Talk in feminised occupations: exploring male nurses' linguistic behaviour

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Abstract

It is widely accepted among scholars that gender is socially constructed. Gender identity is not something one has but does, and language is one resource that is crucial when constructing, maintaining and performing one's identity. Recent sociolinguistic research has illustrated that a speaker's linguistic behaviour can be shaped by their surrounding context, and one such ever-growing area of study is that of workplace discourse, especially within jobs that could be classified as gendered. Scholars have focused mainly on women's linguistic behaviour in non-traditional employment (e.g. engineering). To date, there has been relatively little research into the linguistic behaviour of men working in occupations seen as 'women's' work (e.g. primary school teaching). To address this gap, this article focuses on men's discursive behaviour in the occupation of nursing to investigate whether they utilise language to perform a masculine identity in line with hegemonic characteristics, or whether they use the language indexical of the feminised environment in which they work. Empirical data collected from three male nurse participants within *nurse–nurse* interactions while at work in a Northern Ireland hospital are explored using discourse analysis and the 'community of practice' paradigm. Results indicate that the male nurses' discursive behaviour does not differ from that which sociolinguistic literature has repeatedly classed as 'feminine'. It is then argued that the nurses' language fulfils discourse tasks essential to the work role. In short, the men are *doing* being a nurse.

KEYWORDS: GENDERED OCCUPATIONS, WORKPLACE DISCOURSE, NURSES, MASCULINITY, COMMUNITY OF PRACTICE

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Introduction

It is widely accepted now among scholars that gender is performative and therefore actively constructed and displayed (Holmes 2006; Kelan 2010) entailing that gender identity is not something one has but does (Butler 2004). It is performed through gendered acts meaning that language is one key way we can perform gender, and workplaces are prime examples of local spaces where people can enact, exploit and over perform their gender because of the societal stereotypes to which it is linked (Holmes 2006). As a result, workplace discourse is an ever-growing area of study, especially within jobs classified as gendered; occupations that are not gender neutral but categorised as suitable for one gender or another (Nilsson and Larsson 2005; McDowell and Schaffner 2011). Gendered jobs have emerged from the skills and characteristics that men and women are *assumed* to encompass due to their sex and what society deems as 'feminine' or 'masculine' traits. Feminine workplaces are characterised by stereotypical features of femininity (being caring, facilitative, supportive) and masculine workplaces by those associated with masculinity (aggressiveness, competitiveness, power; Burke and Collins 2001; Trauth 2002; Hendel, Fish and Galon 2005).

While there has been an abundance of research on women working in 'men's jobs' (police, information technology, engineering; Miller 2004; Powell, Bagihole and Dainty 2008; Rhoton 2010; Angouri 2011; Baxter 2012), relatively little research has explored what happens to men who work in

what are seen to be *women's* jobs (primary school teaching, nursing; Holyoake 2001; Whittock and Leonard 2003; Cross and Bagihole 2006; Huppatz and Goodwin 2013). Often seen as different from real men who confirm their masculine identity by doing *men's* work, men in women's jobs are accused of failing to measure up to a real man's role (Padavic and Reskin 2002). Using interview data, scholars have examined the implications of men's non-traditional career choices on their gendered identity as well as the strategies they have developed to maintain, emphasise, or adjust their masculinity. Few scholars however have investigated men's linguistic behaviour and whether they use language to perform their masculinity in such contexts (Holmes 2006; Kiesling 2007; Mullany 2007; Schnurr 2008). Consequently, this paper focuses on men's discourse in the occupation of nursing, which is culturally typified to be women's work and classed as a semi-profession with low pay and low status (Evans 2004). Nursing is a female dominated occupation as its sex composition predominantly consists of women.[1] Moreover, nursing is a feminised role deemed by society as appropriate only for those with feminine characteristics (Britton 2000; Whittock and Leonard 2003). The fact that men mainly hold positions of power and management in the medical profession (e.g. surgeons) while the actual undertaking of nursing (caring, bathing, feeding) is performed mainly by women, supports this point (Padavic and Reskin 2002). In this article therefore, nursing is regarded to be a feminised occupation.

As men are the focus of this current paper, a word on hegemonic masculinity is needed at this point. Hegemonic masculinity is seen to be the socially dominant form of masculinity that embraces the characteristics of leadership, strength, heterosexuality, and perhaps most importantly, is seen as different from and superior to not just femininity, but to subordinate masculinities including homosexuals (Connell and Messerschmidt 2005; Adams, Anderson and McCormack 2010; Hearn, Nordberg, Andersson, Balkmar, Gottzen, Klinth, Pringle and Sandberg 2012). So although multiple masculinities exist, hegemonic masculinity is seen as the ideal, resulting in many men striving to exhibit hegemonic masculinity through the discourse that indicates this form (Kiesling 2007, 2011; Hearn *et al*. 2012). This is what Kiesling (2011:214) refers to as 'ontological desire', defined as 'the desire to have or emulate qualities of a particular identity'. For many of these men, hegemonic masculinity (and therefore heterosexuality) occupies a position of superiority and consequently, homosexuality is an identity with which they do not like being associated. Men self-report to loathe the negative self-identity of homosexuality that appears to be fixed onto any man working within feminised occupations. Coates (2003:196) has noted this 'orientation to the hegemonic norms of masculinity' through various linguistic strategies as the most striking feature of men's talk. Adams *et al.* (2010) refers to this linguistic behaviour as *masculinity establishing* discourse.

