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“Being a Nurse Is Not My Gender, It’s What I Was Professionally Trained to Do”

The Experiences of Male Nurses in Providing Intimate Care to Female Patients at a Health Care Facility in Central Finland

Laura Nipuli
Courtney Salmon

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Abstract
Over the years statistics have shown that there has been an increase in the number of active male nurses. Despite these increases, the question of the appropriateness of male nurses providing intimate care to female patients still lingers. The aim of this study was to find out the experiences of male nurses while providing intimate care to female patients. The purpose was to collect data that can be used to inform future nurses about the experience of male nurses in providing such intimate care.

This study was carried out through qualitative research by conducting a semi-structured group interview among five male nurses. Participants were registered nurses with experiences ranging from one to seven years, and who had had encounters providing intimate care to female patients. The data was retained by an audio recorder and supported by written notes. The method chosen for analyzing the data was content analysis.

Five main themes were established: (1) Male nurses' definition of intimate care (2) Male nurses' experiences regarding providing intimate care (3) Male nurses' personal feelings regarding providing intimate care (4) Strategies used by male nurses when providing intimate care (5) Professional support in providing intimate care. The findings of this study showed that participants had little negative experiences while providing intimate care to female patients. Providing intimate care was considered a natural part of the job. While they had encountered refusal, insults and accusations, they did not view it as something personal. In such situations the participants used two main strategies: self-comfort and patient's comfort.

Keywords/tags (subjects)
Male nurses, intimate care, female patients, experiences of male nurses, gender

Miscellaneous

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CONTENTS

1 INTRODUCTION

Historically, male nurses have been a minority in the nursing profession. The likes of Florence Nightingale, Mary Seacole and a host of other profound female nursing pioneers have cast a shadow over the contributions of males to the nursing profession. In the mid 1800s, Florence Nightingale launched a school to educate female nurses. She was of the view that nursing was a natural extension of a woman's role as a caregiver. In that era, Victorian laws prevented the mixing of male and female students; as a result, men's entry into the profession was limited. (Jacksonville University, 20015.)

Prior to the 1800s, men significantly represented the nursing profession. This was because of the association between nursing and the military and religious orders. (Men in Nursing Occupations, 2013, 1.) The first nursing school in the world was started in India about 250 BC, which included only men (University of Washington School of Nursing 2013). The failure to recognize this contribution leaves male nurses today with little information about their professional background and historical position.

According to Finnish Nursing Association (2013), in the year 2010, there were a total of 79,600 registered nurses. Of this figure 94% were females and 6% were males. The profession is still widely dominated by females. This trend presents unique challenges for male nurses, particularly when providing intimate care to female patients. These findings have prompted the researchers to explore this topic and find out the experiences of male nurses at a health care facility in Central Finland; while they are providing intimate care to female patients.

2 MEN IN NURSING AND INTIMATE CARE

2.1 History of Men in Nursing

The first recordings of men caring for the sick were found from Ancient India, where no formal education for nursing existed, but where men played an important part of nursing of that time. Several cases of males providing care for the sick have been found since - such as the Alexian Brothers, a religious order of men formed in the 5th Century, or the Benedictines in the Middle Ages that included both women and men and worked among the poor. In the Crusades, monastic orders followed the knights to Middle East in order to provide care, as the task was considered too dangerous for women. (Kenny 2008.)

The base for modern nursing started to form when the first nursing programmes were established in the influence of Florence Nightingale. She was the first person who wanted to make nursing a paid profession for women, and the Nightingale School opened in 1860 in London, England. However, the nursing programmes had strict admission criteria, limiting men from entering the career. (Kenny 2008; McDonald 2010, 106-109.)

In Britain, it was not until the Second World War that the percentage of male nurses in hospital nursing significantly increased. Men were recruited in nursing via the armed forces, and after the war some of them switched from the armed forces to civilian nursing. Before this, male nurses had mostly worked in psychiatric nursing, military and prison services. (Hallam 2000, 100.)

2.2 Male Nurses Statistics in Finland

In Finland, male nurses can be seen as a minority among their female co-workers. According to the National Institute of Health and Welfare (2014), only 11.6% of the health and social care professionals in the end of year 2011 were men. At that time, 3.7% of the whole employed male population in Finland were working in health and

social care. Compared to all the employed women in Finland, 28.2% of them were working in health and social care. The percentage of male workers has remained nearly the same through the 21st century. (National Institute of Health and Welfare 2014.)

When limiting the statistics exclusively to practical nurses, registered nurses, public health nurses and midwives, 8.8% of practical nurses and 7.3% of registered nurses in Finland were men in the end of 2011. However, the numbers are even lower for public health nurses and midwives, with 0.5% of public health nurses and 0.3% of midwives. (National Institute of Health and Welfare 2014.)

2.3 Intimate Care

Caring is the moral ideal of nursing whereby the end is protection, enhancement and preservation of human dignity. Human caring encompasses values, a will and a commitment to care, knowledge, caring actions and consequences. All human caring is related to intersubjective human reactions to health illnesses conditions, a knowledge of the nursing care process, knowledge of one's power and transaction limitations. (Alyn and Conway 1995, 8.)

From a nursing perspective, intimate care refers to a person's intimate body parts - meaning "any primary genital area, groin, inner thigh, buttock or breast" - being touched or exposed when implementing nursing care (The Free Dictionary 2014). It requires psychological, emotional and physical interactions. (Inoue et. al., 2006, 8.) The care occupies a significant amount of nursing care and the way it is delivered can have a direct effect on the recipient's quality of life. It is paramount that the care is provided in a gentle and sensitive manner, while respecting the recipient's privacy and dignity at all times. (Guidance For Designated Centres. Intimate Care, 2013, 3-4.) Male nurses in particular are often contended with difficulties in their practices as a result of their gender and the stereotypes associated with male nurses. Providing intimate care for female patients is difficult due to situations that require invasion of clients' personal space. (Inoue et al. 2006, 564.)

2.4 Men's Touch in Nursing Care

Despite the fact that touch is important in nursing care, it poses challenges for male nurses because society has normalized women's use of touch as a caring behavior, while men's touch has been sexualized. Non-sexual touch is often part of intimate care, however, it has been permeated with sexual connotations through the dissemination of films, cards, novels and jokes that sexualize the work of nurses. Young female nurses become objects of sexual desires, while male nurses are viewed as objects of sexual threats. (Harding, North and Perkins, 2008, 89.)

