The impact of gender perceptions and professional values on women's careers in nursing

SCHOLARONE™
Manuscripts

The impact of gender perceptions and professional values on women's careers in nursing

Abstract

Purpose - Within nursing, there appear to be two enduring sets of assumptions: firstly, that woman with children should prioritise the care of children; and secondly, that nursing standards require nurses to put their profession above other priorities. Commitment is linked to full-time working this contrasts sharply with the reality for many women with children who need to work part-time and are not able to change or extend working hours.

Design/methodology/approach - This qualitative research involved the use of 32 in-depth interviews with thirty-two female registered nurses with children and without children. They were employed in 'acute' nursing where aged between 25 to 60 years old and employed in registered grades 'D' to 'senior nurse manager'. They worked or had worked on a variety of employment conditions, some, but not all, had taken career breaks. The rationale for exclusively selecting women was based on the need to identify and describe organisational, situational, and individual factors related to women and the associations and barriers which affect their careers.

Findings - In a female dominated profession, we find the profession resisting attempts to make the profession more accessible to women with young children. The career progression of women with children is inhibited and this is driven in part by a determination to maintain 'traditional' employment practices.

Originality/value – This paper develops Heilman's argument that the restructuring of employment has lead to work intensification which stokes gender tensions. These findings are relevant across many areas of employment and they are significant in relation to broadening the debate around equal opportunities for women.

Key words: Attitudes, barriers, careers, children, flexibility, gender stereotypes, nursing, professional values, working

Introduction

Historically, nursing has been defined by the gender of its workforce and its professional values although there has been less attention on how these two factors inter-relate and impact on careers. There is evidence that this under-representation relates to child rearing (McIntosh *et al.* 2012); yet there is less known about the processes by which this situation is reproduced in an occupation numerically dominated by women. Here we focus on understanding how the relationship between professional values and gender stereotypes contribute to this process.

Values control and validate nursing and are generated from a desire to produce as well as maintain professional standards of competency and efficiency. Conformity and confirmation are mechanisms by which the profession facilitates cohesiveness and co-operation integral to the completion of nursing (Maben *et al.* 2007). Mannion *et al.* (2009) argues that this has resulted in nursing values becoming pre-eminent over the needs of the practitioners. They observed that the core professional values are commitment and the ability to work flexibly at the behest of the service. The nature of this relationship informs personal and professional working arrangements. These influence perceptions and cascade throughout the profession to such a degree that nurses match their behaviour to these values in order to confirm and enhance their professional standing.

Gender perceptions within and outside of nursing are partly the product and manifestation of larger social processes, individuals conform to socio-cultural 'norms' and are socialised by means that constantly reinforce the beliefs and behaviours which are prescribed and presupposed by the social environment. They are conditioned by the notion of 'normal' (Spelke, 2005), this 'normalcy' is often located for women within the sphere of the family and motherhood. Whittock *et al.* (2002) argues that the family is the ideological site in which gender stereotypes are constructed and legitimised within a defined framework of social relations. They suggest that perceptions related to motherhood are generated from this narrative: women are to a large extent, located and defined by family and children. It is the pervasiveness and acceptance of this which facilitates the continuance of gender stereotypical beliefs, values and structures. Gender stereotypes are also reproduced within the workplace, yet the discussion of nursing in this paper demonstrates that this process has mixed implications. Bolton (2003) argues that as nursing is organised within a highly structured and constrained hierarchy that power, prestige, status and careers are developed through these relationships.

2

Here an argument is developed that these two distinct factors (gender stereotypes and professional values) interact and have a negative impact on the career progression opportunities of women nurses. The paper is divided into six sections. The next section considers gender expectations and behaviours in employment, with a specific focus on work commitment; this is followed by a short outline of the research methodology. The fourth section draws on the empirical material to consider the relationship between gender perceptions and professional commitment; fifthly the tensions between these are considered; and conclusions are drawn out in the final section.

Gendered perceptions and professional values

Heilman and Haynes (2004) notes that the perceived lack of fit between stereotypes of women, notably those associated with motherhood and perceptions in relation to employment leads to negative performance expectations and to women's performance being devalued. They consider that the tenacity of stereotype-based expectations and their resistance to disconfirming information was built upon an *"attributional rationalisation"* process in which women are unlikely to be given the same credit as their male counterparts. Building upon this, Legault and Chasserio (2003) sought to examine the extent to which 'commitment' is seen as important to career advancement. They note that women's reasons for flexible work patterns had to do with the context of family and dependent children. They found that while women considered that they themselves possessed commitment and flexibility in employment, they criticised other women with dependent children for not demonstrating these attributes. They suggested that this resulted in career opportunities becoming restricted and inhibited for such women. Paradoxically, this rigidity of thought was not in general imposed upon women by men, but frequently by women upon women.

