Chapter Four: A discourse of caring: A case study of male nurses' discourse and identity construction in the United Kingdom and New Zealand

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Abstract

Despite aims for gender equality in the workplace, certain occupations continue to be categorized as suitable for one gender or another. This entrenched division of labour is arguably linked to traditional gender roles and relies on the stereotypical skills and characteristics that men and women are assumed to possess. But what happens when women and men enter what are seen to be 'non-traditional' work roles, specifically male workers in the arguably feminine 'caring' industry of nursing? Caring is not readily seen as part of hegemonic masculine characteristics in many Western cultures. The match of a gendered profession to gendered behaviour therefore deserves further investigation. Using workplace discourse collected from male nurses in the United Kingdom and New Zealand, this chapter examines male carers' linguistic behaviour and the relationship between gender, profession, and workplace culture, proposing a discourse of caring. It challenges societal stereotypes about gendered professions and argues for a more nuanced understanding of the enactment of professional identity in gendered contexts.

Introduction

Occupations are regularly categorised in society as suitable for one gender or another often resulting in gender-segregated professions (McDowell & Klattenberg, 2018; McEntee-Atalianis & Litosseliti, 2017; Holmes & Marra, 2017; Didham, 2015; Marsden & Holmes,

2014; Huppatz & Goodwin, 2013; Litosseliti & Leadbeater, 2013; Ku, 2011). This division of labour is linked to traditional gender dichotomies arguably underpinned by wholesale acceptance of biological differences (Wasserman, Dayan & Ben-Ari, 2018; Mistry & Sood, 2016; Didham, 2015; Hinojosa, 2010). Acker (1998, cited in Britton, 2000, p418) suggests that industries are gendered because they are "sites in which these attributes are presumed and reproduced". The notion of gendered occupations thus emerges from the skills and characteristics that men and women are *assumed* to possess merely because of their gender. If jobs are gendered based upon ideas about normative masculinity or femininity, in turn the enactment of professional identity in these contexts is likely impacted by these hegemonies (Carli, Alawa, Zhao & Kim, 2016; Fisher, 1999).

As a specific example, caring roles such as nursing are stereotypically defined in opposition to masculine stereotypes (Whittock & Leonard, 2003; Britton, 2000); the ideology of caring roles is centred on normative *female* attributes, such as being kind, motherly and nurturing. These attributes are easy to spot in this typical definition of caring:

> attending physically, mentally and emotionally to the needs of another, giving commitment to the nurturance, growth, and healing of that other (Greenhalgh, Vanhanen & Kyngäs, 1998, p928).

Seemingly gendered stereotypes and surrounding ideologies impact on the workforce and, as could be expected, women dominate the profession. It is also noteworthy that despite being the numerical minority, positions of power and management within nursing are mainly held by men (Didham, 2015; Thorton & Bricheno, 2006). Furthermore, within the literature that uses this gendered lens, authors note that men tend to work within more 'masculine' areas such as emergency wards or psychiatric nursing, rather than in midwifery or elderly care (Brown, Nolan & Crawford, 2000) and female nurses are characterised as relationally-oriented, with the ability to show tenderness and empathy, and it is claimed that they "would rather work with patients" (Nilsson & Larsson 2005, p183). Male nurses are understood to "shape their work role to be more masculine by emphasising the task-oriented, as opposed to people-oriented behaviours" (Whittock & Leonard, 2003, p244, citing Evans, 1997), and as tending to suppress their caring instincts in order to maintain their traditional masculine roles. This suggests that societal hegemonies about divisions of labour are reflected in the divisions within the industry itself.

However, describing a setting as mainly feminine or masculine highlights only one aspect of that workplace setting as an important influence on all the activities. Furthermore, what is perceived to be men's or women's work can differ across different countries (Trauth, 2002). Within New Zealand and the United Kingdom, nursing is still feminised, despite changing gender participation in the field. It is largely regarded as a low status, low paid occupation, which contributes to its classification of being a semi-profession (as discussed in-depth in Lazzaro-Salazar, 2013). This means that men may not always consider nursing and related caring professions as representing viable career options (Britton, 2000).

With more men 'crossing over' into caring roles, their experiences have become increasingly important in regard to further increasing the number of men in these fields (Domrose, 2003; Villeneuve, 1994). A small number of researchers have explored what happens when men work in 'women's jobs' (e.g. librarians, primary school teachers, hairdressers and nursing, see Agapiou, 2002; Bagilhole & Cross, 2006; Simpson, 2004; Whittock & Leonard, 2003; Brown et al., 2000; Williams, 1992, 1993). These studies have examined the implications of men's non-traditional career choices for their gender identity and have investigated how they manage potential conflict in this context (Huppatz & Goodwin, 2013; Whittock & Leonard, 2003; Britton, 2000; Brown *et al.*, 2000; Lupton, 2000; Evans, 1997; Isaacs & Poole, 1996). The authors report that men frequently face challenges to their masculine identity in these professions (Whittock & Leonard, 2003; Bagilhole & Cross, 2006; Lupton, 2000; Chung, 2002; Simpson, 2004).

