

# **The making and marking of men's bodies in the context of nursing care**

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## **Introduction**

This paper seeks to uncover the significance of bodies within the profession of nursing. Bodies have long been a neglected area of research in organization studies – often invisible despite their centrality in any work context. In this respect, we *are* our bodies and they are therefore deployed to greater and lesser extents in the work we do. It is consequently surprising that the significance of bodies has largely been overlooked – exceptions including those instances where some form of manual labour is required or where bodies are the focus of work. This ‘conceptual blindspot’ (Grosz, 1994) in mainstream thinking about gender and organization may reflect the Cartesian mind/body dualism in which men and masculinity, through associations with rationality and the higher order of the mind, have been rendered ‘bodiless’. Bodies have thus been inferiorized, deviant and visibly tied to the realm of women.

As Connell (2000) points out, bodies matter in that biological difference between men and women play an important part in determining what is seen to be ‘masculine’ and ‘feminine’ work. Heavy physical labour, for example, is often deemed more suitable for men and caring roles associated with ‘softer’ bodies of women. Meanings around masculinity and femininity therefore depend partly on the social definitions of the

body. In this respect, as Evans (2004) notes, there has been little work on how men's bodies and dominant social constructions of masculinity shape the experience of men in female dominated occupations. Here, the masculine body does not comply with associated social expectations. Meanings attached to men's bodies (as rational and disengaged) thus collide with conventional notions of care (emotional, nurturing, supportive) naturalised in the embodied dispositions of women. Based on a qualitative study of 31 male nurses in both Australia and UK, this paper attempts to fill this research gap and explore the significance and meaning attached to bodies when men undertake the gender incongruent activities of nursing care.

### **Bodies, Embodiment and Disembodiment**

As Morgan et al (2005) point out, bodies can be seen to be pertinent to work in several ways. Firstly, work requires effort which has a bodily dimension. This has most commonly been recognised in the identification of the bodily efforts of manual labour with the male working class. Beyond this, however, bodily effort can be seen in the tiredness we feel, to greater or lesser extents, from the work we do. The demands of emotional labour for example may involve 'burnout' or emotional exhaustion – felt through our bodies.

Secondly, pleasures and pains of work are equally body experiences. This may include feelings of alienation, as predicted by Hochschild's (1983) account of emotional labour as individuals assume a caring bodily demeanour captured, in the case of cabin crew, in the everlasting smile – to more positive feelings of satisfaction and pleasure. As with tiredness from effort, these pleasures and pains are experienced through our bodies – the glow of satisfaction from a job well done to the feelings of frustration (and the headache!) brought on as we deal with difficult situations.

Thirdly, in a Foucauldian sense, we must discipline our bodies to conform to organizational requirements – to produce for example docile bodies, controlled through different organizational techniques. From this perspective, employee bodies have become an important site of control. For example, as Trethewey (1999) argues, by being brought into service bodies must be controlled so that they will ‘behave’. This may involve conformity to professional and gendered discourses – of deference, service, care - inscribed on bodies of men and women. Norms of deference or of nurturance are often inscribed on female bodies or on those enacting service and care, influencing the ways women walk, sit, interact and occupy space. Equally, professional norms (e.g. of competence, expertise) can be ‘written’ on the body through the wearing of uniforms – signifiers also of differences in status as, for example, uniformed bodies are in some contexts positioned against the non-uniformed bodies of more senior personnel.

Finally, all work situations are characterised by different degrees of embodiment and disembodiment. The concept of embodiment captures the meanings attached to bodies referred to above, an awareness of the body that is shaped by wider cultural frameworks and expectations (Morgan et al, 2005). By contrast, disembodiment refers to situations where individuals see themselves and are seen by others as divorced from considerations of the body. In this respect, some work can be seen to be more embodied than others. Manual labour and the care of others, where the source of labour and the chief focus are bodies, can be seen to be explicitly embodied while other work, such as management or administration, may be seen as disembodied in that such work relies on the ‘rational mind’ with less obvious bodily associations.

However, as Hall et al (2007) have recently pointed out, even occupations that require few bodily dimensions demand a body representation that accords with and conveys particular meanings. Estate agency for example is not on the face of it 'bodily' – it does not demand manual labour or body performances of care - but it nevertheless requires a body presentation to clients and customers that conveys particular meanings such as those relating to business acumen, trust and reliability.