Heilman *et al.* (2004) supports this position and note the powerful impact when gender stereotypes are applied to women by women. Women influenced by gender perceptions created and reinforced barriers between themselves. They rejected the proposition that self-interest was the underlying intention of the women exhibiting these behaviours. Heilman and Chen (2005) argues that it is the relationship to gender stereotypic norms which dictate the ways in which women 'should' behave, and the disapproval and approbation women experience for violating these 'shoulds'. They suggest that inferred violations of gender norms resulted in women being penalised in employment domains that are considered to be

female and the underlying dynamics of this process penalised women, while men were not subjected to employment penalties. Interestingly Teasdale (2013) found that women who work alongside others working flexibly exhibited both resentment and support.

Professional commitment is a subjective and elusive concept. Aarons and Sawitsky (2006) equates commitment with prioritising the professional at the expense of the personal. They argue commitment within nursing is defined by operational needs as opposed to individual considerations. Davey *et al*. (2005) argues that this type of commitment is 'total' with the practitioner subservient to the profession above any other considerations, particularly personal circumstances and needs. This form of commitment is defined primarily by an individual practitioner's relationship with the profession as opposed to any other determinant factor: it is the essential arbiter in career progression. However, Robinson *et al*. (2006) presents a more sophisticated model of 'commitment'. One which is an exchange given by the nurse to the profession and received by the nurse from the profession. They argue that nursing 'commitment' for many nurses is a multi-layered split between the personal, the patient, the colleague and the corporate. This suggests a potential conflict between the desire to adhere to organisational values and personal attachment and loyalties. The context and specifics of particular careers and work situations is important (including the need for adequate staff coverage of certain nursing duties at all times and the emergency situations for some parts of nursing), they shape organisational and professional values, as well as the individuals perceptions and how they interact with each other.

Within the literature, professional commitment within registered nursing appears to have been perceived to have a strong relationship with flexible working, although there is a debate as to the meaning of this term. Wise (2004) argues that nurses are defined by their ability to work flexibly, in relation to the needs of the service. She indicates that there is a strong belief that qualified nurses are required to be flexible in respect to their own working patterns to ensure the success of the nursing processes, the satisfaction of the patient and the profession. The quality of practice and care is deemed directly proportional to the exercise of work flexibility and commitment. She contends that the discipline has been myopic in its understanding of the nature of flexibility. In nursing, perceptions of flexibility were centred on the requirements of the service as opposed to the needs of the individual nurse. The demand for *flexibility for the organisation* has been counter-productive and denied the profession access to a wider range of able practitioners; *flexibility for the employee* is the key

4

to developing skills in the long-term and preventing the loss of skills. Carney (2006) argues that professional attitudes to flexible working have been more influenced by traditional roles and conservative values, than the rational development of nursing. Full-time working is regarded as essential and that part-time working in nursing is considered undesirable. Full-time working with a willingness to work flexibly according to the needs of the organisation have become synonymous with high quality care and professional standards; part-time working to meet employee needs to care for children (or others) has become an indication of lack of commitment (Maben *et al.* 2008).

Heilman *et al.*s (2004) suggest that gender perceptions are biased against women and these produce gender inequalities in employment. Within the nursing profession, commitment appears to be demonstrated by working full-time and by showing a willingness to work flexibly according to the demands of the service (work full-time and working over if needed); to put the needs of the profession first. This raises questions about: how far do female nurses adhere to stereotypical assumptions about the role of a mother; how does this combine with professional assumptions about 'commitment'; and how does this impact on female nurses' career progression?

Methodology

The research is based on interviews with 32 female registered nurses. Those interviewed were aged from 21 to 60 years of age. Selection of interviewees was based upon a quota method to ensure that the required groups were selected for interviews covering the variety of experiences across different registered grades, part and full-time working, employment conditions, nursing areas and their different family circumstances. Twelve of them had some management responsibilities (Grade 'G' staff may combine management with some patient treatment, with Grades 'H' and 'I' usually full time managers). They had either worked whole-time continuously or had worked on various hours throughout their careers prior to having taken career breaks.