It has been noted that just because men go into feminine work environments, it does not mean they abandon their gender identity. An interesting observation by Williams (1995) is that the construction of masculinity is much more explicit in female dominated work contexts than in traditional male occupational roles. To 'do gender', men employ several strategies to separate themselves from the traditional nursing role, their female colleagues and the feminine image of nursing (C. Williams, 1992; L. Williams, 1995; MacDougall, 1997; Evans, 1997; Holyoake, 2001). They have been found to 'play up' their masculinity to emphasize that they are different from their female co-workers and to create a professional and personal distance from them (Evans, 1997, p. 226). Men's gender is seen to be 'a positive difference', giving male nurses "an incentive to bond together and emphasize their distinctiveness from the female majority" (C. Williams, 1992, p.259). By engaging in certain behaviours and avoiding women, male

nurses can convey to their superiors and work colleagues that they are unlike their female co-workers. Male nurses are often aware that "to be a male nurse you are identified by your ability to reproduce *stereotypic* views" (Holyoake, 2001, p78). Redefining their position in these jobs as masculine and creating 'masculine tasks' to fit with traditional male characteristics legitimises their presence in these fields. This includes men emphasising their physical presence (i.e. controlling angry patients), cauterising a male patient, stressing the physical aspects of the job, boasting about their technical knowledge or managerial ability (Holyoake, 2001). Differentiating between the roles that male and female nurses perform sustains the idea that even within the same occupation, men have different functions and bring different abilities to the job that women cannot offer (L. Williams, 1995). If masculine aspects are necessary to perform the job, this devalues and de-emphasises the feminine to emphasize the masculine and contribute to gender hierarchies that favour male nurses (Bagilhole & Cross, 2006).

It is important to stress, however, that not all men in this situation want to emphasise their masculinity. Some male nurses wish to reject hegemonic masculinity in order to adopt an alternative identity (C. Williams, 1995; Shen-Miller & Smiler, 2015). This illustrates further that masculinity is not a fixed entity but is continuously re-constructed, especially in non-traditional work roles, where it can be over-emphasised or rejected by interactants and wider ideologies. Thus, the broad-brush claims about the effect of gender on enactment of professional identity deserve 'troubling' by exploring contextualised evidence of the practice of enacting a masculine identity in these industries. The majority of existing research on men in non-traditional jobs like nursing focuses on the *nonverbal* coping mechanisms that men use. There is some research into linguistic behaviour of men in women's jobs (e.g. Schnurr & Zayts, 2017; Schnurr, 2008; Kiesling, 2007; Mullany, 2007; Holmes, 2006), but little which examines the language of male nurses whilst convening with their nurse colleagues (see however, McDowell, 2018, 2015a, 2015b).

In this chapter we offer authentic data of nurses who identify as male constructing their identities while enacting their caring professions, analysing their identities within the contextual constraints in which they are operating.

Identity construction within contextual constraints

In approaching our analysis, we follow a realist model in which identity negotiation is understood as taking place within a number of structural constraints, comprising (at a minimum) team norms, shared professional values and wider societal discourses (see Holmes, Marra & Vine, l 2011, chapter 1 for a description). While all levels are relevant to ongoing negotiations (as encapsulated in Blommaert's (2005) concept of layer simultaneity), in what follows we focus in particular on gender and professional identity as co-constructed by the men in our dataset. Gender is understood as a social construct and not a fixed inherent category in line with the Interactional Sociolinguistic paradigm which informs our constructionist approach. This allows us to draw on micro-linguistic and macro-social information in the analysis, giving consideration to the possible constraints of the context in which the speakers are situated (Milani, 2011).

The data involves audio (United Kingdom) and video (New Zealand) recordings of male nurses interacting with others at work. Using this kind of authentic data is a central aspect of the ethnographic tradition which dominates workplace discourse research. This study draws on data collected in a hospital in the United Kingdom and in a private clinic in New Zealand.

United Kingdom data set (Northern Ireland)

Data were collected from three male nurse participants when interacting with their fellow colleagues whilst at work in a hospital in Northern Ireland. The three primary participants, who were in full control of the data collection process, wore audio-recording equipment to collect their interactions over a six-month period. Getting participants to self-record is beneficial when research is attempting to collect data with a group such as the nursing community, which is relatively closed off (Cameron, 2001). Furthermore, granting participants the freedom over what they choose to record is a method that is seen as advantageous and is being used more frequently in language research (Angouri, 2011; Coates, 1999).