Evans et al (2002), presented in Harding et al (2008, 89), outlines that through stereotypes, a discourse has been formed where it is acceptable for female nurse to touch patient intimately, whereas, it is strange for male nurses to do so. The author goes on to explain that nurture also plays a significant role in what people consider acceptable and what is deemed intolerable. For example, people have been conditioned from childhood to expect intimate care from women, whereas, such care from men can leads to discomfort from both patients and male nurses. According to Harding et al (2008, 90), a female respondent in a study conducted by Lodge et al (1997), stated this suspicion: "I can't help wondering what would make a male nurse undertake duties involving intimate care of females - i.e., curiosity? Males obviously lack understanding because of their gender... human nature being what it is- I feel careful vetting would be needed to prevent perverted personnel being recruited- by that I mean people who seek gratification from certain aspects of their work."

2.5 Patients' Gender Preferences in Different Cultures

Different cultures and religions include a diversity of beliefs, traditions and views that are related to intimacy and exposure. According to Statistics Finland, the five biggest ethnic groups in Finland in 2013 were Estonians, Russians, Swedes, Somalis and Chinese. In 2013, 75.3% of the Finnish population were Evangelical Lutherans, 1.1% Orthodox and 1.4% belonged to some other religion. (Statistics Finland 2014).

Somalis are a significant client group in Finnish health care services, especially in the capital area. The majority of Somalis are Sunni Muslims, a branch of Islam, and their beliefs reflect to their health care. A Muslim often wishes to be treated by the same gender as themselves. If the patient is of different a gender, they should undress and be examined or touched only as much as necessary without causing embarrassment to the patient. In case a Muslim woman must meet a male doctor for example in a life threatening situation or when no female doctor is available, she might be accompanied by her husband as a chaperone. (Brusila 2008, 108-110; Mölsä & Tiilikäinen, 2007.)

One of the oldest ethnic minorities in Finland is the Romani people, whose native language is Finnish, but whose culture and traditions differ significantly from the Finnish population. Brusila (2008) describes the Romani people to be bashful patients. They have strict rules concerning intimacy, and thus a female patient often wishes a health care professional of the same gender to attend for example labor or gynecological examinations. A Romani woman can be ashamed of talking about intimate matters to male health care workers. (156-163.)

A study carried out in South Australia in both 1984 and 2000 aimed to discover the respondents' preferences for a male or female nurse, depending on the level of intimacy involved in an imagined hospital situation, and whether they had changed between the years. In 1984, the respondents had no preference over the nurse's gender when having their temperature measured or an intravenous drip inserted. Female respondents strongly preferred another female to bathe or shower them, while this preference was not evident for the male respondents in the same situation. However, both males and especially females preferred a nurse of their own gender to shave their pubic area for surgery. In 2000, the results were similar with no significant differences. (Chur-Hansen 2002, 193-197.)

A relationship between the age of the respondent and a preference for a male or female nurse was found in situations where having a bath or shower and having the pubic area shaved was necessary. The results indicated that younger respondents mainly preferred a female nurse, whereas the older ones tended to have no preferences

in the mentioned situations. It appeared that the respondents were more accepting with either gender in situations that were not emotionally invasive, but preferred a nurse of their own gender in more intimate situations. (Chur-Hansen 2002, 193-197.)

2.6 Professional Support and Strategies Used by Male Nurses in Providing Intimate Care

Several male nurses believe that there is lack of guidance provided in using intimate care appropriately or developing strategies to protect themselves from accusations during their nursing education. Nursing education inadequately prepares male nurses on female intimate care issues. Failure of the education system to help men in developing protective strategies along with lack of support in clinical areas may have significant interest on their job satisfaction and subsequent career development. Men are often marginalized during clinical training because of focus on female stereotypes and roles. (Harding et al. 2008, 97.)

Male nurses have used various coping strategies to help them in delivering intimate care to female patients. Strategies included suppressing feelings, self-protection and breaking the ice. Participants revealed that if they felt uncomfortable or embarrassed when providing intimate care, they managed the experience by suppressing these feelings and focusing on the task at hand. The rationale was that if they showed their feelings then that would make the situation more awkward for both themselves and the patient. Some of the male nurses also used the strategy of not focusing on the sex of the patient. This approach helped them to desensitize the female patient's body; therefore, they were better able to control their feelings. (Inoue et al. 2006, 563-564.)

Another strategy was self-protection. This was used to avoid misunderstandings, suspicions and/or rejection from female patient and their family members. If the male nurses encountered a situation where the female patient was uncomfortable or refused their care, then the male nurses would request that a female nurse takes over the care of the female patient. The nurses declared that this approach was useful in ensuring patient comfort. In order to protect themselves so that no one can misconstrue what

they are doing, some male nurses use various techniques while they are providing intimate care to female patients. For some put on gloves to prevent skin to skin contact while washing female patients. Some male nurses also used female nurse chaperones as a form of self-protection. According to the nurses, female chaperones eased their level of discomfort, as well as the level of discomfort for some female patients. The issue of legal protection was also highlighted as a reason for having chaperones. A few male nurses reported that in the event that there was not an available chaperone, they would either leave the curtain opened or delay the intimate care. (Inoue et al 2006, 563-565.)

Similarly, a male student alleged that he was barred from providing intimate care such as electrocardiograms test on female patients unless a female chaperone was present. The adoption of a chaperone policy is prudent. However, there is the possibility that the female patient may take offense if the male nurse requests a chaperone to be present. The rationale is that the patient may believe that she is suspected of being prepared to make false allegations of improper conduct against the male nurse. Having a chaperone can inadvertently perpetuate the prevailing dominance of heterosexual values and presumptions based on gender, as a result overlooking the sexual orientation of patients who may be homosexual, lesbian or bisexual. The author suggests that when informing patients of chaperone policy, rather than assuming that the chaperone should be the same sex as the patient, the nurse should enquire about the patient's desire. This would show recognition and respect for sexual orientation. (Prideaux 2010, 45.)

A third strategy that was used is breaking the ice. This was used to help male nurses in dealing with various feelings while providing intimate care. It was also considered that humor could reduce possible stress that was experienced by female patients. Techniques that were used included humor and jokes, providing explanation to clients about procedures to be done and minimizing the amount of body exposed during the intimate care. (Inoue 2006, 564.)

3 AIM, PURPOSE AND RESEARCH QUESTIONS

The aim of this study was to find out the experiences of male nurses in providing intimate care to female patients at a health care facility in Central Finland.
The purpose was to collect data than can be used to inform future nurses about the experiences of male nurses in providing intimate care to female patients.
The researchers intended to obtain answers for the following research questions:

1. What are the experiences of male nurses while providing intimate care to female patients?

2. What are some approaches that male nurses use while providing intimate care to female patients?

3. What support do male nurses get in providing intimate care for female patients?

4 METHODS

4.1 Research Methodology

This research used qualitative methods for data collection and analysis. While there is no unambiguous explanation to define qualitative research, both Fain (2004, 193) and Liamputtong (2010, 13) describe that it uses strategies emphasizing words, concepts and language instead of measurable numbers or quantities. This research has its focus strongly on the social world, addressing the subjective feelings and experiences of human beings that it also aims to understand. Qualitative data can be observed, written, taped or filmed, and the methods of data collection include for example interviews, direct observation, case studies, diaries or documents. (Fain 2004, 144;

Liamputtong 2010, 13-14.) In this study, the primary method for data collection was interview.