Bodies thus carry meanings - meanings which are both gendered and hierarchically arranged. Forms of 'body work' (Wolkowicz, 2003) which involve caring have accordingly been associated with work of women – whose bodies are conceptualised as caring bodies - while work involving the deployment of specific skills or expertise have been associated with men. In a similar vein, women have been seen as more 'embodied' than men, linked to nature and containing bodily associations of fluidity, flux, fecundity and passion (Hassard et al, 2000). Women's bodies have been associated with the private sphere such as the family where 'natural' bodily, emotional and hence lower functions occur. Men by contrast signify the 'organized body' (ibid) associated with dryness, solidity, containment - a body to be disciplined and controlled. The organization – as rational, ordered, hierarchical and disciplined – is thus written on the male body. As the standard body at work, the disciplined male body is disengaged from its own performance and from reproduction, emotionally under control, symbolically cleaner than women and the standard against women and their bodies are judged problematic. In short, men in general are disembodied in their divorce from bodily considerations – standing for universal personhood as well as for organization and rationality – with possible implications for how the masculine body is deployed in service and care.

## **Bodies, Emotions and Emotional Labour**

Despite the recognition of the gendered nature of emotional labour, where service and care carry strong associations with femininity and the female body, the concept of emotional labour has largely overlooked the body. As Warhurst and Nickson (2007) point out, emotional labour ‘foregrounds the worker as a mindful feeling self but loses a secure conceptual grip on the worker as an embodied self’ (Warhurst and Nickson, 2007: 36). While this has been addressed to some extent by Witz et al’s (2003) work on aesthetic labour as embodied labour as well as by Warhurst and Nickson (2007) who have explored aspects of aesthetic labour in interactive service work, there are a limited number of studies on the embodiment of emotional labour where there may be few aesthetic dimensions.

This neglect is surprising given the obvious links between emotions and the body. As Morgan et al (2005) point out, and as we have seen above, we both experience the pleasures and pains of work in and through the body. The body is significant in emotional labour and service work in other ways. Specifically, given that the performance of the worker is constitutive of the product, bodily characteristics such as gender, age, personality and other dispositions cannot be separated from that product. As Leidner (1991) has argued, these performances draw on looks, voices, personalities and emotion as well as physical and intellectual capabilities. Facial and body displays are crucial to the performance of emotional labour and to service work generally where embodied attributes and capacities are often used as a source of competitive advantage (Warhurst and Nickson, 2007). From this, there are likely to be strong associations between the body, emotions and emotional labour. Drawing on

interview data from the male nurses in the study, some of these links are explored below.

## **The Study**

This paper is drawn from a larger study of men in non-traditional occupations which explored issues relating to career dynamics, perceptions of gender differences in attitudes to care; the implications of gender/masculinity for work practice; and strategies adopted to align mismatch between gender and occupational identity. From this larger study, discourses of the body permeated male nurses' accounts, particularly in relation to perceptions of gender differences in attitudes to care and in work practices – and the challenges that men face in their caring role. The research was conducted in two stages over a four year period. The first stage took place in the UK between 2002 and 2004; the second stage consisted of a smaller scale Australian based study, funded by the Nuffield Foundation, conducted in 2006.

Fifteen nurses, from six different hospitals in London and the South-East, were interviewed in the UK: five were involved in mental health, four in accident and emergency, one in palliative care and the remainder in general nursing. The Australian based study comprised sixteen nurses from six hospitals located in and around Sydney, New South Wales. Of the male nurses, four were senior managers, two were midwives and two were psychiatric nurses. The remainder were located in various specialisms (intensive care, HIV, accident and emergency, working in operating theatres) or were still in training and/or working in general nursing on the ward. All but two of the nurses were registered, a professional status, having completed a university level course. The two remaining nurses were 'enrolled'. Enrolled nurses in Australia usually spend twelve months training at the equivalent of

a further education college, followed by practical experience in hospital wards for the remainder of the time.

Interviews were semi-structured, following a set of themes that concerned the issues outlined above (careers, perceptions of gender difference in attitudes to and practices of care, challenges faced in aligning occupational and gender identity). Interviews mainly took place in the place of work and lasted between one and one and a half hours. All interviews were recorded and subsequently transcribed.

