.151	0.042	3.573	1.162	1.07	1.263	3.53E-04
Contract.TypePart	-0.241	0.023	-10.481	0.786	0.751	0.822	1.06E-25
GroupWomen without children	-0.052	0.045	-1.133	0.95	0.869	1.038	2.57E-01
GroupWomen with children	-0.052	0.046	-1.12	0.949	0.867	1.04	2.63E-01
Log odds of progressing from Grade E to Grade F							
(Intercept)	-3.002	0.132	-22.69	0.05	0.038	0.064	5.61E-114
Contract.TypePart	0.027	0.065	0.416	1.027	0.905	1.166	6.78E-01
GroupWomen without children	0.32	0.141	2.265	1.377	1.044	1.816	2.35E-02
GroupWomen with children	0.315	0.144	2.186	1.37	1.033	1.817	2.88E-02
Log odds of progressing from Grade F to Grade G							
(Intercept)	3.04	0.133	22.884	20.914	16.119	27.136	6.76E-116
Contract.TypePart	-1.171	0.069	-16.922	0.31	0.271	0.355	3.08E-64
GroupWomen without children	-0.736	0.142	-5.191	0.479	0.363	0.632	2.09E-07
GroupWomen with children	-0.874	0.145	-6.019	0.417	0.314	0.555	1.75E-09
Log odds of progressing from Grade G to Grade H							
(Intercept)	-0.411	0.047	-8.81	0.663	0.605	0.726	1.25E-18
Contract.TypePart	-1.446	0.088	-16.467	0.236	0.198	0.28	6.33E-61
GroupWomen without children	-0.15	0.055	-2.748	0.861	0.774	0.958	6.00E-03
GroupWomen with children	-0.685	0.065	-10.456	0.504	0.443	0.573	1.38E-25
Log odds of progressing from Grade H to Grade I							
(Intercept)	-1.197	0.075	-15.908	0.302	0.261	0.35	5.57E-57
Contract.TypePart	0.227	0.176	1.288	1.255	0.888	1.773	1.98E-01
GroupWomen without children	-0.2	0.091	-2.197	0.819	0.686	0.979	2.80E-02
GroupWomen with children	-0.419	0.123	-3.401	0.658	0.517	0.837	6.72E-04

Appendix 10 Calculation of progression from adjacent grades adjusting for number of career breaks taken

	logOR	SElogOR	z-value	Odds Ratio	LCL-OR	UCL-OR	p-value
Log odds of progressing from Grade D to Grade E							
(Intercept)	-0.17	0.013	-12.958	0.844	0.822	0.866	2.13E-38
Nbreaks=1	0.5	0.028	17.769	1.648	1.56	1.742	1.22E-70
Nbreaks=2	0.499	0.044	11.346	1.648	1.512	1.796	7.77E-30
Nbreaks3+	0.675	0.066	10.229	1.963	1.725	2.234	1.47E-24
Log odds of progressing from Grade E to Grade F							
(Intercept)	-2.838	0.041	-69.079	0.059	0.054	0.063	0.00E+00
Nbreaks=1	0.232	0.074	3.138	1.261	1.091	1.457	1.70E-03
Nbreaks=2	0.703	0.093	7.543	2.019	1.682	2.423	4.59E-14
Nbreaks3+	0.295	0.153	1.935	1.343	0.996	1.811	5.30E-02
Log odds of progressing from Grade F to Grade G							
(Intercept)	1.654	0.044	37.947	5.228	4.8	5.694	0.00E+00
Nbreaks=1	0.427	0.076	5.581	1.532	1.319	1.78	2.40E-08
Nbreaks=2	0.518	0.094	5.501	1.678	1.396	2.019	3.78E-08
Nbreaks3+	1.13	0.152	7.427	3.095	2.297	4.17	1.11E-13
Log odds of progressing from Grade G to Grade H							
(Intercept)	-0.691	0.03	-22.866	0.501	0.472	0.531	1.02E-115
Nbreaks=1	-0.218	0.049	-4.405	0.804	0.73	0.886	1.06E-05
Nbreaks=2	-0.251	0.059	-4.276	0.778	0.693	0.873	1.90E-05
Nbreaks3+	-0.297	0.074	-4.02	0.743	0.643	0.859	5.82E-05
Log odds of progressing from Grade H to Grade I							
(Intercept)	-1.308	0.053	-24.45	0.27	0.243	0.3	5.04E-132
Nbreaks=1	-0.146	0.093	-1.573	0.864	0.721	1.037	1.16E-01
Nbreaks=2	-0.084	0.11	-0.765	0.919	0.742	1.14	4.44E-01
Nbreaks3+	-0.195	0.145	-1.339	0.823	0.619	1.094	1.81E-01