The qualitative approach was chosen for this research since, in the current research, it offered more flexibility and fluidity than quantitative research. Flexibility was considered necessary for understanding the subjective experiences of the participants in this study, and showed for example in the possibility of making several interpretations of the findings. In the current research this was expected due to the uniqueness of different individuals, and it aimed to contextual understanding instead of hard, reliable data and generalization. (Liamputtong 2010, 13-14; Hohl, Priest & Roberts 2010, 150-151). According to Denscombe (2010, 304), alternative explanations should not be seen as weaknesses, but as "a reflection of social reality being investigated", and as a prospect for more than one valid conclusion. Furthermore, the approach used in the current study allows the marginalized proportion of people to be heard (Liamputtong 2010, 13), therefore having made qualitative methods appropriate for the current research, as male nurses are a minority in the nursing field.

4.2 Sampling

Sampling is a process of choosing individuals from a larger group to represent it in a study. The two major categories of sampling are *probability sampling* (all parts of the population have an equal chance to be selected) and *nonprobability sampling* (the sample is not selected randomly), and they are further divided into different forms of sampling. However, before conducting sampling it is necessary to define the *population* – the larger group where the sample will be selected. It is a set of subjects, objects, events or elements that are being studied and has certain attributes defined by the researchers. (Fain 2004, 104-105.) In this research, the population was male nurses in Central Finland, and the researchers chose to use purposive sampling. *Purposive sampling* is a form of nonprobability sampling where the researcher selects the cases that are thought to best represent the studied subject and be typical of the population (Fain 2004, 116). Purposive sampling was employed in this study as it

allowed the researchers to build up a sample to meet their needs, and to reach individuals with knowledge about the subject, constituting a suitable method of sampling for this research. In qualitative research, it is more essential to carefully select a meaningful sample rather than a sample with great quantity. (Cohen, Manion & Morrison 2007, 114-115; Liamputtong 2010, 19).

For the current study, a population of five male registered nurses was selected. After permission for research was granted in a health care facility in Central Finland, the researchers requested ward managers to report through e-mail if any of the male nurses working there were interested in participating in the study. The selected male nurses had to meet certain inclusion criteria: they had to be educated registered or practical nurses working either permanently or temporarily in the health care facility, and the participants should have encountered intimate care of female patients in their work. The researchers wanted to include both new nurses with little working experience and more experienced nurses to create a wider variety of experiences considering the subject of study, as the object of sampling was to create a sample as representative as possible (Fain 2004, 117).

4.3 Data collection

The method of data collection used was a semi-structured group interview that was carried out in May 2015. The interview lasted approximately an hour and fifteen minutes, and was conducted in the health care facility during the male nurses' working hours. The language used in the interview was English. The main issues covered in the interview were divided into three themes according to the research questions (Appendix 1). Before the actual implementation of the interview, the interview questions were piloted with five fellow male nursing students. Piloting allows the researchers to test the questions and receive feedback from the piloting group, and to see possible issues occurring in the interview questions (Gillham 2000, 53-56). In the pilot interview, the participants thought that most of the interview questions were appropriate and adequate. Some of the original interview questions were modified based on the opinions of the piloting participants.

Interviewing allows the researchers to explore the participants' feelings, emotions, opinions and experiences about the topic, and is suitable for creating an honest discussion even around sensitive subjects. The semi-structured interview is a technique between structured and unstructured interviewing. By introducing open-ended questions to the participants, the interviewees are more able to develop ideas, speak wider and emphasize their topics of interest instead of being limited by a form of strict questions. With this method, the interviewers allow the participants more freedom to answer the questions on their own terms, but can still maintain more structure than in an unstructured interview. (Denscombe 2010, 172-177; May 2011, 134-136.). Moreover, a group interview enables the participants to hear others' opinions, to support views they agree with and question views they disagree with, and might increase the variety in opinions and experiences (Denscombe 2010, 176-177).

The primary means of retaining the data was audio recording supported by taking written notes. Both researchers participated in the interview: one asked the questions as the other researcher took notes. The benefit of audio recording is a permanent record of the interview, and this way the researchers do not need to rely on incomplete or misinterpreted notes. However, written notes taken along with the audio recording might fill in relevant information missed in it, such as non-verbal communication or the atmosphere of the interview. (Denscombe 2010, 186-188.)

4.4 Data Analysis

Braun et al (2013, 20) likened data analysis to telling a story; it is essentially brining the data to life; and every storyteller will have a different way of narrating the story. Researchers of qualitative studies recognize that data analyses are like stories; these stories are partial as well as subjective. However, any good analysis needs to be credible, logical and grounded in the data.

The analysis of the data took place during May 2015 and was conducted by using the principles of content analysis. It is an analytical approach that can be used both in

qualitative and quantitative research. Content analysis can describe relative frequencies in any type of written material – in this study, the interview transcript – and thus point out the importance of certain topics. (Cohen et al. 2007, 475; Liamputtong 2013, 374.) In content analysis, the researchers identified codes and categories they wanted to look for from the data. A code is a word or a short phrase, and coding is used to find and define the meaning of the data. Coding allows the researcher to name pieces of data with "a label that simultaneously categorizes, summarizes, and accounts for each piece of data". (Liamputtong 2013, 368-370.)

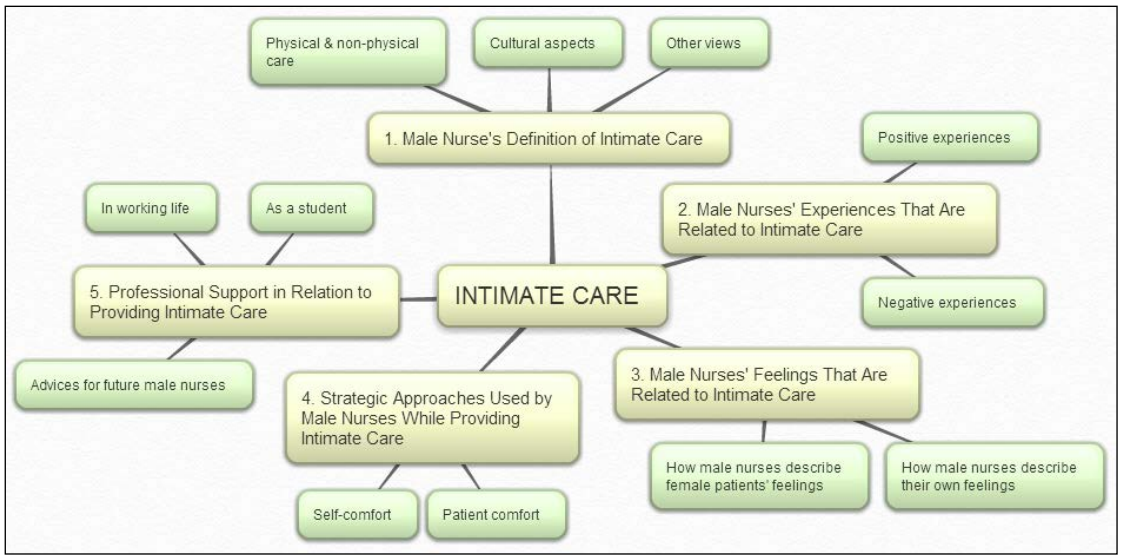
Content analysis itself is a process of the following steps: breaking the text into units (codes) that in the current research were words and phrases; reviewing the units in order to code them; creating categories around the issues and themes concerning the text; placing codes into categories; comparing categories and making links between them; and finally, concluding the process by attempting to explain why the categories, codes and units occur the way they do. (Cohen et al. 2007, 475-483; Denscombe 2010, 279-282.) View appendix 4 for sample of coding.