The nurses interviewed were all employed in 'acute' nursing. Acute nursing care is short-term nursing care for patients with acute, chronic or surgical conditions. This was selected as it is the largest area of employment within nursing, possessing the greatest number of disciplinary specialties and offering a variety of career trajectories. We list the spread of employee characteristics in Table 1:

Table 1: Details of nurses interviewed

Recruitment took place after liaising with NHS managers, nursing management and human resources. In the first instance the research structure and purpose were detailed to the senior managers via e-mail; face-to-face meetings then took place. Upon ethical approval those invited to participate were contacted by the researcher in writing. Participation was entirely voluntary and those involved were fully informed of the purpose of the research. The analysis was based on an iterative process involving themes drawn from the literature and a detailed and repeated review of interview transcriptions using sub-themes (Morgan, 2008).

The relationship between gender perceptions and professional commitment

Consistently across the interviews, the most powerful contested relationship amongst those interviewed, regardless of age, class, ethnicity, experience or circumstances, was centred upon gender perceptions associated with women as mothers and the relation of this within their working commitment.

There was a consensus amongst those interviewed, that professional commitment was defined by personal choices. As nurse 'A' stated, *"I'm not saying nurses should sacrifice their careers for their outside life but they have choices and sometimes it comes down to one or the other"*. She added, *"Nursing's duty is towards the patients, nurses have no 'divine' rights – the profession isn't run for the benefit of nurses at the expense of patients"*. She added that *"The nursing task is built upon discipline"*.

The underpinnings of this may relate partly to the nature of the job, in that in acute areas where emergencies may regularly occur, the creation of certain organisational cultures to deal with the stress and requirements to operate effectively under extreme pressure and in extreme circumstances, in an intensive work environment. However, Nurse 'Q' a senior nurse with several adult children stated, *"I know, I'm a bit old fashioned here and people might find me a bit of a contradiction but I actually think it's a woman's responsibility to look after her children, particularly the babies"*. A consensus emerged which prioritised professional commitment, defined within the context of the desire to prioritise the service above other factors. The essence of this ethos was that, *"the jobs must always come first, you can't really do both. I have sympathy for young mums but you can't really do both"* (Nurse 'F'). The extent and scale of this type of gender perceptions was revealed by nurse 'P':

If you were talking about someone just married or young enough to have children or who talks about having children quite a lot, then you would have to think about that. They can't work as flexibly or really be as committed to the job as much as they need to be. It's really got nothing to do with the children; it's the hazard of them.

Nurse 'A' was more overt in her criticism, "*I know from experience that it's not always effortless juggling children, a house and nursing and being **truly committed** to the job. I've heard enough about the supposed difficulties of combining work and motherhood to last a lifetime*". She added, *"In my day, we just got on with it."* These sentiments were frequently held amongst nurses over 45 years of age. Nurse 'D' believed, *"Having a proper family life is not a basic human right. Women who bleat about the trials of combining a career with motherhood just need to get a grip. They have never lived; I had just had to get on with it."* Although many acknowledged that having children and being in a stressful job in nursing was difficult, there was little sympathy from these nurses. Nurse 'A' comments were indicative of these sentiments:

All the childcare talk is just an indulgence. When I and many other women of my generation entered nursing we had children, left and looked after them. When we returned we never made a big deal of our responsibilities – far less an excuse. We got on with it and simply made arrangements – the job must always come first.

It was argued that gender perceptions reinforced these; when asked why this was the case those women interviewed were of the consensus that they were *"pre-programmed with these views and expectations"* (Nurse 'M'). It was apparent that amongst those women interviewed, these perceptions were powerful in terms of forming the expectation that women have of other women in nursing. This exists despite, or possibly because of, their personal experiences and expectations. This fissure was most distinct and had greatest agency between women with young children and women with older or adult children. The lack of sympathy was highlighted by Nurse 'D' who commented that she was *"unwilling to support another women's life style choice - the jobs the thing."* This was a significant remark which exposed a paradox at the heart of the profession. A profession intrinsically linked to caring, and one considered a female occupation was enveloped within a situation which actively discriminated against women for being mothers.