In recognition of the researchers' implication in the production of accounts (Pullen, 2006), interviews took the form of a dialogue. Reflexivity was sought through a shared process of exploration. Here, interviewer and interviewee discussed the meanings of recounted experiences and respondents were encouraged to consider, in the manner of reflexivity put forward by Martin (2006), their attitudes, emotions and behaviours. In this respect, men had often thought long and carefully about their occupational choice and reflexivity was in some ways built into everyday practice as men coped with challenges to their masculinity and as they performed 'care'. Therefore, while conversations in interviews often took a turn which was new, in the sense that respondents had not thought about certain issues before, many reflected ably on their attitudes and experiences.

Issues around the body emerged as a key theme for understanding men's attitudes towards and experiences of nursing. These relate to physical effort, discipline and restraint; the intimate care of bodies; and the marking of men's bodies in the context of nursing care.

## **Physical Effort, Discipline and Restraint: Producing and Managing the Masculine Body**

Bodies are significant to nursing in several ways, not least, as Dahl (2005) notes, because much of care work is concrete, bodily and heavy. Research suggests that the co-option of men's bodies in physically demanding nursing work is widespread. Heikes (1991) has referred to a 'he-man' role assigned to male nurses as they are called upon to undertake heavy moving and lifting and Milligan (2001) found male nurses are routinely expected to deal with physically aggressive patients. In the current UK/Australian study, all nurses commented on these expectations. In this respect there was often explicit recognition of the physical advantages of the masculine body and associated meanings of threat and authority. This could, for example, relate simply to differences in voice and tone:

*“As a male because you have a larger tone you can actually lower the tone without raising the volume and actually bring instruction underneath the surrounding sound...and I think there's also that male like safeness...like males you know we all have our traditional stories...there's the hero type side, turning towards men for safety”.*

As this nurse suggests, meanings attached to male bodies also come from past history and from narratives of masculinity, which powerfully influence the way men's bodies are perceived. These meanings were often welcomed by men - they were listened to more readily than women and had more authority as a result. Most nurses welcomed a 'protector' role which they presented in a traditional way as masculine chivalry and a concern for the welfare of women. This provided opportunities for men to affirm their masculinity and special contribution to nursing:

*“I may have to look after somebody that’s two hundred fifty kilos because you’re the only male on and you’re working with some sort of wee slips of girls you know? ... I don’t mind because I have more ability to do something. It’s like anything else; I have physical ability to do something extra so I won’t mind to relieve my mates from doing that”.*

Men routinely deployed their bodies as ‘boundary setters’ (Forseth, 2005) in aggressive situations to present an authoritative, reassuring and in some cases intimidating presence. Some nurses described episodes in which, in a masculine display of aggression, they used force to subdue violent patients:

*“I had him before he got the second hit in, I had him with his arm behind his back facing to the bed and lifted him up, he was about 80 kilos, and on the bed and I said behave, behave. I said I’m bigger than you are and I’m stronger than you are I said security is on its way”*

As Monaghan (2002) has argued, when institutionalised and used legitimately in the interests of protection, ‘good violence’ can be constitutive of masculinity and valour (Monaghan, 2002 p 420 cited in Evans, 2004: 19). Not all nurses however were so proactive in aggressive displays, though they acknowledged the meanings attached to the masculine body (e.g. of courage, bravery, fearlessness). These meanings could be activated through an authoritative and regulatory ‘presence’, even though in the following quote, they did not reflect notions of the authentic self:

*“When you have people who are intoxicated and wanting maybe to throw their weight around, it is helpful to have a male ...if there’s a problem with accident and emergency I’m more than happy to go down and just stand there just as a presence...even though I have to say I’m not actually your aggressive type”.*

As Evans (2004) points out, this 'enforcer role' is not easily avoided and can, as in the case of the above nurse, who professed to a non-aggressive stance, be inconsistent with personal and professional values. Thus, irrespective of men's actual body size or personal disposition, men are expected to undertake physically demanding work and to act as disciplinarian in the organization. Evans found that nurses of just average stature were expected to intervene in difficult situations, suggesting that 'variable body capital' such as body build and physical characteristics such as strength can become 'the currency of masculinity itself'. (Evans, 2004: 18).

In some instances however, these meanings are out of place and men must manage their bodies, for example reducing semblance of body size and volume of voice, in order to present a non-threatening, caring self. Men thus strove to redefine the meanings around the masculine body – speaking in deliberately soft tones to patients or sitting at the end of the bed to reduce the appearance of size. Here men spoke of the need, particularly when dealing with female patients, to create trust – in ways that suggest a need to overcome the inherent disadvantages of the male body in a context of some nursing care.