So if gender is not a fixed entity, and language is one resource people draw on to construct their gender, linguistic resources would not be uniformly used across all situations. Indeed, current research on language has found that men and women often adopt the gendered speech styles of the 'other' when influenced by their surrounding context (although this is not always an easy task to accomplish for some speakers; see Baxter's (2012) study of women executive leaders or Rhoton's (2011) study of female scientists). Research has also shown that men and women often use a very similar range of linguistic strategies when in the same work role or Community of Practice (Holmes 2006, 2009; Mullany 2007; Schnurr 2008; Angouri 2011; McDowell 2015).[2] This paper adopts a social-constructionist approach to investigate naturally occurring interactions collected by three male nurses while at work. It aims to explore male nurses' linguistic behaviour in this work context, and whether they utilise language to (i) perform a masculine identity as suggested by the majority of non-linguistic research in this area, or (ii) the language indexical of their work environment. Where previous research has focused on patient-nurse communication, this paper investigates the discourse of nurses

within *nurse–nurse* interactions to discuss the applicability of gendered speech stereotypes to this context. It begins with a discussion of men in feminised jobs and nursing as a community of practice, before moving on to outline methods of data collection and analysis. Main results are then presented followed by an in-depth discussion and conclusions.

Men in feminised jobs

The man's role as chief breadwinner in the home is frequently linked to demonstrating hegemonic masculinity in many societies (Padavic and Reskin 2002). Therefore the type of work a man performs is an important aspect used to shape a masculine identity. Strong opinions still exist in regards to gender segregated jobs with many men feeling that any care related job is only suitable for women (McDowell 2001). And although the UK has seen more men entering into feminised professions, this increase is small. For example, the Nursing and Midwifery Council (2008) state an increase of men in nursing from 9.20 per cent in 1998 to 10.73 per cent in 2007.

As masculinity is defined in opposition to femininity, men who work in feminised jobs are seen to be more effeminate or anomalous, and thus initiate a challenge to the traditional ideas of what is seen as appropriate gender behaviour (Williams 1995; Evans 1999; Lupton 2000). Previous research although limited, has examined the implications of men's non-traditional career choices on their gender identity and investigated how they manage possible conflict in this context (MacDougall 1997; Evans 1999; Brown, Nolan and Crawford 2000; Cross and Bagihole 2006; Whittock and Leonard 2003; Huppatz and Goodwin 2013). With reference to male nurses, when masculinity is under threat men often strive to exhibit characteristics associated with hegemonic masculinity via various social performances designed to separate themselves from their female colleagues and the 'feminine' aspects of nursing. Unlike women in male dominated professions who feel they must downplay their femininity often adopting more normative masculine styles (see Miller 2004; Powell *et al*. 2008; Rhoton 2011) men often experience an incentive to engage in the reproduction of their masculine identity (Cross and Bagihole 2006). Masculine embodiments are as positive giving male nurses incentive to emphasise their distinctiveness from all things feminine (Kiesling 2007, 2011). As a result, men exaggerate the stereotypical male attributes associated with their gender. This is *doing* gender, and men make their masculinity much more explicit when in feminised work contexts than traditional male occupational roles (Williams 1995).

Nursing as a community of practice

When investigating discourse, the *community of practice* paradigm (henceforth CoP) has been increasingly embraced by linguistic scholars in their research (Holmes and Schnurr 2006; Mullany 2007; Holmes and Marra 2011). CoP has been defined as 'an aggregate of people who, united by a common enterprise, develop and share ways of doing things, ways of talking, beliefs, and values: in short, practices' (Eckert and McConnell-Ginet 1999:186). These practices relate to the discursive strategies and interaction styles specific to each particular CoP in which members mutually engage (Wenger 1998). This knowledge is acquired over time, the extent of which distinguishes between core and peripheral members. Workplaces consist of groups of people who work together, who share a work purpose and a common goal based on work related knowledge so they can assist each other. Arguably then, workplace groups can be communities of practice, each with their own linguistic repertoire and language pattern to negotiate meaning, so shared repertoires help develop and display relationships. This allows members to retain an effective work relationship, which can increase work productivity and ensure work is completed efficiently (Fletcher 1999). Debatably, the observed

practice in any workplace could be a direct result of its occupational role, as a CoP can originate via mutual engagement by means of a localised repertoire. However, to what extent are such practices localised and negotiated by the members in a specific CoP, or just generic practices used in numerous other CoPs? Due to the many CoPs to which a person can belong (some of which may be gendered), and hence the various identities a person can acquire, it seems practical then that speakers use a range of verbal repertoires that include features traditionally associated with both masculine and feminine speech (Cameron 1997, 2000; Holmes 2006; Schnurr 2008; McDowell 2015). It is also reasonable to assume then that certain linguistic strategies may not be specifically localised to a certain CoP, but are rather more standard features commonly used in variety of CoPs. King (2014:61) postulates that groups of people who share a common entity (e.g. being gay) may actually only *imagine* themselves as a community, and share similar practices merely as a result of this imagined alignment. Therefore, it is important to examine whether the seemingly localised practices used in any CoP are actually localised and 'distinct from more widely recognisable practices'. To help with this issue, scholars stress the importance of looking for linguistic patterns in relation to the particular CoP (e.g. workplace and job role) as the established speech norm in the workplace may become part of the member's communicative style (Eckert and McConnell-Ginet 2003). In non-traditional occupations then, this allows men and women to step away from the stereotypical manner in which society expects them to behave and enables them to perform according to the requirements of their job (Holmes and Schnurr 2006). However, this accommodation is proven to be more problematic for females than males (see Baxter's 2012 discussion of 'double voice'). Therefore, when examining the linguistic repertoire of any workplace it is important to consider the ideology and rules of said workplace; how it is viewed by society; and whether it is gendered (Holmes 2006; Baxter 2010). So here a brief outline of the nursing role is provided.