Nurse 'Q' considered that the restrictions imposed by the family and external responsibilities outside the working environment had "*an unsurprising debilitating effect upon women's capacity to perform their duties.*" She repeated, the often held view, that "*nurses do have a choice - children or their career, it's one or the other. You really have to be truly flexible to meet the needs of modern cutting edge nursing. You can get away with this 'form' of commitment in care of the elderly but not here."* Nurse 'N' who had worked in various grades and working bases throughout her extensive career conjectured, "*In my experience women with younger children are inevitably less committed because they are trying to balance more than one thing".* Nurse 'E' stated "*Whilst I am willing to consider requests from existing staff to change their hours they don't need to be told that I don't really like it."* When pressed on why, she explained:

> *The profession needs long-term certainty not short-term accommodations; it is the most effective and efficient means of service delivery. Women can play men like tunes but a woman can't play any stunts on another woman, particularly those in relation to children. If a woman tried it on me they would not get away with it, they would last five minutes.* **Nursing has been created by women for women**; *and children aren't going to fling those gains away.*

There appeared amongst those interviewed to be an acceptance of perceptions associated with a women's role in relation to children. The impact of this in part, created a profession in which gender perceptions linked to parenthood and childcare were detrimental to career outcomes as Nurse 'T' explained:

> *We, as women, know about the needs of motherhood and bringing up children; we know what's needed. We also know what's needed by the profession and it is that which is critical.* (pause) *Yes, it a fine balancing act but when push comes to shove, when you are a nurse it doesn't start when you put the uniform on – you are a professional, it's not an optional extra. There have to be accommodations but we are responsible for people's lives, we know that when we sign up to the job, that quite simply is the priority; we don't take the job eyes wide shut!*

There was no ambiguity within these comments: commitment was located clearly within the terms of the profession, inferred violations of gender norms are heavily penalised. Gender stereotypes were tied to gender norms directly related to the role of the mother and children.

8

However, women who challenged these expectations were subject to disapproval and approbation (Heilman *et al.* 2004). Verbal and emotional challenges appear to dictate the ways in which women 'should' behave and the difficulties women experience for violating these 'shoulds'. Reactions to actual violations of prescribed behaviours are conspicuous amongst many of those interviewed, grounded in acceptance of perceptions associated with women's roles in relation to children. The impact of this, in part, creates a profession in which gender perceptions linked to parenthood and childcare were detrimental to women. Women judge women with dependent school-aged children on different and harsher standards that they would judge any other group. This is a critical factor that Heilman *et al*. (2004) do not develop; it is not women generically but women with dependent children who are subject to the strongest censorship. While gender perceptions are coarse they are influential, but the sophisticated inter-action taking place between gender-stereotypes and perceptions concerning 'commitment' appear to directly influence careers. The dynamics underlying these responses result in women penalising women. Not because they are women but because they are mothers of dependent children; and the degree of hostility appears to be directly related to the age of the child (and hence the commitments of the mother to childcare).

The tension between gender perceptions and professional values

However, there was a difference of opinion and emphasis amongst those interviewed as to whether this was a direct product of gender stereotyping or a product professional conservatism. Nurse 'O' argued this position, "*There are many dinosaur attitudes in nursing, they are not just attached to an inward conservation related to gender but a profession which considers itself under attack."* This was supported by nurse 'G' in her mid-thirties who reflected upon this situation, "*On paper, the nursing profession looks innovative and it is in when it comes to care. However, when it comes to the nurses, it is a different story. Its values in relation to the perceived role of women are like something out of the Old Testament."* Nurse 'J', a nurse due to retire, noted that *"Nursing values are conservative; there is a reluctance to change. In my thirty years in nursing it hasn't changed one iota. The pervasiveness of these values changes people, not the other way about."* Nurse 'R' offered an insight and explanation of how this situation emerged, "*There is a conflict within nursing - it is still rooted in the medical model with outdated attitudes and a reluctance to change".*

Nurse 'P' elaborated further, *"instead of using their enthusiasm to help promote positive change, the need to be accepted overrides this and they allow themselves to be "sucked in" to*

9

the ward politics and outdated attitudes." She stated, *"Gender stereotypes are powerful, they are a form of glue within the profession – they bind the place together"*. When pressed about this she added:

> *Think of it, historically it was to women's benefit to have a strong control of the profession (pause) to make it exclusively ours. When nursing was the only means of social mobility for most women, complete ownership of the profession was critical. Gender perceptions make it immune to certain challenges which in the short and long term are beneficial to women…..that's why we, as women, need to police the profession and preserve nursing and if that makes it difficult for some women, well that is a price worth paying because at the end of the day there is a greater good.*

When asked if there were tensions she said, *"yes, but it is needed and worth paying, it's simplistic to assume that we are in (an) age without sexism. We, as women, need to make stereotypes work to our advantage. We just need to be clever about it."* Gender stereotypes from this position were not considered to be detrimental to women but a positive safeguard. Nurse 'T' considered that:

> *In most professions, women can't come back after maternity or a leave of absence with ease, but in nursing they can. Despite the challenges and uncertainties, we are strengthened. Surely having a career when we are older, what's the alternative - no career at all? That is why the status quo is a price worth paying.*

There were divergent views from this position; Nurse 'T' did not consider this process to be proactive or positive as she stated, "*Well that's some logic (pause) ….it has nothing to do with protecting womankind, God that is something else. It's got everything to do with protecting themselves and making sure they benefited from the system they maintain. They are not at all interested in change. It frightens them and (is) not in their interest.*

The interests appeared to be a critical aspect of professional resistance to structural change. However, there were concerns about this, as Nurse 'B' reflected, "*I never cease to be surprised that women can behave negatively to other women but then that is what happens when you become institutionalised by a system built upon a complex relationship of conflicting vested interests".* The concept of self or vested interests emerged constantly

10

throughout the interviews and was an apparently significant factor in creating the tension as Nurse 'C' reflected upon:

One of the problems we've got in nursing is that certain segments within the profession have directly benefited through the benefits gender stereotypes which it brings in terms of accelerated careers. Others haven't benefited but the cosy consensus supports the status-quo and the strategy towards professionalism. Nothing is ever said but then it doesn't need to be; that (is) how the system works.

Their ties to the profession were important in linking professional values to gender perceptions. Nurse Manager 'B' conceded that gender perceptions and professional values were indelibly linked to nursing *"obsession"* with its professional status, *"you cannot isolate nursing's long campaign for 'professional' recognition with the strong desire for personal professional development."* Gender stereotypes or perceptions acted as a mechanism of control, Nurse 'Z' considered that this was not achieved only by subtle conditioning and subterfuge but through coercion:

This is not done in an underhanded way or subconsciously, it's done quite openly. I've seen newly qualified nurses being bullied into submission and told to keep their new ideas to themselves. Or, they argue for keeping their old ways and then make life difficult for the newly qualified nurse. In the end, beaten down or fed up fighting against the stream, the newly qualified nurse falls into line and the ward stays as it always has been. So instead of affecting the culture, the culture affects them.

Perceptions concerning work flexibility, as Legault and Chasserio (2003) contend, have influence, but in nursing working flexibly is a metaphor for continuity of treatment of patients. The concern of those staff was centred on a personal work flexibility informed by the need for a professional continuity of service (e.g. continuity of care for a patient). It is a simplification to suggest that this was a unilateral perception - it is part of a wider fabric of perceptions associated with women and their flexibility in relation to working patterns. These prescriptions, when cumulatively combined, seemed to restrict women's career progression at a senior level in nursing. Nursing appears to be in juxtaposition to what it values and what it aspires to. The profession's emphasis on task at the expense of the personal circumstances of nurses by default reinforces and maintains these perceptions. Career progression in nursing appears to be affected by adherence to an established orthodox view. The observation of

Legault and Chasserio (2003) concerning the negative impact that the organisation of work, and the practicalities of combining working and family responsibilities has on careers has worth. However, something more sophisticated is taking place in relation to gender stereotypes; they appear to be a tool advanced by women to propagate (some) women's careers. This is not a 'soft' option but a hard mechanism designed to protect women's professional positions, particularly from cultural constraints. This is simultaneously coarse and sophisticated as are most stereotypes. In nursing, gender stereotypes and their relationship with professional value exist within the framework of the wider organisational culture. The view that it is one or the other does not reflect the complexities of the issue. It could be argued that gender stereotyping women as 'carers' has benefited them by ring-fencing nursing as a female profession. At the same time professional values in nursing have established that good quality 'care' is associated with commitment, which is in turn demonstrated by full-time working and flexibility Women with young children find it difficult to demonstrate this form of commitment (indeed to do so would be to transgress the stereotype of the 'good' mother) and thus do not conform to the professional values of nursing.