In addition, as communication is a jointly performed task (Nevile & Rendle-Short, 2009) capturing all interlocutors' speech in each interaction was important as it permitted a rounded

examination of how talk was accomplished. Therefore, female nurses, other male nurses, plus any other players in the medical field (e.g. doctors, porters and canteen staff) acted as secondary participants as they interacted with the primary male respondents.[1] .

Approximately 50 hours of spoken interaction was gathered with each participant contributing roughly the same amount of talk time. This provided a vast dataset of language-in-use within a range of contexts (staff rooms, staff meetings, lunch at the canteen), which covered both work and personal topics.

New Zealand data set (Wellington)

The New Zealand data were collected in 2010 in a semi-private clinic in Wellington which specialises in orthotic treatments and receives referrals for acute, short term and long-term disabilities. Users range from those with temporary orthotic requirements to those with ultimately more severe, complex chronic disabilities, requiring longer term use of orthoses. The staff working in this clinic are nurses who have specialized in orthotics.

Three 45-minute long meetings were recorded for this study (see phases of data collection process in chapter 4). Three nurses and a technician attended the meetings (one nurse and the technician were male), which were held on a monthly basis. The meetings took place in the manager's office and they were called clinical meetings because the aim was to share information and scientific papers about new treatments and professional developments in general in their area of practice. These meetings served as consultation and feedback sessions in which the team debated protocols, procedures and the development of patients' cases in depth. Two cameras and two audio recorders were located facing opposite sides of the room to capture all participants.[2]

Nurse identity construction

Across both the United Kingdom and New Zealand data, male nurses (and females) employ a variety of discursive strategies to exhibit the identity of being a nurse. The nurses appear to use

linguistic behaviour to bind themselves to other nurses and demonstrate their in-group status both as professionals and members of their respective teams. In the analysis we focus on *how* the nurses perform caring as they reflect on their professional practices and interact with others in the workplace.

Enacting a nurse identity

In the extracts below, participants reflect on the 'proper' way of doing things in clinical practice by drawing on shared resources to construct professional loyalty and what we interpret as professionalism (Marra, McDowell & Lazzaro-Salazar, 2016). These examples show, to differing extents, different levels of alignments with their teams and with the nursing profession more widely. This is evident in the 'us/them' discourse implicitly constructed across all extracts in both data sets.

One salient topic in both the New Zealand and the United Kingdom data was a preoccupation with the quality of patient care. This was evident in discourse centring on the lack of staff and feelings of burnout, and nurses' concern for potentially unsafe practices and poor patient care, which, in turn, often led to being overly cautious to ensure safe practice and good patient care.

Example 1 (Wellington)

Context: This conversation involves two clinicians, Martin and Emma, discussing an incident in which Martin had to make a quick treatment decision (later questioned by other team members) when an injured patient entered the clinic in a state of emergency.

1.	Martin:	I always tend to be like cautious
2.		and and + to be like precautionary…
3.		and I always ask myself the question
4.		ok what's the safest thing to do
5.	Emma:	mmm {flat intonation}
6.	Martin:	and um and if it were you sitting there
7.	Emma:	yeah {flat intonation}
8.	Martin:	what would YOU have liked?
9.	Emma:	mmm {flat intonation}

10.	Martin:	so um to me it's like taking no chances
11.		it's another person's life
12.		//and\ um you know if if +
13.		you can't umm weigh up the cost of the [medical
14.		treatment]
15.	Emma:	/mm\\ yeah {flat intonation}
16.	Martin:	to the potential um complications that //the person might\
17.		might v- might have
18.		//it's MY\ experience
19.	Emma:	/yeah that's true\\

Martin begins his turn by explaining how cautious he is in his professional practice (lines 1-2). In any medical profession, being cautious is a quality that is highly valued because it displays a certain level of awareness of the professional uncertainty inherent in health care professions, showing they know their limitations and those of medical treatments (see Lingard, Garwood, Schryer, & Spafford, 2003 and Sarangi, 2010; see 'culture of safety' in McDonald, Waring, Harrison, Walshe, & Boaden, 2005; cf. Green 2006). In explaining how he takes necessary precautions when treating a patient, Martin says he always asks himself what the safest thing to do is (lines 3-4). In this way, Martin supports and strengthens the stance expressed in his opening statement by displaying how he engages in reflexive thinking as part of the decision-making process of treatment-related pathways. Then, structuring it as a hypothetical situation, Martin puts himself in the shoes of the patients and reflects on what they would have liked had they been the patients (lines 6 and 8). The pragmatic function of the rhetorical question resides in the way he conveys empathy for his patients (see Schmidt-Radefeldt, 1977). Emphatic understanding of the patient, as Killeen and Saewert (2007) explain, is closely linked to the value of 'human dignity' and patient worth, and it has been identified as one of the core values of the healthcare professions. Building on the value of human dignity and worth as he continues speaking, Martin restates his stance of lines 1 and 2 when he says that he would take no chances when treating a patient (line 10) as what is at risk is *another person's life* (line 11).