### **Gender, Nursing and the Intimate Care of Bodies**

In nursing, bodies can be seen to constitute the social practice of the occupation. As Isaksen (2005) points out, this is a form of work is both gendered and carries low esteem. Providing intimate hands on care is culturally defined as feminine and generally located within the female domain. The gendered nature of such work may thus have its roots in the assumption that women take responsibility for hands on and intimate care of relatives (children, the elderly) in the home. As Bolton (2005), citing Lawler (1991), points out, nursing work, women's work and dirty work are

inextricably linked through their association with the private realm. The gendered nature of such work is exacerbated by meanings attached to basic body fluids, overloaded with ideas associated with dirt and disgust (Douglas, 1966) and which has low esteem (Dahl, 2005). Medicine is accordingly constructed as an occupation suitable for middle class men only if interaction with the patients' body is limited and given to (female) nurses. Within the nursing sector itself, there are divisions of status which reflect different relations to the body such as the distinction between basic/general nursing, involving care of the physical and bodily needs of patients and technical nursing, coded more masculine and which carries 'cleaner' i.e. more technical tasks and less touching of patients (Wolkowicz, 2002). As Dahl (2005) notes, the tendency for men to move into these more specialist areas represents a 'flight from the body' and a distance from these 'feminine' and more unacceptable aspects of nursing care. This tendency was summarised by one nurse in the present study:

*"A lot of men in nursing feel that the actual bum wiping is not where they want to be, they want to running the bum wiping nursing".*

Care work can thus be seen as dirty work (Isaksen, 2005) so that intimate care is difficult to combine with ideas of masculinity. This 'incompatibility' is highlighted in the following quote, in which a nurse recalled the reaction of his brothers to the news that he was taking up nursing as a profession:

*"so when I told (brothers) them I was going to be a nurse they said, you don't need a brain if you want to be a nurse. We can teach black women how to do that work, you know? So that is one kind of stigma I actually experienced because they thought that it was inferior, it was only good enough for black women to do"*

Nursing as an embodied practice is thus coded feminine and inferior – as well as ‘raced’ – and is perceived to be of little value and requiring minimum expertise. However, despite common perceptions of such work as ‘dirty’ and unsuitable for men, male nurses working on the ward - with responsibility for the day today care of patients - often took pride in their ability to carry out such work, celebrating their special skills over the ‘squeamishness’ of male friends and acquaintances as well as over female colleagues. One nurse commented on his choice of career viz. a viz. those of his male friends:

*“Some of it’s (the work) upsetting, they couldn’t cope with the smells, can’t cope with blood, can’t cope with opening bodies, with crisis and emergencies and disaster, but particularly just unwell people...so many males find it quite foreign to take on a role as a nurse.”*

Another recalled how, faced with his own child ill with breathing difficulties through a bad cold, he had used a tube and ‘sucked out’ the mucus from her nose- much to the disgust of his wife. As he commented nonchalantly, *“My wife gagged and went running and I said why not, I figured it would work”*.

Men thus embraced the Other status of such work, creating a distinctive space for the practice of masculinity through meanings associated with endurance and fortitude. These meanings carry heroic qualities and sit in contrast to commonly reported feelings of disgust and fastidiousness. Many men, for example, claimed that female nurses were often reluctant to undertake such ‘dirty work’ themselves – presenting them as prevaricating to avoid the day to day cleaning, showering and bodily care of patients. As Dahle (2005) has argued, it is hard for men to construct a credible masculine identity in nursing work where male surgeons colonise the heroic and often

ignore the qualities of bodily care work of nursing staff. By presenting their abilities in 'masculine' terms and as special qualities, men may thus be helping to create a more satisfying identity.

As discussed earlier, in some contexts men have to manage their masculinity to redefine commonly held assumptions and associated meanings concerning their bodies. In the intimate care of female patients, male nurses must renegotiate meanings which commonly view the masculine body as voyeur, as part of the intrusive 'gaze' which 'invades' the private space of women and against which they require protection. One nurse commented on his midwifery experience:

*"I think the most emotionally charged situation I walked into is a woman who's in pain, who's in labour. I find I'm a man in a woman's world, I've got to establish a rapport, I've got to prove to the woman I'm not going to invade her space or take away her dignity and you've got to build up these things before they actually cost you. And a woman's at a particularly vulnerable spot when she's in labour, she's a woman in a man's world..."*