Upon completion of the interview, immediate debriefing was done and notes were collected. The aim was to obtain information about the group's feelings about the interview as well as to note and clarify any non-verbal communication that was observed during the interview. The next step was transcribing the data. This was done by listening to the data several times through media player, and then writing the interview information verbatim on Microsoft Office Word. Transcription data amounted to 16 pages of A4 sized paper with Times New Roman font and font size of 12. Data reduction was then undertaken, which as indicated by Huberman and Miles (1994), refers to the process of selecting, focusing, simplifying, abstracting and transforming the data that appear in written up field notes or transcription (10). In this study data reduction was achieved by repeatedly reading the data word by word to derive at codes.

5 FINDINGS

The researchers have identified five major categories or themes from the responses provided in providing intimate care to female patients. These themes are introduced in Figure 1, along with the subcategories.

Figure 1: A mind map of the findings



5.1 Male Nurses Definition of Intimate Care

The participants found it difficult to precisely determine and define what is intimate care. Definitions of intimate care included physical and non-physical aspects. The **physical** aspect reflects the removal of some or all of the patient's attire and touching of the genital areas while providing care.

> *"Well, physical things that got anything to do with hygiene, where you really come to direct contact with the patient, especially genital area."* - Nurse D

Though exposing or touching of the genital areas was prominent throughout the discussion, the **non-physical** aspect of intimate care was also discussed.

> *"And maybe intimate care, maybe also sometimes when you have to ask questions about personal life or things like that, ... is not connected with*

physical things, but is also quite challenging when men is (sic) asking things of a lady, I don't know, you know about, for example sexual life." - Nurse A

The issue of **cultural** understanding was also raised. The nurses stated that ones cultural upbringing affects his/her understanding of what constitutes intimate care. They compared the cultural understanding in Finland with more conservative countries and cultures. Throughout most of Finland, a female patient may view exposing certain parts of her body as necessary for the provision of optimal care, while in other countries and cultures it may be view as a taboo.

"I guess for me it's not difficult to take care of for example the legs, but I know in some cultures it's also a taboo you know, to see for example the legs or the wrist of the patient or the neck or something like that, or the head for example." - Nurse A

The nurses also agreed that the definition of intimate care depends on **other factors**, such as patients themselves. In other words, the patients' reactions to the procedure will determine whether the procedure is intimate or not.

"It also depends on how the patient… they might feel like something non-physical might be too personal for them and that way it gets intimate, so it's really hard to define." – Nurse B

5.2 Male Nurses' Experiences Related to Intimate Care

The nurses said that they rarely consider their experiences related to giving intimate care to female patients to be either positive or negative, instead, they see it as a part of their normal work. For them, positive experiences were harder to remember than the negative experiences. An example of a positive experience would be when a female

patient first refuses receiving intimate care from a male nurse, but later agrees after an explanation of the procedure.

> *"Well, I guess it's positive every time they let us take care of them."* – Nurse B

In general, the participants had not experienced many negative experiences. During the interview, the main issue considering **negative experiences** and the feeling of being uncomfortable was catheterization, which the participants considered as one of the most challenging tasks related to the topic. This was thought to result from the bigger difficulties of catheterizing a woman compared to that of a man, which could lead to feeling uncomfortable and frustrated. The nurses also described that caring for elderly patients with memory problems was also something that could provoke uncomfortable situations, and they had experienced false accusations and flirting from the patients' side. Other **negative experiences** included inappropriate comments from some patients and as well as the inability to perform tasks due some patients causing disruption while nurses perform their tasks.

> *"With the patients with memory problems, if you are doing something like catheterization or washing, and they start screaming 'rape, rape', that's pretty awful… That is, at least for me, very uncomfortable." – Nurse D*

> *"Sometimes, like, [you are] struggling with them, and you can't do the job when you are trying to explain but they don't understand or they don't care. They start, you know, trying to disturb."* – Nurse C

5.3 Feelings That Are Related to Intimate Care

In describing their **own feeling**, participants stated that if they were to be rejected by a female patient or denied giving care, they would not take it personally, instead, they would consider the rejection as the patient's right. They described feeling uncomfortable in the beginning of their careers as students and new nurses, but later gained confidence through experience.

> *"When I first started it was… I think I was more afraid of it [providing intimate care] than the patients. But nowadays it's just a natural part of the job, and I don't really think about it that much anymore." – Nurse B*

Regarding the **patients' feelings**, the interviewees agreed that usually female patients accept male nurses. However, while some female patients might prefer a female nurse, they do not directly request one. In the interviewees' experiences, majority of female patients are used to male nurses and only a small amount of patients, often the younger women, are uncomfortable with a nurse of the opposite gender. The interviewees also said that they had had experiences where patients had been angry due to the unavailability of a female nurse. Similarly, some patients became uncomfortable when they are suddenly being cared for by a new male nurse at the change of shift after having been cared for by a female nurses prior to shift change

"I think it's only the small part of patients that feel like uncomfortable with male persons and situations, anyway. Actually, some of them are thrilled as well." – Nurse C

5.4 Strategic Approaches Used by Male Nurses While Providing Intimate Care to Female Patients

According to the participants, providing intimate care to female can be intimidating, especially to some inexperienced male nurses. They found it particularly intimidating during clinical practice and during the early stages of their careers. During the interview, it was revealed that male nurses overcame intimidation by applying two

main strategic approaches while providing intimate care to female patients. These were **self-comfort and patient comfort.**

The general consensus was that **self-comfort** is paramount in order to avoid potential misunderstandings, suspicions or possible rejection from female patients or their family members while providing intimate care. One strategy was to have a female nurse accompany the male nurse whenever he thought he might encounter difficulties while providing intimate care to a female client. According to participants, having a female nurse in the patient's room often reassured or quelled any uneasiness that the female patient experienced.