As he talks through the narrative of his decision making, Emma's early turns comprise minimal feedback in flat intonation which suggests she still needs convincing of the argument he is making. Towards the end of his turn, Martin introduces a new concern when he explains that clinicians *can't weigh up the cost of the [medical treatment] to the potential complications that*

the person might have (lines 13 and 15). Emma then concedes (line 19) that there is legitimacy to the stance he is taking. Martin reflects on the fact that sometimes health practitioners have to make decisions that may be in conflict with the interests of the patient and/or those of the institution, actively aligning with (and simultaneously constructing) an understanding of best practice that he suggests is shared by his colleagues. In this way, Martin indirectly addresses the issue of "the ontological divide between nursing practice as caring and nursing practice that is product orientated" (Hardy, Garbett, Titchen, & Manley, 2002, p. 201). In the age of business-led medical services (Wong, 2004), one of the main goals of institutions is arguably to reduce the costs of health care (see value of efficiency in Rawlins and Culyer, 2004), to the point that health care professionals are more highly evaluated by the management when they achieve better outcomes at lower costs (Wong, 2004; consider discussion of examples 3 and 4). These two goals, however, may at times be problematic since providing the best care possible may involve costly treatments (see Dall'Alba and Sandberg, 2006). It seems then that the market-driven focus promoted by the dominant culture of managed health care is at odds with the humanistic, altruist values and practices of nursing (Kenny, 2002). Thus, if these nurses prioritise lowering the cost of the medical treatment, they may risk providing unsatisfactory or even unsafe care, as Martin points out in line 11. In this instance, Martin seems to foreground the goal that is more closely related to the professional values dictated by his discipline, that is to say, providing good quality health care in spite of its cost. Finally, building his expertise from his professional experience, Martin finishes his argument by stressing that what he has discussed is based on his own experience of professional practice, leaving the door open to other professional experiences of the team.

Thus, in this example, Martin seems to navigate the boundaries of disciplinary in-groups and out-groups as concerns for providing high-quality, patient-centred care collide with institutional interests of lowering care costs. To achieve this, he moves along the professional-personal continuum by reflecting on what his views mean for their professional practice as well as for patients, showing that even health care professional can at times play both roles in the health care system. This seems to work to somehow 'humanise' patient care (Haslam, 2007) as he builds his accountability for the treatment decision he took during the incident.

As the following example illustrates, this concern for the professional and more personal dimensions of care is also present in the United Kingdom data set.

Example 2 (United Kingdom)

Context: The following conversation involves one female nurse and two male nurses, one of whom, Tim, is the charge nurse. They discuss the staff they need to cover the shifts on the ward.

1.	Mike:	you see your woman (.) you see your woman down
2.		there (.) those 2 <?> all morning (.) they're being sick (.) just
3.		constantly <?> I've got a lady who has a massive wound that size
4.		there sticking out of her back so she needs care as well like (.) and
5.		I have a wee woman in there with a below knee amputation and
6.		she's about 60 something (.) and she's been needing a lot of
7.		care=
8.	Tim:	= yous aren't getting cover for that are yous↑
9.	Mike:	at quarter to elev[en]
10.	Tim:	[are] yous alright for night staff (.) are there
11.		enough of them↑=
12.	Mike:	=yeah (.)there's enough of them
13.	Tim:	3 of them is there↑
14.	Mike:	you see they have all night to do everything (.) you [know] ↑
15.	Tim:	[yeah (.) I
16.		know] (.) I know (.) tonight well I have just started the data round
17.		but if I can get somebody spare I will send them up to you (.)
18.		alright↑and you have somebody else coming out from casualty did
19.		you say↑=

In this extract, we see the nurses enacting both levels of caring, that is, professional (concerning patients' state of health and treatment) and personal (concerning staff shortages and what this means for the nurses on the floor). Mike is explaining to Tim that their ward is extremely short staffed. Naturally, these staffing resources, or lack of, may not only have a direct impact on nurses' burnout (Twigg, Gelder & Myers, 2015) but also indirectly effect patient care. Thus, Mike draws Tim's attention to two patients who are constantly being sick to make his point; one patient with a large back wound, and another *wee woman* who has been needing a lot of post-operative care (lines 1-7). This listing of patients is a common strategy used by nurses in the data to express how overworked and understaffed they are, with implications that patient

care will suffer due to a lack of resources. Tim and Mike talk about the 'other' here, which is the *night staff*. It is established that this other group are adequately staffed as *they have all night to do everything*. Similar to example 1, the use of *you know* has a pragmatic function in line 14. It indicates shared knowledge created by being a nurse, showing Mike's assumption that Tim will understand that night staff are less busy than day staff, so just three members of staff can cope. Tim shows his understanding through his agreement in line 16.