The impact of perceptions concerning gender and professional values upon women's career progression and outcomes

There is a consequence of the tension between gender perceptions and professional values on the individual practitioner. It could be argued, that this tension was a product of organisational pressures with the professional having greater agency than the personal.

Nurse 'K' observed, "*You come into the job, you know the conditions of the job, you have got to work these hours, you really have got to work these shifts.*" However, her following remark conveyed a frequently held sentiment that nurses were often unwilling to support other nurses, "*You know (you) have just got to adapt round these situations. Every nurse' has to…. (Slight pause) it's expected…. (Slight pause) it makes the place function, that (is) the job you sign up for!*" As stated previously, as much as there was strong support for these sentiments amongst many of those interviewed, Senior Nurse Manager 'C' eloquently conveyed the actualities, sentiments and outcomes of this process, "*When you've created work to suit child-rearing regimes and still the person concerned is not performing their duties, it's something you have to take on. I've always managed to resolve it but it can be*

pretty difficult particularly with the women who are in more senior posts, you can't just leave."

This inability to reconcile perceptions and values with individual needs persuaded many amongst this group to reassess the role of work in their lives and seek to 'improve' their work - life balance. Nurse 'B' considered that the pressure of these tensions led her to re-evaluate her career choices, *"Working in nursing was like being on a runaway train in terms of pressure. It was harrowing to say the least. I made a deliberate choice to leave to get the balance right in my working life. I had no real option."*

It is notable that many of the most strident of those interviewed were not mothers but there was more to this than a simple dichotomy between mothers and non-mothers. Within both groups there were variations of views, but these variations were generally minor. There appeared to be a deep and underlying prejudice by women against women centred upon the division between family and work. 'Traditionalists' were particularly dismissive of internal childcare provision and appeared unwilling or unable to recognise the 'modernist' position that, the lack of comprehensive childcare provision was detrimental to the individual, the family and the service. This may be a generational cohort effect as many of those nurses who made these pronouncements were middle aged, although this is not always the case as these viewpoints were held by many nurses in their twenties and thirties. What it does suggest is that these protectionist viewpoints transcended age. They reflect upon the power of gender perceptions and values when they act either consciously or subconsciously with a belief in employment protectionism. Regardless of this debateable point, the interviews did establish that these divisions were fuelled by perceptions associated with gender and gender stereotypes. The manner in which this active discrimination operated supported the observations of Heilman *et al.* (2004) - that women discriminate against each other. However, the significant factor is that the 'discrimination' is seen as the means to ensure ownership of the profession as a profession of women, for women and run by women. In many ways this is a perverse relationship – to preserve the role of women, it seems that women's personal needs (or rather the personal and household needs of one group – mothers) are secondary, indeed to the point of difficulty for their own career and career progression.

Conclusions

13

There is a difference between personal and professional values but they are at times symmetrical and symbiotic. Professional nursing values were deeply rooted in a model which prioritises the patient and their needs. The *'patient comes first'* mantra is the core of nursing. The loci of gender perceptions are firmly rooted in perceptions associated with dependent children and women's role as primary carer - *"the family comes first"* view. These perceptions had considerable power amongst many of the women interviewed. At a certain level; women who had children, especially of a pre-school age, were overtly and implicitly expected to prioritise their children, and variations from this were met by, at times, open hostility. This was a 'norm' within nursing which centred on the role of women in relation to the family and children. In relation to this, , the paper develops Heilman's (2004) argument that the restructuring of employment has led to work intensification which stokes gender tensions: gender perceptions and the expectations they produce result in the devaluation of women's abilities, a denial of opportunity and a penalisation in respect to their careers. However, this is only part of a more complex relationship: the interaction between professional values and gender perceptions acts both as an inhibitor and arbiter upon the career progressions of women with dependent, (pre-) school-aged children in registered nursing. It also acts to preserve the profession as the domain of women.

