Male nurses and the protection of female patient dignity


Summary
Nurses need to be aware of their professional, legal and ethical responsibilities towards patients. Male nurses in particular face problems in their practice as a result of their gender and the stereotypes associated with male nurses. Such stereotypes can act as a barrier to their duty of care. This article examines the challenges associated with male nurses carrying out intimate, physical care. It discusses the ethical, legal and professional issues that male nurses should consider in relation to maintenance of patient dignity during nursing care provision, particularly in relation to female patients.

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Keywords
Discrimination, job satisfaction, male staff, nurse-patient relations, nursing image, staff attitudes

The NMC (2009a) has reported a rise in the number of nurses referred for investigation regarding their conduct and character during the past five years. Even though men comprise only 11% of the nursing workforce, Clover (2010) reported that male nurses made up 23% of referrals to the Investigating Committee panel of the NMC in 2009/10, with 42% being removed from the register.

These figures highlight a need to examine the role of men in nursing and to determine whether gender creates ethical and legal dilemmas that call into question the integrity and professionalism of male nurses. An analysis of how male nurses respond to ethically challenging clinical situations is outside the remit of this article. However, as part of an examination of why male nurse referrals to the fitness to practise panel are high, this article examines ethical, legal and professional issues in relation to the maintenance of patient dignity during care provision, particularly in relation to female patients.

Male nurses
Nursing has historically been defined as a caring profession (Maggs 1996) and caring is viewed as a feminine trait (Evans 2004). Male nurses constitute only 11% of the nursing workforce (Clover 2010). Harrison (2005) stated that the perceived talent to provide empathetic care by male nurses is viewed as praiseworthy by society and that their minority status in the nursing workforce serves to emphasise their supposed innate talent. This is in contrast to the prevailing gender stereotype of female nurses, which presupposes that nursing is a natural extension of feminine caring characteristics and, therefore, unremarkable and taken for granted (Harrison 2005). It may be that men who enter nursing are admired because they have the confidence to adopt a career that has been associated with women (Evans 2004). However, it could be argued that male nurses are in a vulnerable position by virtue of their minority status. A male nurse...
who is perceived to be rude or disrespectful is likely to be remembered by a patient and therefore more likely to be exposed to complaints. The Fitness to Practise Annual Report showed that of the nurses referred to the NMC, 22.9% were male and 68.9% were female, while the gender of the remaining 8.3% is unknown (NMC 2010a). Research by Fisher (2009) sought to explore male nurses’ approach to and experiences of intimate care. The findings revealed that male nurses can be defensive about their nursing status because of their gender. They may make more effort than their female colleagues to reduce the distress caused by intimate care because they fear potential challenges regarding their practice and abilities.

Loughrey (2008) pointed out that male nurses are often defined by their gender. The small number practising engenders curiosity about why they would choose a traditionally female profession. There is suspicion that men would only wish to undertake a non-masculine career, such as nursing, if they were interested in female nudity (Inoue et al 2006) or children (Evans 2002). The prominence in the media given to sexual crimes committed by a minority of male nurses also serves to validate this suspicion (Evans 2002).

Their minority position in the workforce leaves them vulnerable to stereotyping, for example being referred to as sexual predators and deviants (Evans 2002). Research has indicated that male nurses ascribe this stereotyping to themselves and develop ways to protect themselves when carrying out nursing care (Evans 2002, Keogh and Gleeson 2006). Such stereotyping is an obstacle to male nurses’ desire to provide nursing care and their hope of developing safe and trusting relationships with female patients (Loughrey 2008).

McQueen (2000) stated that a partnership between the nurse and the patient is essential to promote holistic and optimal clinical care. The therapeutic, trusting relationship forged between male nurses and female patients is at further risk of irreparable harm due to professional sexual misconduct of a minority of male nurses, which serves to confirm the stereotype of the male nurse as sexual aggressor. In the UK between February and October 2010, eight male nurses were found to be guilty of sexually inappropriate behaviour towards female patients (NMC 2010b).

The desire of pre-registration male nurses to receive guidance and mentorship in caring for female patients (Keogh and Gleeson 2006) suggests that they recognise the anxiety female patients may experience as a result of the nursing care provided by a male nurse. Therefore, a deeper appreciation of the emotional effect of the ethical and legal issues surrounding intimate care provision for members of the opposite sex should be emphasised in pre-registration education. The dichotomy of appearing as a carer or aggressor may be troubling to men, however much they understand and empathise with the concerns of female patients (Duffin 2006).

Fisher (2009) contends that the development of chaperone policies in health care is covertly suggestive of the potential for male nurse sexual aggression towards female patients. This may be because of the insistence by female patients, hospital employers and the NMC that female chaperones are present when male nurses provide intimate care for female patients. A female chaperone can also protect a male nurse from misunderstandings that sometimes occur when men provide intimate care for confused or emotionally distressed female patients. These individuals may misconstrue or incorrectly recall the motivation behind intimate care provision and incorrectly attribute a sexual or abusive motive to that care. This is despite best practice, clear explanations of the procedure, patient consent and exemplary conduct of the male nurse.