Mike is indirectly making argumentative appeals to their shared professional knowledge. This is a common strategy in the 'us/them' discussions used to build an in-group and to create consensus among the group members, especially when criticizing others, making decisions on what to do (as in example 1), or deciding to act on a problem (Wodak, 2011). Here, the problem is lack of staff resources, which could be taken as a criticism of the nursing team or the senior staff who made the staff rota. Tim is one of these senior staff members. Therefore, the listing of patient care (resulting in nurses' excessive workload) is used to justify the critique of lack of staff, whilst simultaneously appealing to Tim for more staff help. The critique demonstrates Mike's stance, the fact that he feels that patient care may be at risk due to staff shortages. Unlike the female nurse in example 1 (consider flat intonation in her responses), Tim demonstrates his sympathy, and evidence of this collaborative agreement is apparent in the nurses' use of simultaneous turns throughout the conversation. The two males partly coincide with each other to show their agreement and support for one another's comments with overlaps and latching (Tannen, 1994). This is evidence of relational practice, where speakers collaboratively take turns and facilitate each other's comments (Fletcher, 1999; Holmes, 2006). We see something very similar in example 3, which represents another common complaint linked to staff shortage and the care patients receive if they are admitted at the weekend.

Example 3 (United Kingdom)

Context: Charge nurse Tim and staff nurse Ruth are discussing the issue of patients being admitted on a Friday. This is an issue as there is always skeleton staffing and no doctors or surgeons present over the weekend.

1. Ruth: it was nurse Pont something but <?> Smithy (.) has said to
2. take him in anyway just in case he needs anything done over the

3.		weekend then he's + he doesn't get it done
4.	Tim:	em
5.	Ruth:	this is only (.) see this kind of stuff like that's what they're trying to + stop (.) on this rest project
6.	Tim:	yeah
7.	Ruth:	cause there's no point he's sitting in here
8.		[that's what it said he says]
9.	Tim:	[there must be (.) there must be a reason] behind it though
10.		RGM* obviously knows him or something you know what I mean
11.	Ruth:	but he came to see me you see and he specially asked me
12.		[…]
13.	Ruth:	these people are taking up beds [basically] for another three days
14.	Tim:	[mhm]
15.	Ruth:	and they don't need too I know- it's so they can get a bed
16.	Tim:	there must be a (.) there's no body in on Sunday that's really
17.		strange (2.2) and you see the problem <?> is the consultants are
18.		starting to notice that on Friday we do that blood round that's when
19.		they get most of these discharges
20.		[and there's] hardly any on a Sunday
21.	Ruth:	{[mumbles]} yeah
22.	Tim:	and it goes down like a lead balloon with patients

*Regional General Manager

In this extract, the nurses are discussing the issue of patients who are admitted before the weekend. Due to staff shortages, not much gets done at this time regarding patient healthcare. A shortage of doctors at the weekend means that patients must wait all weekend *taking up beds* (line 13) but not getting any treatment. This again is reflective of what we see in the New Zealand data, where the nurses are often put into positions that conflict with other principles in regard to patient healthcare. Here, one of the main principles of the institutions across contexts is to reduce health care costs due to, for example, funding cuts by national or regional bodies. This then results in staff shortages which means providing the best care possible is simply too costly (see example 1). The complexity of this situation is reflected in Tim's various discourse orientations. Tim's ambivalence over his concerns for the nursing practices of the ward can be

observed throughout the example. He first positions himself from an institutional standpoint to try to understand (and maybe possibly even justify) why the RGM requested the nurses to free beds before weekends (*there must be a reason*, lines 9, see also false start in line 16), then from the perspective of what the current state of affairs means for the nurses working on weekends to the point of even critiquing the fact that consultants realize of the need to discharge patients only on Friday (lines 16-20). Finally, from the patients' point of view, he describes them expressing their dissatisfaction for the kind of service provided on weekends (line 22). Tim's various alignments (in addition to those explored in the other examples in this chapter) show that professional considerations are complex and have multiple dimensions which reflect the interests and values of the different stakeholders in the health care system. In this light, enacting a nurse identity seems to involve knowing what these interests and values are for each party involved and instrumentally using this knowledge to build arguments that support their stance. Making the wrong decision (reducing staff as argued here) may lead to unsafe or unsatisfactory care, which is also challenging to these nurses who are orienting to high professional standards. Conflict then arises when the choices that favour high quality care are influenced by strong stakeholders with competing interests. The next example serves to further support this point.