Communication is a vital tool in nursing as it can affect the standards of the care given and consequently patient well-being. Nurses have a range of acceptable linguistic resources that must be utilised when dealing with colleagues and patients (see Murray-Grohar and DiCroce 1997). It is noted at this point that the main body of existing research in this field focuses on nurse-patient communication and although findings of this research does not automatically extend to inter-professional communication among nurses and their colleagues, it is suggested here that the ideology behind nursing may have an effect on what is seen to be appropriate behaviour among staff in order to maintain employee rapport. For instance, Angouri and Bargiela-Chiappini (2011: 213) suggest that employees are expected to work collaboratively in many workplaces so any disagreement in workplace talk seen to be face threatening is 'typically rare … as interactants pay special attention to the face needs of their interlocutors'. Fletcher (1999) refers to such linguistic work as relational practice, a particularly feminine style of discourse that attends to the needs of both individuals and the collective group to enhance team spirit, essential in any workplace for workers to achieve the collective goal. Arguably then, maintaining a harmonious nursing group is an important element of the ward environment as nurses often work in teams to address work-related problems using their combined knowledge and expertise. Indeed, Timmens and McCabe (2005:66) suggest that 'being isolated, disliked or punished, by nurse colleagues was a barrier to assertive behaviour'. In fact, nurse–nurse harmony is so vital, nursing managers need skills to negotiate internal conflicts to 'help the antagonistic groups work together towards their shared goals. He/she also provides encouragement and support, releases tensions, harmonises misunderstanding and deals with disruptive or aggressive behaviour' (Hendel *et al*. 2005:138). The linguistic resources and communicative behaviour acceptable within a nursing group could therefore be a direct result of the occupational role of a nurse, the ideology behind nursing, and how nurses are expected to behave.

Methodology and data collection

This paper draws on over 50 hours of naturally occurring conversation recorded by three male nurses when interacting with their fellow colleagues while at work in a hospital in Northern Ireland. At the time of data collection there were approximately 20 male general care nurses working across the nine wards in the case study hospital. Following an advertisement in the hospital for male participants to take part in a communication study, three men volunteered to take part.[3] An unforeseen benefit of the volunteer sample was that it was not a homogeneous group as variation in identity often creates disparity in how individuals utilise speech (Holmes 2006).[4] All three were at different stages in their nursing career; of different religions (protestant and catholic);[5] had different status (charge nurses and staff nurses);[6] worked on different wards specialising in different areas of care, and one participant (Tim) had a different cultural background. All male participants can be described as core members of their CoP as all have been in this workplace for numerous years.

The male nurses were the primary participants in this study as they carried and were full control of the recording equipment.[7] However, as communication is a jointly performed task (Nevile and Rendle-Short 2009) capturing all interlocutors' speech in each interaction was important as it permitted a rounded examination of how the talk was actually accomplished. Therefore, female nurses, other male nurses, plus any other players in the medical field (e.g. doctors) acted as secondary participants as they interacted with the primary male respondents (after their verbal consent was acquired). This provided a vast dataset of language-in-use and therefore identity in action (Holmes and Meyerhoff 1999).

Data collection also involved interviewing participants to provide contextual knowledge to aid the analytical process of the spontaneously spoken data (Angouri 2011). Semi-structured interviews were conducted with each nurse to provide some insight on whether they felt they integrated in the nursing environment; whether they ever felt their job was a challenge to their masculinity; and how they dealt with being outnumbered by female nurses. These questions were motivated by recurrent key themes evident in previous research on men in feminised jobs (Issacs and Poole 1996; Holyoake 2001; Cross and Bagihole 2006). The interviewer was female, which may have affected the participants' responses, especially concerning issues of masculinity. However, interview responses are secondary to the main corpus of spoken interaction and only referenced to analyse participants' perceptions of how they behave at work, acting as an accompaniment to the main analytical focus of examining how they actually linguistically behave.

Analytical framework

The discursive analytical approach taken was interactional sociolinguistics (IS), a multidisciplinary paradigm which allowed a fine grained examination of the data set to focus on how language is used actively to perform social identities. The IS paradigm embraces both social-constructionist views of gender and CoP as a qualitative framework to address the possible *why* behind speakers' discursive behaviour, allowing a detailed analysis of the language used within the constraints of the context in which the speakers are situated (Hertiage and Clayman 2010; Milani 2011). Of particular interest was whether language was used to enact and reflect a masculine identity in line with hegemonic characteristics, or an identity more indexical of the environment in which they work.

The remainder of this article will highlight evidence of male nurses utilising normative feminine speech styles and where significant, corresponding interview data will provide insight into each participant's own views on their communication style. The extracts in this article represent typical

linguistic strategies recurrent in the corpus and take place during interactions in mixed-sex and single-sex groups.