Appendix 11 Percentage of whole-time registered nursing by Age and Sex - Grade 'D' to 'I'

Bands	M 'D'	F 'D'	M 'E'	F 'E'	M 'F'	F 'F'	M 'G'	F 'G'	M 'H'	F 'H'	M 'I'	F 'I'
20-24	9.91	9.97	2.82	2.06	1.96	0.93	0.87	0.74	0.00	0.00	0.00	0.00
25-29	16.13	10.08	20.13	15.12	2.84	5.04	2.20	1.80	0.57	0.45	0.61	0.51
30-34	18.71	12.57	19.56	16.13	18.73	11.93	16.46	11.67	17.97	12.04	14.43	11.72
35-39	20.05	17.08	19.02	16.27	25.49	14.89	28.32	24.59	26.03	19.13	23.35	15.85
40-44	17.08	17.93	19.94	19.05	23.53	20.48	25.18	25.29	24.91	22.31	23.13	18.41
45-49	11.13	15.78	14.06	18.45	19.61	20.74	16.99	18.93	17.10	20.50	20.42	19.21
50-54	6.41	8.94	4.01	8.06	7.84	20.78	8.67	12.40	10.02	16.35	14.02	20.89
55-59	0.58	6.22	1.46	3.08	0.00	5.21	1.20	3.49	3.05	8.11	3.31	12.21
60 Plus	0.00	1.43	0.00	1.78	0.00	0.00	0.11	1.09	0.35	1.11	0.73	1.20
%	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**
Total	**852**	**7195**	**1141**	**7796**	**51**	**538**	**1138**	**5092**	**559**	**2490**	**230**	**587**

(Information Services Division - data request)

Appendix 12 Percentage of part-time registered nursing by Age and Sex - Grade 'D' to 'I'

Bands	M 'D'	F 'D'	M 'E'	F 'E'	M 'F'	F 'F'	M 'G'	F 'G'	M 'H'	F 'H'	M 'I'	F 'I'
20-24	0.00	9.21	0.00	0.87	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
25-29	0.00	17.32	0.00	4.69	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
30-34	2.31	18.43	0.00	18.09	0.00	10.32	0.00	14.34	0.00	0.00	0.00	0.00
35-39	13.33	18.54	2.02	20.18	33.33	23.84	0.00	16.12	0.00	13.15	0.00	4.54
40-44	14.28	13.56	18.74	19.86	33.33	24.77	20.58	21.98	0.00	23.00	0.00	16.76
45-49	18.19	11.35	35.86	20.35	11.11	22.43	32.36	28.95	50.00	32.41	0.00	35.76
50-54	35.19	5.26	33.21	7.26	22.23	9.75	32.35	12.54	50.00	17.91	0.00	26.54
55-59	13.98	4.19	9.22	6.19	0.00	6.34	8.83	5.11	0.00	10.12	0.00	12.50
60 Plus	2.72	2.14	0.95	2.51	0.00	2.55	5.88	1.96	0.00	3.41	0.00	3.90
%	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**
Total	**217**	**8570**	**65**	**7563**	**9**	**524**	**34**	**1511**	**2**	**156**	**0**	**45**

(Information Services Division - data request)