> "*I usually do this, I take a female person and I just make her stand beside me. Like side by. And she will be, and I have noticed that the female person [patient] feel more comfortable if the female nurse beside me. I usually do this to comfort myself."* - Nurse E

Another form of self-comforting technique that came up in the interview was humor and distraction. Participants narrated that this combination often helped to comfort both themselves as well as some female patients.

> *"I think the process is not as bad if you like talk same time, or joke, like that to keep them [female patient] distracted."* - Nurse C

The interviewees also believed that being transparent with the patient and respecting patient's dignity helped to ease their discomfort. This means providing detailed information to the female patient prior to and while providing any form of intimate care, and at the same time maintaining the patient's privacy.

> *"This way you are explaining what you are doing, what is the outcome of this caring. Respecting privacy, not speaking so loudly, keeping calm and quiet."* - Nurse E

> *"I try to explain the person [female patient] what I have to do, and I try to explain in a way that there is no alternative you know, we have to do and that's all. I mean, I don't try to speak more about that. And maybe what I'm trying to do always, I'm trying to maybe to maintain the privacy of the person [female patient]*. - Nurse A

It was agreed by the participants that **patient comfort** is of utmost importance while performing an intimate care procedure. According to the participants, providing clear and detailed instructions about a particular intimate care procedure, as well as ensuring the patient's privacy patient-privacy, have had a calming effect on most female patients.

> *"Well, I guess it starts with you explaining what you're doing and providing the privacy. So you don't expose their private parts for everyone to see and you don't talk too loudly so that the whole hall can hear everything."* - Nurse B

Participants also agreed that humor and distractions were most times effective in comforting anxious patients.

> *"I think that talking and trying to make the situation more relaxed, it's... I think the main idea is to distract the attention from the thing that you're doing."* - Nurse A

Giving female patients autonomy was another popular strategy. The participant believed that the more autonomy female patients had in their care, the more comfortable they were. They reported playing a supporting role in some intimate care procedure, while allowing the patients to take the leading role.

> *"And another thing is - like it depends on what you're doing - but you let them [female patients] do as much as they [female patients] can and you only help them [female patients] when it's absolutely needed."* - Nurse B

Giving female patients alternatives is also linked to autonomy. The male participants explained that when female patients have the ability to choose, they feel empowered.

> *"I think also sometimes if the situation is a bit like difficult, what I've been using sometimes and I think it works is that I say I will try, you know the patient is like not very sure she wants that, but anyway she accepts that I do it and I say that well, if it doesn't work I can go to another female like nurse or whatever, like give the opportunity to you know, to choose somehow you know."* - Nurse A

5.5 Professional Support in Relation to Providing Intimate Care

The nurses responded that they did not receive any form of professional support regarding providing intimate care to female patient while in school or on the job. They also mentioned that the idea of providing such support in schools maybe a taboo.

> *"In my case, none. I think we never talked about it when I was a student, and I think during my working time I have never... I never got any kind of information or instructions of how should I work. I think this just came by practice. I really cannot remember and I don't think I have received any kind of education or instructions, even advice I don't remember."* - Nurse A

When asked if they would have liked to receive any form of professional support, the participants agreed that professional support was not necessary. They narrated that it is not something that can be taught and also that professional support would reflect abnormality regarding male nurses providing intimate care.

> *"I think it's something nobody can really teach you. Every encounter with every patient is different and you know you just learn when you do and you become to pick up signs to see if the patient is for example*

uncomfortable with you. Then you can change the way you do things. - Nurse B

"The professional help would kind of make it [the profession] abnormal." - Nurse D

On the other hand, participants supported the idea of some form of professional support regarding the issue of intimate care. They mentioned the provision of small talk to sensitize male nurses on possible scenarios that they may encounter while providing intimate care.

"I don't know preparation, but something maybe small talk or something. At least to know that this is gonna happen and now is not a big issue, and don't make a big issue about it." - Nurse A

Another suggestion was for male nurses to be sensitized on people of different cultural backgrounds.

"Well, there is one thing that I can think of here, it would be, might be necessary to get some education to people from different cultural backgrounds, because you don't necessarily know what are the habits in their own cultures. Like in some cultures they don't accept male nurses attending care to female patients at all. So knowing where to draw a line." - Nurse B

The topic of male nurses supporting each other was also actively discussed. The nurses revealed that they did not receive any specific male-male support. They pointed out that in instances where they encountered problems, they sought help from anyone regardless if the person is a male or a female nurse.

"And I think it's like when something happens when you're doing and things go south, you just talk about it with anybody who is there and you

> *mention that it didn't go too well, whether a female or male nurse."* - Nurse B

Advice for future male nurses. Regarding any uncertainty that future male nurses may have pertaining to providing intimate care to female patients, the participants had various words of advice, however, the most resounding was respect for patient's privacy. The participants also echoed the sentiment that future male nurses should not take any negative experiences that they may encounter personally.

> *"Don't take too much pressure, and don't take things personally if they [female patients] don't want you to take care of them [female patients]. And other basic things like respect privacy."* - Nurse B

Confidence also ranked fairly high on the scale of recommendations. Participants agreed that confidence results from having knowledge of the task at hand. The point was mentioned that future male nurses should take the opportunity as students to grasp as much information and experience as possible.

> *"But learn anatomy nicely and seek help, respect the person [female patient]. Be knowledgeable, learn and study."* - Nurse E

6 DISCUSSION

6.1 Discussion of main Results

The researchers are of the view that the aim and purpose of the study were met and that the research questions were answered. Both similarities and differences could be found when comparing the results of this research with previous studies. It was also observed that there was little diversity in the participants' answers, even though they originated from different countries and cultures.

Providing a precise definition for intimate care was challenging for the participants, as they believed that there are various factors that determine what intimate care is - such as culture, nursing experience. It was further mentioned that the patients' views and reactions to medical procedure also determine whether the procedure was seeing as intimate or not. The general interpretation, however, was "direct contact with patients, especially genital area." This interpretation is supported by the definition in the Free dictionary (2014), which defines intimate care as any primary genital area, groin, inner thigh, buttock or breast" - being touched or exposed when implementing nursing care. (The Free Dictionary 2014.) Participants also expressed that non-physical aspects such as asking personal questions as well as ones cultural upbringing also determine how intimate care is defined. According to the nurses, personal questions especially those relating to sexual activities may evoke discomfort for some female patients and male nurses. For example, a male nurse and a female patient may view the need to ask questions about sexual activity or vaginal discharge as necessary for the best possible care, whereas the same may not be said about more conservative cultures. This finding is supported by studies done by the Association of Reproductive Health Professionals (2008), which states that many health care providers are hesitant in discussing sexual issues with patients because they lack training and skills, are uncomfortable with the subject, or fear offending the patients. Similarly, 68% of the patients in the study mentioned that they were reluctant to discuss sexual issue out of fear of embarrassing the health care provider.