Perceptions and values related to expectations concerning working flexibility, and commitment exacerbated the impact of gender stereotypic behaviours and values. These values and perceptions appeared to be entrenched. In line with Legault and Chasserio's (2003) position, the perceptions affecting the organisation of work interact with the practicalities of combining working and family responsibilities' and have a negative impact on careers. Nevertheless certain fissures related to their critiques become apparent. In some instances the 'hostility' between women with dependent children and those without appear to have a greater influence on careers for women than Legault and Chasserio envisaged. Professional commitments and gender stereotypes are not incompatible; it appears that within nursing they may be compatible with, but not determinant of, some women's careers, particularly those without dependent pre-school children. However, there is an irony here that in a profession so dominated by females numerically, that it has developed a set of professional values superficially in conflict with the needs of working women with dependent children. Yet this is not the full view, as this arrangement evolved in circumstances when women 'rights' were not adequately legally-protected. It could be argued, that as the relationship between professional values and gender stereotypes developed at a time when

14

there was a pressing need to protect women's position, in a relatively well-paid and highly respected employment, that overt protectionism became a necessity. The severity of actions against women with dependent children appears to be designed to protect women who are free of the demands of dependent children although, whether this was an unconscious or conscious process is unclear.

15

References

Aarons, G A & Sawitsky, A C (2006), "Organisational climate partially mediates the effect of culture on work attitudes and staff turnover in mental health services", *Administration and Policy in Mental Health and Mental Health Services Research*, 33(3), 289-301.

Bolton, S C (2003), "Multiple role? - Nurses as managers in the NHS", The International *Journal of Public Sector Management*, 16 (2), 122-130.

Carney, M (2006), "Understanding organisational culture: the key to successful middle manager strategic involvement in health care delivery?" *Journal of Nursing Management,* 14 (1), 23-33.

Davey, B, Murrells, T & Robinson S (2005), "Returning to work after maternity leave: nurses' motivations and preferences", *Work, Employment and Society,* 19 (2), 327-348.

Heilman, M E & Chen, J J (2005), "Same behaviour, different consequences: Reactions to men's and women's altruistic citizenship behaviour", *Journal of Applied Psychology,* 90 (2), 431-441.

Heilman, M E & Haynes, M C (2005), "Attributional rationalization of women's success in mixed-sex teams: No credit where credit is due", *Journal of Applied Psychology*, 90 (3), 905-916.

Heilman, M E, Wallen, A S, Fuchs, D & Tamkins, M M (2004), "Penalties for success: Reactions to women who succeed at male tasks", *Journal of Applied Psychology,* 89 (3), 416-427.

Legault, M J & Chasserio, S (2003), "Family Obligations or Cultural Constraints? Obstacles in the Path of Professional Women", *Journal of international women's studies*, 4 (3), 223-256.

Maben, J, Griffiths, P & Robinson, S (2008), "Keeping to the same old pathways", *Nursing Standard,* 21 (26), 62-63.

Maben, J, Latter, S & Macleod- Clark, J (2007), "The sustainability of ideals, values and the nursing mandate: evidence from a longitudinal qualitative study", *Nursing Inquiry* 14 (2), 99-113.

Mannion, R, Davies, H & Harrison, S (2010), *Changing management cultures and organisational performance in the NHS*, London: SDO.

McIntosh, B, McQuaid, R, Munro, A & Dabir- Alai, P (2012), Motherhood and its impact on career progression – the case of Scottish nurses 2000-2008, *Gender in Management: an International Journal,* 27 (5), 342-360

Morgan, D (2008) *The Sage Encyclopaedia of Qualitative Research Methods,* London: SAGE Publications.

Robinson, S, Murrells, T & Clinton, M (2006), "Highly qualified and highly ambitious: implications of workforce retention of realizing the career expectations of graduate nurses in England", *Human Resource Management Journal* 16 (3), 287-312.

Spelke, E (2005), *Impediments to Change,* Radcliffe: Symposium Publication.

Teasdale, N (2013), "Fragmented Sisters? The Implications of Flexible Working Policies for Professional Women's Workplace Relationships", *Gender, Work and Organization*, 20 (4), 397-412.

Whittock, M, Edwards, C, McLaren, S & Robinson, O (2002), "The tender trap': gender, part-time nursing and the effects of 'family-friendly' policies on career advancement", *Sociology of Health and Illness,* 24 (3), 305-326.

Wise, S (2004), *Work-Life Balance and Careers in NHS Nursing and Midwifery*, Employment Research Institute, Edinburgh Napier University.