Example 4 (Wellington)

***Context*:** The team are discussing what kind of orthopaedic shoes to prescribe in order for the cost to be covered for the patient by the Accident Compensation Corporation (ACC). Martin is discussing how stringent ACC regulations have become.

1.	Martin:	that's just a whole thing now
2.		recently with ACC and being much more um
3.		stringeous {=stringent} with with what they pay (and stuff)
4.		for these custom shoes are much more expensive

Further developing the discussion of the previous extract on the role of the interests of stakeholders in nursing practice, Martin explains the fact that this *whole thing […] with ACC* is a recent situation (lines 1-2), which reflects the creeping impact of market-driven interests in healthcare (Wilson, 2009; Wong, 2004). He also highlights the fact that the goal of the new regulations is to reduce costs (lines 3-4) and seems to imply that the purchase of a given type of custom shoes may not be approved by ACC because they are *much more expensive* (line 4). As Martin very clearly points out in this example, these specialised nurses need to be more

cautious as to what products they prescribe to patients because, due to their cost, they run the risk of not obtaining ACC approval for their purchase. Considerations such as this one places the funding body regulations (also see 'ACC speak' in Lazzaro-Salazar, 2013) at the heart of case discussions in clinical meetings; the consideration of ACC policies is playing a pivoting role in this context. Considering the role of competing stakeholders is an integral part of the nurses' professional practice.

As expert healthcare providers, knowing ACC policies and how the ACC operates are vital professional skills if they are to manage their patients' cases efficiently. As Schuck (2008, p. 190) explains, it is "service providers, not consumers, [who] complete paperwork for the ACC." Thus, in many cases, whether a patient receives compensation may depend on the skills of the health professional to interpret current policies and to frame the patient's case in such a way that they are considered eligible for compensation. Reflecting on these issues in clinical meetings and participating in collective interpretations of ACC regulations brings to light the orientation of these nurses to developing shared expert knowledge. Becoming involved in expert activities is a key aspect in the development of professionalism, which, by implication, constructs their professional identity as nurses that are not only aware of current policies but also responsible and assiduous in updating their knowledge in this respect. Similar to the previous examples, this shows nurses attributing shared knowledge with one another that could only have been acquired through their work as a nurse that belongs to this team.

The examples to date have provided evidence of the relevance of professional considerations, with little evidence of markedly gendered behaviour. The transactional content is perhaps an influencing factor here because of the stereotypical linking of relational (people-oriented) talk with femininity and transactional (task-oriented) talk with masculinity (see Holmes, 2006). In the next example, we turn to more relationally-focussed talk to address this extra dimension.

Example 5 (United Kingdom extracted from McDowell 2018, p. 366)

Context: Two female nurses, Bea and Ruth, and one male nurse (Bob) complain about the rota and how often they have to work.

1. Ruth: I'm tired

2. Bea: well its only (1.0) half 10↑↓
3. Bob: I'm tired too
4. Ruth: I've got a [long day] tomorrow as well (.)
5. Bea: [I'm on a long day]
6. Bea: <?> he's tired (.) he's going to have a long day{sympathetic tone}
7. Bob: {laughs}
8. Ruth: but I think we're psychologically traumatized because of a
9. long day + we wouldn't be this tired if we were off at two
10. Bea: no (.) it's a while going in (.) see when it hits 3 o'clock on our ward
11. I hate it (.) from about 3 to 5 is [terrible]
12. Ruth: [<?>]
13. Bea: I know (.)
14. Ruth: I remember one day last week when I was doing the pills
15. and I was trying to talk to people on the phone and listen to the
16. voice and I was trying to listen <?> it's like what/ what did you
17. say↑
18. Bob: {laughs} (3.0) that's right (.) and of course
19. looks who's working on Monday + and on a bank holiday +
20. it just seems like we're always working (.) on holidays

The nurses in both sets of data regularly index shared knowledge that could only have been acquired through their work as a nurse (e.g. medical knowledge, lack of beds, being short staffed, feeling overworked). Extract 5 is a typical example of such use of shared knowledge: nurses complaining about their workload and disparaging their shift rota. Long days (12-hour shifts) were common, and one group in particular felt that they were always scheduled to work on public holidays. As well as providing an opportunity for the nurses to vent annoyance at their workload, these conversations allowed them to use the shared experience of being a nurse to connect with one another, bonding over their negative feelings about being over-worked and underappreciated. This extract demonstrates a recurring pattern in the data which supports the analysis of the participants as members of an in-group: their frequent use of the inclusive pronoun *we* (lines 8, 9, 20). A discussion that begins with one individual's expression of tiredness, *I'm tired* (line 1), quickly progresses to a unified discussion of others feeling the same, and a discussion of why this could be, i.e. *long days* (lines 4-5). Ruth even goes as far as classifying the group as *psychologically traumatized* due to the tiredness brought on by such

long shifts (line 8). Bob adds to the complaints by reminding the group they are working on yet another bank holiday (lines 18-20), which acts to strengthen their connectedness.