In the interview, the nurses' responses were similar concerning their experiences in providing intimate care to female patients. While they could better recall the negative experiences instead of the positive ones, the participants agreed that only a small amount of female patients were unwilling to cooperate or completely refused being cared for by a male nurse. Even though in the comparative study by Chur-Hansen in 1984 and 2000 it was found that female patients strongly preferred another female to care for them, similar findings did not become evident in the current study. However, it was noted in this study that younger female patients often prefer a nurse of their own gender, while most elderly women were already used to male nurse. The same observation was also made in Chur-Hansen's study, whereas older female patients seemed to have no preference concerning the nurse's gender. (Chur-Hansen 2002, 193-197.)

Harding, North and Perkins (2008) stated in their study that touch in nursing, even though non-sexualized, can be problematic for male nurses, as they can be viewed as objects of sexual threats (89). Similarly, while the participants of this study said that negative experience in their work were rare, they had had experiences where they had been directly accused of rape or they had received inappropriate comments in situations where they had been washing or catheterizing a patient. However, the participants agreed that they did not see these accusations or comments being personal, and that the patients' medical background such as memory problems contributed to the particular behavior.

The male nurses conveyed that they did not have specific strategies that they used while providing intimate care. They expressed that they viewed themselves as individuals who were trained to perform intimate care procedures on female patients, and that they did not deliberately outline strategies to help them perform these task. On the other hand, the participants outlined useful strategies that they had used when faced with situations where they encountered issues in providing intimate care. They explained that it is vital that both male nurses and female patients are comfortable during an intimate care procedure. The two main strategies used were self-comfort and patient-comfort. The researchers observed that both male nurses and female

patients benefit from some over-lapping comforting strategies. For example both male nurses and female patients benefit from humor and distraction. In an article written by Padela (2012), how respected and comfortable patients feel directly affect their health outcome. If patients feel uncomfortable with their health care providers they will be less likely to seek their help and recommendations.

Self-comfort involves strategies that the male nurses used to comfort themselves. One such method was having a female nurse present in the female patient's room while the male nurse carried out the intimate procedure. According to the participants, sometimes patient's may display feelings of discomfort, which may negatively affect some nurses. In order to ease this discomfort that the male nurse may experience, male nurses usually invite a female nurse to accompany them to the female patient's room. This strategy has helped to reduce the tension felt by male nurse. Similarly, in previous studies, the practice of having a female nurse accompanying a male nurse while performing an intimate act was also evident. In these studies, having a chaperone [female nurse] was used to avoid misunderstandings, suspicions and/or rejection from female patient and their family members. (Inoue et al 2006, 563-565).

Another form of self-comforting was humor and distractions. The participants explained that they experienced a reduction in anxiety when they talked to female patients or when they told a joke. The rationale is that when the female patients are distracted they appear more comfortable, as a result, the male nurses themselves become more comfortable. Inoue (2006) explains that while this strategy may be helpful to male nurses, the impact on female patients has not fully been explored. There is a possibility that the female patient may view the humor or distraction negatively, thereby further isolating her from the male nurse. The lack of formal education on the use of appropriate humor in an intimate setting may potentially cause harm if the female patient misinterprets the intention.

Being transparent and respecting the patient's dignity is another strategy that participants described. According to the participants, clear and precise instructions about the intimate procedure helped to reassure some female patients, as a result, the

male nurses were more at ease and confident. A similar strategy was observed in Harding (2008), where one participant mentioned that "you are always aware of being careful, telling the patient what you are up to, talking with them as you do it, explaining what you are doing." In this research, the participants also discussed that when the patient's privacy is maintained, this fostered a more secure and less stressful environment. This environment helped to calm any anxiety that the male nurse encountered.

Patient-comfort involves strategies that male nurses used to help to comfort female patients. The participants explained that providing clear and detailed instructions about a particular intimate procedure, as well as patient-privacy helped to reassure and calm any anxiety that the patient experienced. According to the participants, clear communication gave patients the opportunity to ask question and dispel any fears. Similarly, a secured environment promoted a sense of comfort for female patients.

The nurses stated that they had used humor and other distractions to make female patient more comfortable during intimate care procedures. Participants explained that having a relaxed environment helped to establish a good nurse-client relationship. This finding was consistent with the results of previous studies. As was discussed earlier, Inoue (2006) explained that this technique has the potential to create isolation between male nurse and female patient if the patient misinterprets the intention of the humor or distraction.

Other strategies that the participants mentioned included giving the patient autonomy and alternatives during their care. Giving autonomy means allowing the patient to participate as much as possible in the intimate care procedure. The male nurses played a supporting role in such situations. This is a unique strategy that has not been observed in other researches. Providing alternatives means giving patients ability to choose. Male nurses mentioned that sometimes they explained to patients that if the need should arise, a female nurse could perform the task.

Nurses discussed that they did not receive any form of professional support about providing intimate care to female patients during school or on the job. They mentioned that having small talks about the subject in school would have been beneficial. They also stated that there could have been more focus on the issue of cultural awareness since it is not uncommon for nurses to work with patients from different cultural backgrounds. However, they believed that there is no great need for specific support. They further explained that providing education on how to deal with female patient while providing intimate care is not something that one can be taught, it is a skill that is developed through interactions with different female patients. This sentiment is in contrast to findings in Harding et al. (2008), where participants spoke about the lack of professional support in using intimate care appropriately or developing strategies to help protect male nurses from any accusations during nursing school. In the research, the nurses suggested that during nursing school, more focus should have been placed on the female genitalia as well as a procedural guide should have been provided on how to provide intimate care to female patients.

The researchers felt that the interview questions allowed them to capture detailed information from the participants, and that the semi-structured interview technique was suitable for this research. It allowed the interviewers and the participants to speak openly, but to maintain a certain structure during the interview.

6.2 Ethical Consideration

This research has followed principles of research ethics such as fabrication, falsification, plagiarism and misappropriation, as outlined by the Finnish Advisory Board on Research Integrity (TENK). *Fabrication* refers to “reporting invented observations to the research community”. In other words, this means that the methods that a research has claimed to follow have not been used in order to achieve the observations or findings of the study, or the results are invented and false. Furthermore, *falsification* (misrepresentation) is “modifying and presenting original observations deliberately so that the results based on those observations are distorted” (Finnish Advisory Board on Research Integrity 2012, 32-33). In the current study, the

methods of purposive sampling, semi-structured group interview, content analysis and coding were carefully followed. No original observations were modified at any stage of the data analysis. The findings were based on the data collected in the interview, and were presented truthfully

According to the Finnish Advisory Board on Research Integrity (2012), *plagiarism*, or unacknowledged borrowing, refers to “representing another person's material as one's own without appropriate references”. This concerns research plans, manuscripts, articles, other texts or part of them, visual materials and translations, and involves both direct and adopted copying. *Misappropriation*, in the other hand, refers to “the unlawful presentation of another person's result, idea, plan, observation or data as one's own research”. (32-33.) The researchers of the current study had strictly ensured that no material had been used without stating the correct reference, and that the collected data was original.