Men often engaged thoughtfully with how, as men, such intimacy should be negotiated and handled and the implications for the women concerned. Self awareness, i.e. as masculine subjects, was key to managing these situations. For the following nurse, this involved the need for respect and humility

*"..always have that respect, I suppose that slight humility that you're I suppose... you know, you're a man and you've got to be a little bit, have a little bit of humility and step back sort of allow yourself to um... not cause any aggravation".*

As Twigg (2000) has argued, nakedness in a care situation creates vulnerability which takes a special form because of the asymmetric relations between the carer and the cared for. This vulnerability is likely to be exacerbated for female patients under the nursing care of men. In this respect male nurses engaged thoughtfully with these hierarchical and gendered implications and managed their behaviour (and bodies) accordingly. This is in contrast to how female nurses reportedly see men in these and similar roles. Bolton's (2005) study of female gynaecology nurses, for example, found that in actively pursuing the ideology of the 'good woman/the good nurse' and in claiming special expertise in how they cared, women presented male colleagues as dysfunctional (as one nurse in Bolton's study commented, men are 'horse doctors', only good for treating animals) unable to attend the emotional needs of patients.

While women in Bolton's study claimed a special status as Other through their uniquely feminine qualities in the 'dirty work' of gynaecology nursing, a similar story could be told for men. Men celebrated their ability to undertake day to day bodily care of patients, contrasting their ability to deal with such work with the 'squeamishness' of male peers and female colleagues. At the same time, they engaged self consciously with gender and worked hard to 'manage' their masculinity for the female patients in their care.

### **The Marking of Male Bodies in Nursing Care**

While men may be valued for their bodies - assigned for example to work that demands physical strength or discipline - they are also 'marked' as different from the female norm. In a context which draws on essential notions of femininity, it is women's bodies that exist as the 'unmarked' case. When men enter these settings their experiences become marked as men's experiences (they are labelled 'male')

nurses rather than nurses per se) - their bodies 'matter' in these contexts in several ways.

Firstly, drawing on Connell (2000), men's bodies are out of line with their social definition. As we have seen, nurturance and care are inscribed on the 'softer' bodies of women so there is an incongruity between the meanings attached to male bodies – such as strength, independence and intelligence – and the gendered norms of nursing. These meanings can be captured by the organization and put to instrumental use, as in the cooption of men's bodies for heavy physical work, but can also cause problems for men and have implications for practices and behaviours at work. Men can thus experience their bodies as 'marked' and as 'matter out of place' (Douglas, 1966) – their body size and other masculine features sitting uncomfortably with the unmarked bodies of women. This is captured in the following quote in which a male health visitor felt the need to manage his body – to be less 'boisterous' to fit with what he perceived as the more restrained dispositions of women :

*“...I'm tall and big and unshaven and got a big scar on my face... and I think to feel comfortable in a woman's world you have to adapt yourself in many ways... For example, if I was working on a building site I'd be much more boisterous and outspoken, but working as a health visitor with a group of middle aged, middle class women I .. didn't feel able really to be myself”.*

As Dahle (2005) notes, men can be seen as intruders creating disorder in a system over which women claim jurisdiction. Male nurses are thus often fast-tracked by female nurse managers into more 'body congruent' specialties and levels of hierarchy and away from the ward (Evans, 2004). From this study, many men felt these pressures. One nurse commented in this respect:

*“There was this constant undercurrent that a. you shouldn’t be here, either because you’re a bloke or b. because you’re too intelligent and you should be a doctor”.*

Male bodies are thus ‘matter out of place’ in the nursing context. A second aspect of body incongruity concerns the association of men’s bodies with homosexuality. In this respect, the presence of men in a non-masculine role calls into question and challenges the heterosexual norm in the work place. As Dahl (2005) argues, male nurses are considered deviant through a ‘naturalised connection’ with homosexuality. All nurses in the study acknowledged this association, with sometimes painful implications for identity. As one nurse commented on the ‘downside’ of his occupational choice:

*“People who said oh, you’re a male nurse. The community in generally said oh, a male nurse must be...they considered you gay, they considered you strange; they considered you weird as to why aren’t you doing something normally and I just... I had it!”*

Assumptions of and meanings around homosexuality could have implications for the practice of nursing care. One nurse, treating a ‘bushman’ who was dying, quickly discovered that physical touching (‘pats on the back’; hands on foot’) was a ‘no-no’ and he subsequently backed off – a situation he put down to discomfort with (male) body proximity.