Results

Data revealed all nurses (both male and female) employing a variety of linguistic strategies to build a collaborative floor regardless of audience gender. An exploration of the effect of speaker-audience gender illustrated an absence of difference in the speech styles utilised. Both men and women utilise mitigation to soften their opinions, directives and criticisms; avoid the appearance of being an expert in their field; attribute shared knowledge to their listeners; and create an in-group of nursing through various joining-in behaviours (gossip, shared humour). This paper focuses on one of the male nurse participants' most frequently used linguistic behaviours – mitigation and indirect talk. The function of mitigation is to protect speaker and addressee face, maintain a collaborative floor, and reduce status differences between speakers. Where direct speech is typically associated with men and seen as essential for leadership, indirect speech has been stereotyped as a feminine feature, and is thought of as so by the three male participants. One salient feature in all three interviews was their claim that male nurses were generally more assertive and direct, stressing a distinct difference between their own and their female colleagues' communication styles. Tim and Joe even went so far as to accentuate that they dislike certain aspects of 'women's talk' (gossip, mitigation, feminine topics). When asked whether they felt they alter their speech to 'fit in' with their female colleagues' conversational style, all three asserted that they could not conform to feminine discourse as this would conflict with their masculine identity. Joe, in what could be described as an 'us' versus 'them' construction here (Oddo 2011), asserts:

Interview quote 1

```
1  No, I can't do it, assimilate to their conversational
2  strategies … I don't feel comfortable doing it you know,
3  I don't, b-because they're so many of them about, you
4  tend to feel as though you have to make concessions for
5  them sometimes but you know it's going against your grain
6  and against your way of doing things. So I don't.
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When asked if he felt that he differed from his female colleagues when giving orders or making suggestions, Bob in interview quote 2 makes explicit reference to his gender and the direct influence this has on his linguistic behaviour:

Interview quote 2

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1  Well yeah there's definitely a difference between the
2  communication strategies between the two with colleagues or
3  with patients. I'm more direct but I just am I think, maybe
4  'cause I'm a man.
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And when asked the same question Joe describes himself as a leader rather than a follower, again as a result of 'being male':

Interview quote 3

```
1  Sometimes you felt as though you have to take more of a lead
2  as a male I dunno if that's, it's probably just, male
3  psyche, you feel as though you should be leading things,
4  more rather than following … I think that's just being male.
5  Just say you want it done, none of this 'Oh I like your
6  hair, could you possibly do this for me?'
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This reflects a common viewpoint that men are seen as direct and natural leaders with the skills essential for leadership, with women as subordinate followers (Holmes 2006; Holmes and Marra 2011).

Despite such assertions during interview, how the men actually linguistically behave on the job supports recent workplace discourse research demonstrating that male speakers can be indirect when making statements, giving orders or criticising others (Stubbe, Lane, Hilder, Vine, Marra, Holmes and Weatherall 2003; Holmes 2006). The men in this study did not use typical masculine linguistic indices to emphasise their masculinity or separate themselves from their female nurse colleagues. Instead, they frequently use strategies often classed as feminine to perform relational practice and maintain relationships with their colleagues. The interview data may suggest that gender issues are only highlighted when attention is drawn to them. In other words, when talking to a female researcher who is an outsider to their CoP, participants may have felt a need to distance themselves from what they consider to be feminine discourses. Or, it may simply highlight that they use such discourses without an awareness of doing so as these are routine and integral to performing their job. This may also lead us to a stronger theorising of the term *male nurse identity* and what exactly this means to the participants. Previous literature on men in feminised jobs would suggest a link between being associated as homosexual and a negative self-identity, which is an identity that many men fight against. This may be what is being demonstrated here in the interview data: men projecting themselves as masculine by the outright denial of feminine discourse styles which may reflect a desire to be seen as masculine (of the hegemonic variety) and consequently not homosexual. It is noted at this point that linguistic behaviour to perform a hegemonic masculine identity was not found anywhere in the naturally occurring interactions. In fact, the interactions present evidence of the three male nurse participants employing mitigation to soften their directives and opinions regardless of their audience's gender or status. Even Bob, who has higher work status as a charge nurse and therefore need not have reduced the force of his directives (Holmes 1995), continually mitigates orders when talking with subordinate nurses. The extract below is taken from a conversation between Bob and a female first year nurse where Bob is informing her of her mistakes during a medical procedure:

Extract 1
Context: Bob is correcting procedural mistakes made by the female first year nurse.

```
1  Bob: can I show you a wee thing
2  Fn:  <?>
3  Bob: are you the house [from 6C ]
4  Fn:                    [mhm mhmm]
5  Bob: see the way you've disconnected his fluids here (.)
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```
6       w.w.we have to dump that just
7  Fn:  sorry
8  Bob: you're alright (3.0) it's just contaminated so if you
9       say instead of doing that again we put a needle on the
10      end of that we could reuse it again
11 Fn:  put what on it
12 Bob: a needle (.) just a sterile needle (.) as you take it
13      off
14 Fn:  right
15 Bob: and then hang it (.) we can reuse it (.) but as it is
16      we had to dump it
17 Fn:  sorry
18 Bob: you're alright (.) it's okay
19 Fn:  I won't do it again <?>
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In this extract, Bob is not demonstrating his higher status to the female via direct orders and criticism of her work.[8] Instead, he attempts to reduce the status difference between himself (being a charge nurse) and the female (a first year staff nurse). Beginning with the tentative modal verb '*can*' (line 1) Bob seemingly asks the female's permission to 'demonstrate something' to her. Although presented as a request, this speech act has the indirect illocution of a command. He uses the minimising hedge '*wee*' to curtail the level of imposition made by his request (Brown and Levinson 1987; Holmes 1990, 1995). This is also evident in line 8, where Bob appears to make a suggestion rather than give a directive: '*so if you say instead of doing that …*'. Another strategy evident throughout his instruction is his use of the inclusive pronoun *'we'* on several occasions (lines 6, 9, 15) rather than making direct reference to the female nurse with the pronoun '*you*'. Said to be a strategy commonly employed by female superiors when instructing their subordinates (Coates 1996; Holmes 2006), including himself in his own instruction via the inclusion pronoun allows him to mitigate his directive; '*we put a needle on the end of that*'. Furthermore, he is referring to himself as part of a collective of nurses: *'we'* represents the nursing staff on that ward; '*w.w.we have to dump that* (line 5)', '*we could re-use it*' (line 9). The use of '*we*' here is used as a relational indicator: it allows the discursive construction of group identity allowing group consensus and shared decisions. The speaker's selection of '*we*' rather than the personal pronoun 'I' or 'you' is of importance here as the choice of this particular pronoun has certain sociological meaning (Oddo 2011; Wodak 2011). Using the personal pronoun 'I' means the speaker claims sole responsibility for a task or an opinion. *We* however is a collective pronoun and its use allows the speaker to make themselves part of a collective sharing responsibility for actions or comments, and to mitigate orders by reducing authority and creating a sense of equality to create an in-group.

Additional mitigation strategies are notable in lines 6, 9 and 15 where Bob provides various explanations as to why he is criticising the female nurse's work. In doing so, he is communicating to his addressee that by following the correct procedure, she would be helping all her nurse colleagues as a collective rather than appearing that she would only be helping him. This is further strengthened by his continual reference to the collective pronoun '*we*'. He is offering his listener various reasons for his imposition providing justification for his request (Holmes 1995). His slight stammer in line 6 ('*w.w.we*') may act as a covert ploy to further mitigate his criticisms (Coates 1996). Supplementary evidence to suggest that Bob is attempting to mitigate his orders and criticism is realised in his reassuring comments that he is not trying to criticise her; that she is not in any trouble for her

mistakes. In lines 8 and 18 he informs her that she's '*alright*' after she repeatedly apologises for her actions.

Seen to be a form of relational practice (Fletcher 1999) mitigation is frequently employed in feminine workplaces by female superiors to their subordinates (Holmes 2006). But here we have a male superior making use of mitigation and although Bob claims in interview that he is direct when giving orders perhaps as 'he is a man', instead he uses various strategies to reduce the force of directives and change orders into requests including modals, tag questions, hedges, use of the inclusive pronoun '*we*' and, perhaps most frequently, minimisers (e.g. '*give us a wee hand*', '*do us a small favour*', '*can you take a wee look at my patient*'). These findings support research where men have been found to use a range of mitigations when giving directives in the workplace (Vine 2001; Holmes, Burns, Marra, Stubbe and Vine 2003).

During interview, Joe continually distinguishes his role from his female colleges to carve a masculine niche. He argues that for him, masculine identity overrides the need to assimilate to his female colleagues' communicative styles, even going so far as harbouring feelings of resentment toward their discursive style. Indeed, Joe made it clear that men were much more direct and get things done much quicker, stating that he 'resents' how women make decisions and that men do the job 'better':

Interview quote 4

```
1  Sometimes there's decisions to be made and I think males can
2  make decisions quicker, than females … females would
3  all sit down and have a conference about it and share
4  responsibility and decisions and I would resent that.
5  I think they're wasting time … whereas men don't … men
6  interact in a different way … you tend to get the job done
7  better and quicker when you're a man and just go about a
8  more direct way, rather than trying to adopt their approach.
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Joe then equates being direct as (i) something only men can do and (ii) the best way to perform the job. However, the data provides many instances where Joe is indirect when discussing tasks or coordinating work that needs to be done with the other nurses. He mitigates his directives, suggestions and even his medical opinion frequently, and does so via typical feminine discourse strategies. There is a clear gap between his declared beliefs and his actual linguistic practice. Extract 2 highlights a particular instance that was common in his linguistic style:[9]

Extract 2
Joe, one female and one male nurse (Mn) are talking about a patient that needs extra help, while also deciding on treatment for another patient.

```
1  Joe: you know what we'll have to do when Mrs X comes back
2       in (.) we'll have to have a look at those blisters on
3       his feet and his//
4  Fn:                  //he's the[re]
5  Joe:                            [is] he there/ we could do
6       that now Clare couldn't we/ have you seen him yet/
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```
7  Fn:  no
8  Joe: they are putting eh Nadine in and a tubby fast on it
9       (1.0) so I'll go and set the trolley up and we can go
10      and have a look at them
11 Mn:  I spoke to Jenny about em <?> and I've asked
12      her to speak to Mr X again to see…
```

Throughout this discussion Joe recurrently uses the inclusive pronoun '*we*' to implicate that the three nurses will work together rather than appear he is dictating orders (lines 1, 2 5, 6, 9). By including himself in his directives, Joe is not taking an authoritative stance to instruct others to complete said task, perhaps as the two other participants in this group are of equal status to him. So, he mitigates his directive by including himself in the instruction, turning into somewhat of a suggestion. In line 6 his use of the tag question '*couldn't we*' functions to turn his declarative '*we could do that now*' into a suggestion (Holmes 1982).