Ethics pertains to doing 'good' and avoiding harm through the application of appropriate ethical principles. Therefore, the protection of human subjects or participants in any research study is imperative. (Orb, Eisenhauer and Wynaden 2001, 93.) Since data was collected in this research, it was crucial that ethical considerations were taken into account. One important principle that the current study followed was autonomy, which refers to the recognition of participants' rights. Similarly, autonomy means that the participants can exercise their rights as autonomous individuals to voluntarily accept or refuse to participate in the research. (Orb et. al 2001, 93.) Autonomy in the current study was achieved through providing consent forms (see Appendix 3) to the participants, where they were informed of their right to withdraw from the interview, and it explained that participation was voluntarily.

The potential of revealing the identities of participants is a moral obligation of any researcher. The publication of research information including quotations or other data from the participants, even though anonymous, could reveal their identity. (Orb et. al 2001, 95.) Hence, participants should be informed of how results will be published.

To minimize this risk, participants' names or identification number were not used in the current research, and the name or exact location of the health care facility where they work were not revealed. Reassurance was given that after data analysis is completed, all transcripts would be carefully destroyed. The participants were informed about where the data is published and how to access it.

In this research, a formal application requesting permission to conduct the research was submitted both to the health care facility in central Finland, and the city's development leader of services. The letter inquired for permission to conduct the research in the facility; it outlined the aims of the research and procedures to be used. A letter of information was later sent to each participant. (See appendix 2.)

6.3 Credibility, Dependability and Transferability

In undertaking this research, an element of great importance to the researchers was trust. The researchers believe that trust facilitates both cooperation between the researchers and the participants, but also the whole research process. According to Merriam-Webster online dictionary (2015), trust is the belief that someone or something is reliable, good and honest. In qualitative research the concepts of credibility, dependability and transferability have been used to describe various aspects of trustworthiness. (Graneheim and Lundman 2004, 109.)

Credibility encompasses the focus of the research and refers to confidence in how well data and the process of data analysis address the intended focus. Credibility comes in to focus when researchers make decisions on the focus of the research, select content of study, participants and approach to gathering information. It is important to choose participant with various levels of experiences. This increases the possibility of shedding light on the research questions from various aspects. Factors such as age, gender as well as observers with different perspectives, contribute to a richer variation of phenomenon under study (Graneheim and Lundman 2004, 109.) To promote richness in data of this research, the researchers decided to select a variety of male nurse participants. For example, registered and practical nurses, nurses of varying

ages, experienced and new nurses as well as Finnish nurses and nurses of foreign origin.

Choosing the most appropriate method for data collection and the amount of data are critical for research credibility (Graneheim and Lundman 2004, 109). In the current research, semi-structured interview was used to collect data. In this approach, researchers prepared an interview guide before the interview, which allowed an opportunity to alter the precise wording of questions, or the order in which questions were asked. (Braun and Clarke 2013, 78.) As mentioned earlier, the researchers organized a pilot interview and modified the original interview questions based on the feedback from its participants. Piloting gave the researchers an opportunity to evaluate the functionality of their interview pattern and helped to avoid overlapping questions, which, according to Gillham (2000), is more productive to the researcher in the actual interview, and more motivating to the participants (25, 72). Semi-structured technique was chosen for this research since it allowed the researchers to appear prepared and confident, allowed participants to express their own views as well as provide reliable, comparable qualitative data.

The researchers are of the view that the environment in which the interview was conducted positively affected the credibility of the information received. The researcher ensured that the interview was conducted in an area with little or no background noise. This helped to prevent distractions that could possibly affect the answers given by the interviewees. Similarly, prior to starting the interview, both interviewers engaged in small talk to help to create an easy-going atmosphere. This also helped to ease any tensions that the interviewers or interviewees could have been experiencing. All these strategies helped to enhance the credibility of the information. These strategies are supported by Braun and Clarke (2013), who state that a safe and quiet location helps both interviewers and interviewees to feel at ease and improve concentration level (91).

Selecting the most suitable meaning is also important in achieving credibility. A meaning unit, that is, the constellation of words or statements that relate to the same

central meaning, has been referred to as a content unit or coding unit, an idea unit, textual unit, a keyword and phrase, a unit of analysis, and a theme. (Graneheim and Lundman 2004, 106.) To achieve this, the researchers avoided meaning units too broad since these were difficult to manage and could present ambiguity. Similarly, too narrow meaning units were avoided since they could result in fragmentation.

Burnard (1991) in Cutcliffe and McKenna (1999), maintains that qualitative researchers can maintain the validity of their work through the categorization method. Creating categories is the core feature of qualitative content analysis. A category is a group of content that shares a commonality. (Graneheim and Lundman 2004, 107.) Krippendorff (1980) in Graneheim and Lundman (2004) emphasizes that categories must be exhaustive and mutually exclusive. This means that no data related to the purpose should be excluded due to lack of a suitable category. Furthermore, no data should fall between two categories or fit into more than one category – instead, they may often include sub-categories or sub-subcategories. The sub-categories can be sorted and abstracted into a category or a category can be divided into sub-categories. Themes are defined as threads of meaning that recur in domain after domain. (Graneheim and Lundman 2004, 107.) In this research, the authors thoroughly reviewed all transcripts several times in order to get categories correctly and to avoid overlapping categories. Categories were re-examined in order to get accurate themes that covered all valuable data. Both researchers were present at all phases of the data analysis, and it was done in co-operation and mutual understanding.

Another aspect of trustworthiness is dependability, which is the degree to which data change over time and modifications made in the researcher's decisions during the analysis process. When data and data collection are extensive there is a possibility of inconsistency. Researches should, therefore, strive to question the same areas for all participants. (Graneheim & Lundman 2004, 110.) In the current study, the risk of inconsistency was minimized by asking the same questions from each participant, and allowing them to answer questions also in Finnish if they so desired.

Polit and Hungler (1999), Graneheim and Lundman (2004), state that transferability refers to the extent to which the findings can be transferred to other settings or groups. Writers can give suggestions, but it is up to the readers to determine if the data is transferable. To facilitate transferability, it is valuable to give a clear and distinct description of culture and context, selection and characteristics of participants, data collection and process of analysis. A rich and vigorous presentation of the findings together with appropriate quotations will also enhance transferability. (Graneheim and Lundman 2004, 110.) In this study, the descriptions of all the parts of the study were given as accurately and richly as possible, thus the results of the study can be used in other studies. The findings were accompanied with carefully selected quotes from the interview transcript.