The interaction goes beyond simply complaining. Venting in this manner (although it changes nothing) allows them to negotiate solidarity. As a repeated theme found throughout both the data sets drawn on in this chapter and in other data collected by the authors, being over-worked and tired is part of being a nurse, whatever the institution or country in which the person is employed. Therefore, complaining about it aids nurses in the construction of their professional identities, establishes co-membership, and builds rapport with the other community members (Spencer-Oatey, 2005; Lazzaro-Salazar, 2007, 2013; McDowell, 2015b). Unlike the previous extracts, here we do not see any explicitly discussed concern for their professional practices or patient welfare (though it may be implied through this type of discourse). Instead, the interaction attends to in-group membership through solidarity.

All in all, these interactions show the male nurses' participating in ways that are not noticeably different to their colleagues, nor in ways that could be attributed to gender identity per se. Instead they seem to reflect a shared understanding of the professional identity of nurse. They use language to create and maintain self and group alignments based on nursing values, practices and shared knowledge. A more important point that emerges from this analysis is that the discursive orientations and linguistic resources explored in this chapter are needed in order to do being a nurse regardless of gender (consider female-male nurse alignments in examples 2 and 5, for instance). The evidence provided in this chapter challenges gender norms in two ways: (1) by focussing on interactions involving men enacting their caring identity in normatively 'feminine' contexts we challenge the emphasis on gender as the most salient category in interpreting behaviour; (2) recognising that interactional behaviour represents cultural and occupational contexts, both of which open the door for other explanations and considerations (besides gender) of communication phenomena in workplace settings.

A discourse of caring

To summarise this argument, we propose the normative constraint of *a discourse of caring*. Caring in the data has been investigated in terms of how successful the nurses are in providing (holistic, i.e. physical and emotional) patient care, embodying the values (or virtues) of the

nursing profession. By a discourse of caring we refer to those instances when nurses reflect upon their caring practices. In the data, we found that this is displayed at two different levels: at the professional level (when discussing patient care and other care-related institutional practices) and at the personal level (when nurses express their concern for other nurses, e.g. having work-life balance).

From a macro-contextual point of view, values are regarded as an integral aspect of the nursing profession and culture as a whole since these represent the ethical principles of the discipline (Killeen & Saewert, 2007). Like other professions, for nursing these are regulated by a value system that "give[s] direction and meaning to its members, guide[s] nursing behaviours, [is] instrumental in clinical decision making, and influence[s] how nurses think about themselves" (Killeen & Saewert 2007, p. 58). The values are regulated in the *Code of Ethics for Nurses* (ANA 2001 cited in Killeen & Saewert, 2007) and nurses entering the workforce are responsible for practicing nursing in accordance with these values. Thus, as part of the cultural system of the discipline, these values are responsible for some taken-for-granted assumptions and normative expectations for the behaviour of a professional community regardless, ideally, of the actual physical location of specific nursing communities (see Mennino, Rubin, & Brayfield, 2005).

From a more local but still rather macro-contextual perspective, a system of shared values is often investigated as the core aspect of organizational culture (see Bloor & Dawson 1994). This is made particular apparent in examples 2, 3 and 4 where the context of the particular worksite are brought into focus, whether it is the availability of staff, the lack of action over the weekend, or the ACC regulations which have significant impact on practices at the clinic (when compared to hospitals in New Zealand). As Mennino et al. (2005) explain, neo-institutional theory claims that workplace culture encompasses its practices, assumptions of the relationship among workers and a shared set of beliefs about the norms, values, and goals of an organization.

Finally, at a more micro-contextual level, nursing values are also at the heart of smaller communities, or sub-communities, of practitioners within organizations or workplaces. In the case of small communities in particular, nursing values may often be crucial when making decisions involving local practices, because these may guide nurses' discussions of which practices best reflect their caring values in their local work context. The interactions of these

practitioners arguably balance the practices of the team, the culture of the institution and the values of the profession.

The relationship between these levels of contextual perspective is complex. In practice, workplace culture, and, as a consequence, the culture of smaller communities within workplaces, simultaneously also "reflect and reinforce the culture of the wider society" (Mennino et al. 2005, p.125). This impacts on the way in which the values informing the profession, or discipline, are applied to local practice, that is to say, how things are done in one specific workplace by certain sub-communities in relation to the values that characterise a discipline. Thus, as they emerge in reflections of local professional practice, the display of discipline-based values serves to index and construct complex social meanings when nurses support or reject certain practices. In this way, nurses build their expertise as part of a professional community at multiple levels by indexing their alignment, or dealignment, with their discipline or professional group, with the institution where they work and/or with their local practice group or community. This enables nurses to position themselves within the social system of the discipline and the workplace, as they appropriate large-scale values to shape and reinforce certain features of their downscaled professional practices. This is achieved through what Blommaert (2010) calls 're-scaling'. Thus, when nurses express their opinions of the local professional practice they are evaluating, they draw on the higher scale discipline values that inform these opinions as a means to support their stances. The display of these higher scale value orientations and the negotiation of certain lower scale professional practices also allow nurses to construct themselves as core members of both, wider, or distant, and local professional communities (see Jingree & Finlay 2008).