The data discussed so far illustrates that the key participants use linguistic devices stereotypic of female speech to mitigate their directives and suggestions when talking to their female colleagues. It could be assumed that this 'feminine' strategy would not be deployed when interacting in a single sex dyad and that more direct speech styles would be evident. However, the same strategies are found when the male participants interact with other men. Extract 3 is taken from a conversation held between Bob and a (subordinate) male staff nurse and demonstrates a conversation laden with collaborative techniques to come to a joint decision regarding their patient:

Extract 3
Bob and another male nurse are organising a patient's bed allocation.

```
1  Mn:  I have side wards//
2  Bob:                  //right so we're gonna give that away
3       then
4  Mn:  yes yes(.)I have a side ward (1.0) 3 going at 2
5       o'clock(.)so they can [<?>  ]
6  Bob:                       [so they] both can [get in](.)
7       and then 6c ha[ve: ]
8  Mn:                                          [going to
9       there]
10                    [6 she] can come into mi[ne ](.) Mrs X
11 Bob:                                       [yeah]
12 Mn:  (.) she's coming from Derry which is a bit of a travel
13 Bob: right (.) I'll get Jay to phone them then and em:
14 Mn:  <?> [6. 6. 6. F's]//
15 Bob:     [and    ]// 6F's patient could go into Mrs Y's
16      then
17 Mn:  oh no it's a man (.) it's a him he's a (.) it's a man
18      [it's a man] (.) so he can go into
19 Bob: [is it/ ]
20 Mn:  there (1.0) my woman can go into [there]
21 Bob:                                  [and ]Mr Y:=
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22 Mn:                                                =Mr Y
23      and <?> into the side ward =
24 Bob:                              =into the 19 side ward(.)
25      that'll do
26 Mn:  I'm trying to tell you how to do your job((both laugh))
```

Here, Bob uses specific types of interruption to construct a cooperative floor. For example, when his male companion stalls (‘*6. 6. 6. F’s*’) as he is thinking of what he wants to say (Strenström 1994), Bob’s interruption ‘*and 6F’s patient could go into Mrs Y’s then*’ finishes the male’s sentence to show his attempts to follow what the other male is saying. Such turn completion is identified as a method used to share the floor by allowing one another to give their opinions (Coates 1996, 1997). Bob is working along with his male colleague to sort out the lack of bed space. These interruptions are supportive (Roger, Bull and Smith 1988; Tannen 1984, 1994), providing the opportunity for the male speakers to work as a team performed successfully through their linguistic behaviour, a common communication technique found in this dataset.

Further support for construing this data as collaborative relational talk is provided in the other male’s linguistic behaviour when the he latches onto Bob’s turn to complete it in line 22. Bob latches onto the male’s utterance and repeats it word for word, ‘*into the side ward*’ to show his agreement. These men do not interrupt each other in a competitive manner or fight for the floor, but work together to solve a problem of bed shortage. Perhaps speakers can reach a joint conclusion quicker when working together rather than when competing with one another. The two males partly coincide with each other through their use of simultaneous turns to show collaborative agreement illustrated through simultaneous speech (overlapping of each other’s turns) and turn latching (Coates 1996, 2004). Such cooperation is depicted to be a normative feminine speech style fundamental in performing relational practice (Fletcher 1999).

Discussion

Despite differing in certain aspects of their identity and levels of hierarchy all three males utilised linguistic strategies considered typical of a feminine style for comparable purposes. Moreover, the linguistic practices found in the data were also used by the *secondary* participants. Throughout the entire dataset all nurses appear to pay a great amount of attention to reducing social discontent and building solidarity, perhaps as the consequences of not linguistically behaving as part of the in-group can be particularly grave (see McDowell 2015). It is argued at this point that the features used are indicative of a nursing CoP, and that the nurses are functioning as a real CoP based on a shared professional identity, and not an imagined CoP (King 2014). While it is beyond the scope of this paper to provide detailed analysis of the language used to construct this CoP (see McDowell 2015 for further discussion), an explanation of how the practices used here are negotiated by the members as a localised repertoire is warranted.

The data exhibits the three critical characteristics required to constitute a CoP, (mutual engagement, joint enterprise, and a shared repertoire gathered over time), as well as the sub-group of features that a CoP can contain (King 2014; Holmes and Meyerhoff 1999). These three critical dimensions offer a framework to examine how the nurses in this community gain membership and exhibit their shared goals. Firstly, mutual engagement; the regular engagement that helps members construct relationships which form the basis of any CoP. Data collected in this current study demonstrates that the nurses

have regular interaction with each other, both formal and informal. Interactions included a range of communication types, formal meetings (e.g. shift change meetings), informal discussions (e.g. about patients) and small talk (e.g. personal lives). Secondly, a joint enterprise within a CoP entails that those inside it have the shared goal of working together to build and maintain that enterprise. The nurses in this current study share a joint enterprise; each nurse's contribution is vital to the medical environment. They form a major part of the running of the hospital; caring for patients; ordering medicine; finding beds for new patients etc. And finally, to achieve this joint enterprise, the nurses exhibit a repertoire of joint resources they used to communicate effectively, for instance they use specialised terminology (i.e. medicines, technology terms). Shared knowledge of linguistic routines was also evident. For example in shift cross over, nurses had set ways of running a meeting and delegating orders. They demonstrated shared ways of doing things together; illustrated common knowledge and ideologies; and had shared practices all formed around their one common interest: caring for patients on their wards (Eckert and McConnell-Ginet 2003).