6.4 Limitations and Recommendations

This study has some limitations. The researchers are of the view that if there had been more than five participants, the results would have reflected a wider perspective of experiences. According to Braun and Clarke (2013), with small groups, researchers are at risk of not getting diverse-expressed perspectives. There may also be a stutter in conversation if participants do not engage in the interview. (115). Since the language used in the interview was not the native language of most of the participants, the researchers believe that this could have affected the way the participants expressed themselves. The minimal amount of earlier research done on the subject also meant that there was insufficient information from which to gather a broad literature review.

The findings from this research can be exploited by current and future male nurses to raise awareness about the experiences of male nurses in providing intimate care to female patients. Nursing programmes can use this information to provide greater support for male nursing students regarding providing intimate to female patients. We recommend that nursing schools incorporate information and guidance to male nurse during training.

Over the years, little research has been done to unearth the experiences that male nurses face while providing intimate care to female patients. Though this study has provided invaluable information on the experiences of male nurses while providing intimate care to female patients, the researchers recommend further studies in this area.

This research has generated a few unanswered questions, which can be researched in the future. The questions are:

What are the experiences of female nurses while providing intimate care to male patients?

What are the experiences of female nurses while providing intimate care to female patients?

What are the experiences of male nurses while providing intimate care to male patients?

What are the experiences of nurses who care for homosexual patients?

How do male nursing students feel about providing intimate care to female patients?

7 CONCLUSION

Despite an increase in the prevalence of male nurses in recent times, there are still concerns lingering about the appropriateness of male nursing providing intimate care to female patient. This research has provided vital insights about what male nurses experience while providing intimate care to female patients. The research has also brought to light effective strategies that male nurses used whenever they encounter difficulties with providing intimate care to female patients. Lastly, the research has shed light on support that male nurses receive regarding providing intimate care to female patient.

While other studies have reported that male nurses encountered major problems while providing intimate care to female patients, the findings from this research revealed that male nurses did not encounter any major negative or positive experiences. The nurses revealed that they rarely thought about their experiences as negative or positive, instead, they viewed them as part of being a nurse. The general consensus, however, was that any time that the female patients allowed the male nurses to take care of them that could be considered a positive experience. On the other hand, negative experiences included, the challenges of catheterizing a woman, false accusations by mentally challenged patients and inappropriate comments made by patients. The nurses also said sometimes patients' negative behavior prevented them from performing their task.

Regarding strategic approaches, the nurses expressed that they did not deliberately use specific strategies while providing intimate care to female patients. However, in cases where they encountered difficulties with patients, they used two main strategies, which were self-comfort and patient-comfort. For self-comfort, nurses used strategies such as humor and distraction, and having a female nurse with them when going to provide intimate care. Strategies that worked best for the patient’s comfort were providing instructions and being transparent, respecting their dignity and privacy, giving the patient autonomy and alternatives, and using humor and distraction.

The nurses in this study had not received any professional support during their studies or their time in the working life, and neither did they feel the need for it. They said that they had learned to provide intimate care to female patients as they progressed in their careers and there is not great need for professional support. On the other hand, the nurses mentioned that sensitizing male nursing students about the topic of intimate care would be beneficial.

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9 APPENDICES

Appendix 1: Interview Questions

What are the experiences of male nurses while providing intimate care to female patients?

- What is intimate care in your opinion?
- What do you think about male nurses providing intimate care to female patients?
- How often do you provide intimate care to female patients?
- Describe a situation where you have had a positive experience while providing intimate care to a female patient.
- Describe a situation where you have felt uncomfortable while providing intimate care to female patients.
- How would you feel if you were rejected by a female patient?

What are some approaches that male nurses use while providing intimate care to female patients?

- Describe strategies that you have used to help to make you feel more comfortable while providing intimate care to female patients.
- Describe strategies you have used while providing intimate care to female patients that helped to make them feel more comfortable.

What support do male nurses get regarding providing intimate care to female patients?

- Describe any professional support that you have received regarding providing intimate care to female patients.
- How do you (male nurses) support each other?
- Describe any changes you have noticed in the way male nurses care for female patients throughout your career.

Additional questions

- What advice would you give to a male nursing student regarding providing intimate care to female patients?
- Do you have anything that you would like to add?

Appendix 2: Letter of Information

Jyväskylä University of Applied Sciences

School of Health and Social Studies
G6567@student.jamk.fi /G6730@student.jamk.fi

February 9, 2015

Dear Participants,

We are third year nursing students at Jyväskylä University of Applied Sciences. We are writing our bachelor's thesis on the topic 'The Experiences of Male Nurses in Providing Intimate Care to Female Patients at a Health Care Facility in Central Finland". The main objective of this research is to find out the experiences of male nurses while providing intimate care to female patients.

Participation is voluntary and there are no known risks involved in participating in this research. Participants are free to withdraw at any time and they are not obliged to answer any questions they find objectionable or which may cause discomfort. The interview will be conducted in English and will last for approximately 60 minutes. The interview will be recorded with a tape recorder. Information received from participants will be used solely for the purpose of this research and your confidentiality and anonymity is guaranteed. The thesis will be published at www.theseus.fi.
The supervisors of the thesis are Marjo Palovaara and William Garbrah from Jyväskylä University of Applied Sciences. They can be contacted respectively 040-0976746/marjo.palovaara@jamk.fi and 040-0917405/william.garbrah@jamk.fi.

Thank you for your participation

Sincerely yours
Courtney Salmon _____
Laura Nipuli _____

Appendix 3: Consent Form

CONSENT FORM

1. I confirm that I have read and understood the information letter dated ( ) for the above research study, and I have had the opportunity to ask questions.

2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason and without compromise to my privacy as well as my legal rights.

3. I agree to take part in the study.

Name:
Date:
Signature:

Appendix 4: Coding Sample

Category: Intimate Care		
Subcategory: **Physical**	Subcategory: **Non-physical**	Subcategory: **Other Views**
Without clothes Underneath the clothes Chest area Genital area Hygiene Direct contact	Privacy Personal life Personal questions	Cultural Taboo Hard to define Haven't thought about it Something thought about as a student Depends on the patient Natural part of the job Part of being a patient Nursing experience

Category: Experiences		
Subcategory: **Positive**	Subcategory: **Negative**	Subcategory: **Neutral**
Every time the patient lets the male nurse to take care of them Refusal rare	Catheterization Nasty comments Struggling with patient Unable to do the job Patient refuses Patient disturbs Patient flirts Patient misunderstands Patient doesn't care Patient with memory problems Doing something down below	Daily job Mostly female patients Male nurses more common Not a positive or a negative experience Cannot think of examples Most patients cooperate Right to refusal Young female patients refuse male nurse's care.