Men’s sexuality and masculinity are thus seen as undesirable, potentially dangerous and disruptive in some of the caring work that they are required to do. This brings us to the third way in which men’s bodies ‘matter’ in nursing - namely the sexualisation of male nurses’ touch (Evans, 2002). This can create discomfort and suspicion on the

part of patients, impacting on nurses' own perceptions of their safety while performing intimate care giving tasks, and leading Evans to refer to male nurses as 'cautious' or vulnerable caregivers. This is contrast to women's touch which is seen as harmless and non-threatening - a natural extension of her caring role. As Evans (1997) points out, the labelling of men as deviant or odd can further explain the choice of gender congruent specialisms such as mental health, because of its association with physical strength, anaesthetics because of its association with technical prowess and autonomy, and A&E because of their association with technical prowess and cool-headedness. The masculine nature of these areas is further reinforced by their lack of association with feminine nursing traits specifically the need to touch and the delivery of intimate care.

The marking of men's bodies as potentially dangerous, disruptive and problematic can have implications for how intimate care should be managed. One nurse recalled a sense of confusion over the appropriate practice and procedures when he worked in a gynaecology ward:

*“ Dealing with or working with females on surgical wards, gynae wards, my managers went through great problems to work out whether I needed a chaperone or not to do a procedure on a female patient. I thought how stupid, I'm a nurse. It doesn't matter whether you're male or female, you've got the skills and the knowledge to do a procedure”.*

All male nurses acknowledged these potential problems – often identified as an 'issue' or 'problem' relating to their masculinity - when dealing with women in their care. As the above quote illustrates, confronted with body ascriptions of danger and deviance, men resisted painful implications for subjectivity by drawing on discourses

of body integrity, captured in a language of a-gendered and a-sexual professional expertise. In this way, meanings attached to the masculine body can be rendered irrelevant through identification with a professional body and the possession of necessary skills and proficiency.

## **Conclusion**

In this paper we have acknowledged the neglect of the body in much of the work on emotional labour and we have considered the different ways in which bodies may be relevant for men's performance of nursing care. While in general terms, men may be considered to be largely divorced from considerations of the body, associated with the rational domain of the mind, this association is overturned when men undertake a non-traditional role. Here, men's bodies matter and need to be managed – so that men can create a valued identity within a 'feminized' role and to negotiate the 'marking' of their bodies in the context of care.

In these respects, men deploy meanings around the masculine body - often in a strategic manner - to perform a valued 'boundary setter' in the organization, differentiating themselves from women and helping to create a respected identity. Through countervailing practices, they also seek to diminish those meanings and attributes that are incongruent with the demands of some nursing care (e.g. reflexively managing body size; avoiding unnecessary touch). Men create a space in the Other domain of (devalued) intimate care, manufacturing a form of dis-embodiment as, positioned against the bodily experienced feelings of revulsion of female colleagues and acquaintances, they celebrate their capacities to overcome disgust and aversion. However, male bodies can also be experienced as liabilities in nursing – experienced as dangerous, disruptive and problematic in the context of a dominant heterosexual

norm. Here, some men draw on discourses of dis-embodied integrity to neutralise the implications of the sexualisation and associated dangers of their touch.

This paper has indicated some of the ways in which men's bodies are managed and marked in the context of nursing care. In so doing, it also points to how doing gender in the context of emotional labour has a bodily dimension. In other words, we do masculinity and femininity through our bodies, drawing them into displays of appropriate (or inappropriate) gender behaviour. At the same time, bodies are inscribed with meanings, beyond our control, which have implications for how we do gender and for our sense of self. As Butler (2004) has pointed out, we therefore both do and have gender done to us. Bodies are not completely our own in this respect as 'the body has its invariably public dimension; constituted as a social phenomenon in the public sphere, the body is and is not mine' (Butler, 2004: 21). The lived body, i.e. the ways in which it is represented and used in specific contexts, is an amalgam of active and passive, of doing and being done to, of signifying and signified, of making and marking - which together strongly influence how gender is performed in specific contexts. Male nurses thus 'make' or manage their bodies - drawing on traditional body ascriptions to present a particular self, telling stories of prowess and stoicism, self consciously co-opting body meanings to produce a desired effect - and negotiate the implications of the marking of their bodies in day to day practices by presenting alternative discursive positions. In short, bodies, their meanings and discursive effects as well as their day to day 'co-option' can be seen as both a process of making and marking, as well as an integral part of doing (and undoing) gender at work.

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