Each nurse's linguistic performance could be to some extent determined by their mutual workplace culture with the linguistic repertoire of their setting having *some form* of influence on their linguistic choices (Holmes and Schnurr 2006; Powell *et al*. 2008). In other words, the language used allows speakers to communicate effectively in this particular milieu. The nurses use language that allow them to fulfil discourse tasks essential to their profession and form a positive and collaborative relationship with other nurses to show a united team (Fletcher 1999). Take the example of hedges for instance. A recurrent feature in the data, it could be argued that hedges are merely part of more widely recognised practices and not highly localised to the nursing environment (King 2014). However, the use of hedging within the medical profession could be a direct result of the professional language required in the arena of medicine. When discussing hedges in written science, Salager-Meyer (1997:105) classifies them as a way to fulfil the objectives of the 'fundamental characteristics of modern science', which are 'uncertainty, scepticism and doubt'. Hedges allow the medical speaker an element of distance from what they are saying, allowing their claim to be stated without full commitment, rather than as a fact. This is similar to Coates's (1996:160) definition of 'avoiding playing the expert'; where hedges are used to purposely demonstrate uncertainty to reduce social distance between speakers. In doing do, speakers can benefit their profession (and patients) by working closer as a team (Timmens and McCabe 2005). This also permits the speaker to protect his or her own face while minimising the risk of addressee confrontation (Holmes 1995), and all of these hedging functions where deployed by all participants.

In contrast to the literature that frequently perceives men in nursing differencing themselves from women colleagues in order to establish their masculinity (Heikes 1991; Lupton 2000; Simpson 2004; Hendel *et al*. 2005; Cross and Bagihole 2006) these male nurses use lexical strategies to emphasise their belonging to the nursing community and their professional identities (see McDowell 2015 for empirical evidence for this claim).[10] Arguably, the overriding mechanism behind such behaviour here is to express collegiality and solidarity (Wenger 1998). What is regarded by society as a feminine ability of supporting and nurturing others, building solidarity, and creating a sense of teamwork has been recently described as good qualities for all employees, especially nurses (Murray-Grohar and DiCroce 1997; Barrett 2004; Priola 2004). Evidence for this can be illustrated for example by examining Bob's linguistic behaviour. As power can enacted through the workplace discourse of interactants (Angouri and Bargiela-Chiappini 2011), nurses higher up in the hierarchy hold managerial roles that require skills to allow them to negotiate potential work conflict. Although leadership skills are traditionally associated with stereotypical masculine characteristics (e.g. unmitigated directives), in *this* context, the skills needed for nurse managers are arguably the opposite

of this as research has shown that good leaders in a nursing context are not overly assertive (Hendel *et al*. 2005). Bob's speech has portrayed him as a democratic leader with suitable skills for the area in which he works. He did not exert his authoritative status, but minimised the social distance between himself and his subordinates using mitigation which kept communication open and all members involved, a notable speaker skill according to Marquis and Huston (1998). It could even be described as a covert technique used to manage others as it is clear that Bob often gives orders: but has learned how to do so in a way that can't be adversely commented on by his subordinates. This is not to suggest that because Bob has more status he automatically has more choice over whether or he accepts and utilises a speech strategy while his subordinates must use the linguistic repertoire to gain acceptance (Eckert and Wenger 2005). In fact, since conflicts between workers can interfere with teamwork and subsequently patient care, how nurses manage conflict is of key importance to the nursing environment, and deploying the appropriate discourse is perhaps even more critical for managers in this area. If normative masculine strategies are not effective in the nursing CoP, one could argue that all nurses must adopt strategies to maintain a harmonious group and not cause offence (Barrett 2004). There may therefore be a link between Bob's linguistic behaviour and his higher status, but the extent to which his status affects his language in this CoP is unclear, especially as individuals belong to multiple CoPs (Eckert and Wenger 2005). It is not known how Bob, Tim and Joe participate in other CoPs and what the standard linguistic behaviours in their speech actually are. What is evident however is that when examining the micro-level of interaction *on the job*, the specifics of the work-role do exert some influence on the nurses. This is evidenced by the lack of any significant differences in communication style of the male and the secondary participants who are mainly female. All nurses observably maintained normative feminine speech styles (even in male single sex interactional groups). There was also a lack of female nurses' accommodation to features stereotypical of male speech in mixed sex dyads, as well as the lack of purposive divergence in the male nurses' speech that is claimed to occur when masculinity is threatened (Heikes 1991; Lupton 2000; Hendel *et al*. 2005; Cross and Bagihole 2006). This is similar to previous research concerning women in masculinised jobs, where women (albeit more consciously) move away from femininity to embrace masculine characterises in order to perform their job as they are aware of the threat potential of using language inappropriately in their CoP (see Barrett 2004; Rhoton 2011; Baxter 2012). It could be argued that the men use a discourse seen as typical of female language to align themselves with their surrounding interactional context which just so happens to be feminised (Milani 2011). Or, as masculine and feminine identities are multiple, it is also plausible to suggest they are demonstrating a subordinated version of masculinity (McElhinney 1995).