Conclusion: Moving beyond stereotypes and gender

Instead of emphasising the gender identity of the nurses, we instead argue for the foregrounding of professional identity. We consider the possibility that the linguistic repertoire of nurses is used simply because it is the most suitable language for the job role (see Holmes & Stubbe, 2003; King, 2018). We do not know if the ideology of the role stems from the stereotypical female characteristics of nursing, or the fact that the nursing staff is largely female. But regardless of their origin, the linguistic tools of nursing suitable to display and negotiate relevant alignments and to show respect and care for patients and colleagues are those that demonstrate solidarity and that build on shared knowledge of the profession.

We contend that context can overrule gendered identity; the nurses in this study are using what we have described as a 'discourse of caring', which involves the use of a common language and discursive orientations (professional and personal) that are functional in their workplace contexts and that help them fulfil their duties as a nurse. Their work needs override those of their gender orientations. The professional language in this context creates an in-group and a professional identity that rests upon the core value of nursing, caring. In this way, reflecting on professional routines and practices serves as empirical evidence to show that those high scale values upon which nurses build their professional affinities are not fixed but are locally enacted and negotiated through re-scaling, recognising speakers' interpretations of how these values should be reflected in actual practice (Lazzaro-Salazar, 2016). Through the display of professionally relevant values, as is the case with caring, and their ability to incorporate and communicate value-based ways of thinking in their clinical practices, the nurses build their expertise as part of a professional community (Fook, Ryan & Hawkins, 2000). This enables them to position themselves within the social system of the discipline and that of the workplace, and to shape and reinforce certain features of their professional identity (see Bucholtz & Hall, 2005). Being able to navigate the various dimensions of the discourse of caring is part of what it means to be professional, to be 'a good nurse' (see Lazzaro-Salazar 2013 and McDowell 2015a, 2015b and 2018).

Within workplace discourse analysis there is a strong preference for data driven findings. Rather than taking a view that assumes gender issues are the most salient, our data encourages us to prioritise the influence of professional values on identity construction. For example, if the nursing population were mostly male, the characteristics of the job remain the same. While all identity construction is arguable a balance of a range of identities constrained by layers of context (Holmes & Marra, 2011), a discourse of caring would still be relevant and likely foregrounded in the linguistic tools used. And as more men enter into nursing, surely it is no longer viable to call nursing a 'women's job'; the feminisation of the industry is a hegemonic ideology that is ready to be challenged. Linguistic styles should become de-gendered and more associated with the *role* that men and women are playing in their workplace (Cameron, 2000). While the work activities that men and women engage in are changing, stereotypes still exist in public perception (Haines, Deaux, & Lofaro, 2016). By recognising that the linguistic repertoire of nurses' speech is aligned with professionalism rather than a mythical notion of 'women's talk', there is potential for a helpful de-gendering of the field.

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Transcript conventions

{laughter}	Paralinguistic features and clarifications in curly brackets
+	Pause up to one second
(.)	Breath pause
=	Continuing speech / latching
/ \ OR [ ]	Simultaneous speech - // beginning \\ end
(ok)	Transcriber's best guess at an unclear utterance
?	Question intonation
-	Incomplete or cut-off utterance
ME	Increased volume of material and emphatic stress
me:	Colon indicates stretching of sound it follows
↑	Rising intonation
↓	Falling intonation
↑↓	Rising then falling intonation
[…]	Ellipsis
(2.0)	Timed pause length in seconds if over 1 second
<?>	Speaker utterance is not audible for transcription

All names used in the excerpts are pseudonyms.

Notes

[1] Approval to conduct this project was granted by the University of Ulster and from the Department of Health in Northern Ireland. To minimise the effects of the observer's paradox (Labov 1972), all participants were only told that the study examined how nurses communicate. Meetings were held with all staff to explain the research and answer any questions. No staff member opted out of the recording process. Written informed consent was obtained from the primary participants and secondary participants gave oral consent.

[2] Approval to conduct this project was granted by the School of Linguistics and Applied Language Studies' Research Committee (Victoria University of Wellington) and from the Central Regional Ethics Committee which regulates research in healthcare institutions. Written consent was obtained from all attendees.