Table 1

Nurse	Grade	Age	Length of service in years	FT/PT	Children
'A'	'H'	45	24	Continuous F/T	None
B'	'H'	53	26	F/T	2 adult children
'C'	'E'	50	23	F/T previously P/T - career breaks totalling 6 years	2 adult children
'D'	'E'	39	17	Three year career break; previously F/T now P/T	2 teenage children
'E'	'I'	52	25	Career breaks totalling six years - F/T	2 adult children
'F'	'D' now 'E'	51	27	2 career break totalling 6 years; F/T now P/T	3 adult children
'G'	'G'	31	8	F/T	None
'H'	'H'	51	26	2 career breaks totalling seven years; F/T then P/T now F/T	2 teenage children
'I'	'E'	37	15	F/T	2 children under 12
'J'	'I'	60	32	Career break of 8 years -F/T then P/T now F/T	2 adult children
'K'	'G'	56	28	3 career breaks totalling seven years; currently P/T	2 adult children
'L'	'E'	45	8	F/T	1 adult child
'M'	'E'	35	14	Two career breaks of 3 years; F/T then P/T now F/T.	2 children under 5
'N'	'D'	47	25	Three careers breaks totalling 9years –P/T	2 adult children, one child under 16
O'	'E'	29	7	Two career breaks totalling 20 months; P/T	2 children under 5
'P'	'G'	33	11	Continuous F/T	None
'Q'	'G'	36	11	Continuous F/T	1 child under 5
'R'	H'	33	9	Continuous F/T	None
'S'	'G'	36	14	Continuous F/T	None
'T'	'D'	39	13	Two years Maternity leave - F/T now P/T	1 child under 12, 1 One under 5
'U'	'E'	35	12	Two year career break; F/T	2 children under 5
'V'	'D'	38	6	Ten year career break - F/T ('E') now P/T ('D')	1 child under 12, 2 under 5
'W'	'E'	22	1	Continuous F/T	None
'X'	'H'	28	7	Continuous F/T	None

'Y'	'D'	37	16	P/T	1child under 12 another under 5
Senior-Nurse A'	Manager	47	26	Continuous F/T	None
Senior-Nurse 'B'	Manager	57	35	Continuous F/T	None
Senior-nurse 'C'	Manager	41	19	Continuous F/T	None
Senior-nurse 'D'	manager	48	30	Continuous F/T	None
Senior-nurse 'E'	Manager	44	25	Continuous F/T	None
Senior-nurse 'F'	Manager	51	28	career breaks - 2 years F/T then P/T now F/T	1 teenage child

Appendices

Appendix 1 - Interview questions

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

Prompts:

- Grade; area; job (specialty and geography)- How did you end up working in
  <u>this</u> area of nursing?

- Life choice - How have you balanced your working and personal life i.e. in
  relation to your family?

- Children - Have children impacted on your career?

- Training - What major training opportunities have you had or not had during
  your career? Why did you think this happened?

- Working patterns – What hours and patterns of working have you worked?
  Why?

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

Prompts:

- Family – What jobs does your partner do? Did it impact on your career
  decisions

- Working patterns – How were your hours or your colleagues affected by
  these personal circumstances?

- Jobs - What job did you occupy and why?

- Area (specialty and geography – Why did you choose to these areas?

- Training – What were the consequences for your training opportunities?
  Why do you think this happened?

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

Prompts:

- Working patterns - How were your hours or your colleagues affected upon re-entry after a break? Why do you think this happened?

- Grades – What job and grade did you return on? Why?

- Area (geographical or nursing specialty) - Why did you choose to return to that area and job?

- Training - What were the consequences for your training opportunities? Why do you think this happened?

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

Prompts:

- Grades – What effect do they have on grade and jobs occupied? Why?

- Personal choice - Did you choose to return at this grade?

- Area – Do the number and length of career breaks affect the areas and jobs that returning nurses can work in?

- Training – What is the impact on training?

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

Prompts:

- Career – what impact did this have on your career?

- Training - Do the amount of hours worked impact on training received and offered?

- Children – What is the relationship between your selection of hours worked and children and the family, if any?

- Personal – Do nurses who work full-time have more career outcomes, if so can you tell me why you think this happens and how this takes place?

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

Prompts:

- Career – What do you think are the predominant values in registered nursing?

- Working patterns – Are full-time workers preferred to part-time workers? – Why do you think this happens?

- Do you think having children has an impact on careers? Why?

- Gender – Does being a woman have an impact on women's careers? Why?

Q7   General closing questions

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

- Why?

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

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

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

- Is there anything else would you like to say?

Appendix 2   **Interviewee Profile**

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

4