Nevertheless, what *can* be deduced is that gendered identity is therefore not always of primary importance in the workplace, as people can focus instead on their role construction (Thimm, Koch and Schey 2003). Of course this is not to suggest that male nurses do not 'do' masculinity in other ways. But they are using the unmarked speech style in this environment as the feminised work role may guide, shape and permeate their discursive choices (Holmes and Schnurr 2006) as collaborative language creates a less confrontational environment' and therefore a stronger sense of 'team spirit' (Fletcher 1999:81). This appears to be a subconscious act when their interview data is taken into consideration, demonstrating a difference between what male workers self-report about *doing* gender (they could never conform to the discourse of females) and what they actually do *on the ground*.

Conclusion

Spoken data collected from three male nurses (as well as that of their fellow interlocutors) while at work was examined. All participants utilised linguistic strategies characteristic of normative female

language supporting recent debates that men and women can use the same strategies to enact their professional identity in their work role context (Holmes 2006; Cameron 2007; Mullany 2007). These findings contribute to studies of men and women in non-traditional occupations (Kelan 2010; Angouri and Bargiela-Chiappini 2011; Baxter 2012) by lending support to existing arguments that gender is not the only influencing variable on speech. In fact, nursing gives men the contextual license to use this linguistic repertoire. Adopting a CoP's speech style can be linguistic tool to perform a job while simultaneously exhibiting membership identification. The language allows them to perform discourse tasks essential to their profession supporting that certain linguistic forms are not exclusive to one gender or the other and moreover that appropriate terminology is required to discuss the behaviour in these workplaces rather than *normative feminine*. The language used is the language of *being* a nurse regardless of the gender of the person in that work role. To explore this, further research in this area would involve additional data collection from a larger number of male nurses across different regions of nursing (e.g. emergency wards, psychiatry). This would provide a comparison of men across various CoPs within this non-traditional work role while also demonstrating whether various nursing practices have higher levels of status and are therefore deemed more appropriate for men to enter.

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About the author
Dr Joanne McDowell is a Senior Lecturer in English Language and Communication at the University of Hertfordshire. Her specialist areas include gender identity in workplace discourse, sociolinguistics, discourse analysis and educational language. Dr McDowell has recently published a paper on the topic of workplace discourse and Community of Practice in the journal of Gender Work and Organisation, and a collaborative book chapter on the trajectories of European students aged 14-16years old. She is currently working on a book chapter for the Handbook of Workplace Discourse, and leading two projects that examine the language of male and female primary school teachers.

Appendix: Transcription conventions

=	Turn latching
[]	Overlapping speech
<?>	Indecipherable speech
//	Point at which speech is interrupted
(.)	Very brief pause
(1.0)	Longer pause with length in seconds
/	Rising intonation on word or part or syllable
:	Lengthening/drawing out of final syllable/sound
(( ))	Paralanguage

Notes
1 In this article, a job is classed as female dominated (feminised) where female staff composition is more than 70%. A job is classed as male dominated (masculinised) where male staff composition is more than 70%. Women in nursing make up more than 85% of the staff population (Nursing and Midwifery Council 2008).
2 Terms such as 'feminine' or 'masculine' speech are still utilised by many scholars despite the acceptance that gender can be placed on a spectrum (Kelan 2010; Angouri 2011). This paper adheres

to the premise that men and women can use both all types of linguistic strategies regardless of their gender and provides further support for this paradigm. But as no other terminology yet exists to refer to such behaviour, and perceptions of gendered discourse are still strong, the author will use the terms 'masculine' or 'feminine' in this article when referring to speakers' linguistic behaviour and when discussing certain previously gendered linguistic features.

3 To maintain anonymity, the three nurses have been renamed as Bob, Tim and Joe. All female nurses are renamed as Fn and other males as Mn.

4 Bob was 34 years old; staff nurse for 8 years, over 2 years as charge nurse. He is a general care charge nurse on a ward that specialises in rectal colon surgery after care. He is from Belfast, white and catholic. Tim was 35 years old; staff nurse for 10 years. He is a general care staff nurse on a ward that specialises in care for elderly patients. He is from Philippines and lived in Belfast for 15 years. Joe was 38 years old; staff nurse for 4 years. He is a general care staff nurse on ward that specialises in liver disease and transplant surgery after care. He is from Belfast, white and protestant.

5 Research has demonstrated that speakers from different backgrounds often speak differently depending on their religious and demographic background so speech is seen an important identity marker.

6 Staff nurses in the UK provide pre- and post-care to patients who are in hospital for surgery. It involves tasks like changing dressings, changing adult nappies (diapers), delivering meals and administering medicine. These nurses in this study work in direct general care to patients rather than indirect care (cleaners, porters etc). Charge nurses are in charge of all staff nurses on the ward.

7 Key participants were in full control of all data collection and any recordings would be erased at the participant's request. This was never requested.

8 Extract has been shortened.

9 Extract has been shortened.

10 It is beyond the scope of this paper to provide a full analytical discussion of how the male nurses (and their nurse colleagues) linguistically demonstrated their belonging to their nursing CoP, and how their language was indicative of a nursing CoP rather than other widely acceptable practices. See McDowell (2015) for this discussion.

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