Problems surrounding men caring for female patients also occur as a result of cultural sensitivities and values (Davidson et al 2008). Ruddock and Turner (2007) commented that nursing care has had to address the challenge of caring for culturally diverse groups in the UK. Nurses are charged with the responsibility to provide care that is equal and non-discriminatory (Peckover and Chidlaw 2007). Cultural sensitivity and a proactive understanding of cultural competence, developed through critical self-reflection and a desire to understand the values and experiences of patients from different cultural and ethnic backgrounds (Campinha-Bacote 2002), are integral to addressing the health inequalities experienced by numerous cultural and ethnic groups (Peckover and Chidlaw 2007). Dissatisfaction arising from unjust treatment by healthcare professionals can inhibit members of ethnic populations from accessing much needed health care (Saver 2007). The reality of globalisation and the migration of people in search of work and security mean that cultural awareness is essential to inclusive care provision (Ruddock and Turner 2007). In some cultures, the idea of a man or a woman caring for a member of the opposite sex is unacceptable and would be offensive to patients and relatives (Davidson et al 2008).

Whitstock and Leonard (2003) remarked that men have featured prominently in the history of nursing. They referred to the tradition of male caring in Europe, practised by religious institutions.
organisations and monastic brotherhoods. However, members of such religious-based organisations would have taken vows of chastity, which would have gone some way to desexualising their presence and any care they might give female patients. This is in stark contrast to the experience of today’s male nurses who find the sexualisation of their nursing care a barrier to care provision (Fisher 2009). The problem of providing intimate care for women can be insoluble for some male nurses and a factor in their decision to leave the profession (Patterson and Morin 2002). Male nurses at times feel bereft of ethical support in their practice and a perceived lack of support can induce feelings of isolation and even depression (Clarke-Jones 2004, Nordam et al 2005).

Nursing law and ethics

Nurses encounter matters of ethics and law in their daily work and therefore need to be sensitive to ethical matters and ensure their nursing care meets the requirements of the patients in their charge (Jensen and Lidell 2009). Ethical sensitivity involves being attuned to conflicting moral issues such as providing intimate nursing care for a patient who may benefit from that care, but who is episodically confused and who may later protest at the care provided. Ethical practice in nursing is determined by professional codes of conduct that seek to regulate the patient-practitioner relationship using standards to which the practitioner is expected to adhere (Liashenko and Peter 2004).

Nurses are moral agents with their own values and ideas about what is right and wrong, even when guided by ethical principles intended to prevent harm to a patient. Decisions about what is the right or wrong course of action require nurses to recognise their responsibilities, the consequences and that they are accountable (Lützén et al 2006). There is no blueprint in many clinical situations, but there is an ethical requirement to act in a way that the values and preferences of patients are promoted and addressed (Allmark 2005). Professional ethical principles are intended to shape and clarify decisions about how best to care for a patient (Doane 2002).

Allmark (2005) maintained that ethical principles can evolve over time. An illustration of this would be the recognition of patient autonomy, which is now promoted above paternalistic practice and care. The attempt to address the ethical needs of patients, such as the promotion of dignity and autonomy, can sometimes be hampered by institutional practices and hierarchical rules that can lead to staff dissatisfaction with themselves and their role (Corley et al 2001).

Research by Varcoe et al (2004) based on an interpretative, focus-group model found that nurses find it difficult to navigate the demands imposed by time rationing, hierarchical struggles and biomedical models of care as they try to provide holistic ethical care. Staff explained how lack of time to focus on the patient and attend to his or her emotional and personal needs contributed to reliance on cure and technology. The nurses felt emotionally detached from their work because they felt unable to do what they believed was best for patients. Their efforts to promote patient interests were impeded as managers struggled with resource constraints and the nurses revealed that they were often ignored by physicians in discussions about patient care.

The UK adoption of the Human Rights Act 1998 in 2000 requires nurses to increase their understanding of the ethical and legal aspects of nursing care (Box 1). Section 6 states public bodies, such as the NHS, are not permitted to contravene the act.

Nurses should consider the place that the legal rights of patients occupy in their duty of care, rather than being concerned solely with ethical virtues and obligations (McHale and Gallagher 2003a). Rowson (2007) contends that most nurses have little understanding of the principles of the legal rights of patients. A study conducted

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**BOX 1**

**Articles of the Human Rights Act 1998 relating to rights and freedoms**

- Article 2. Right to life.
- Article 3. Prohibition of torture.
- Article 4. Prohibition of slavery and forced labour.
- Article 5. Right to liberty and security.
- Article 6. Right to a fair trial.
- Article 7. No punishment without law.
- Article 8. Right to respect for private and family life.
- Article 12. Right to marry.
- Article 17. Prohibition of abuse of rights.
- Article 18. Limitations on use of restrictions on rights.
by the University of Nottingham’s school of nursing involving patients and members of the public revealed that patients regard recognition of their legal rights to be an important quality of what makes a good nurse (Rush and Cook 2006).

This article considers how the Human Rights Act 1998 influences the promotion of dignity in nursing care, with particular emphasis on the care provided by male nurses.

Dignity

Dignity has become a serious issue in health care (Dignity in Care Network 2010). Numerous campaigns and initiatives have been designed to support patient dignity. The DH (2008, 2010) has called for greater attention to be paid to the concept and has launched campaigns to reinforce that message. The Royal College of Nursing (RCN) (2008a) and the NMC (2009b) have also sought to promote respect for patient dignity.

Repeated calls to recognise patient dignity in care provision may suggest that there is a lack of understanding on the part of healthcare staff of what constitutes dignity (Matiti et al 2007). Some authors have even challenged the use of the concept in nursing care (Macklin 2003). Ashcroft (2005) stated that the recurring problem in promoting dignity is that the concept is not clearly defined, therefore nor is what constitutes its promotion and infringement. Parish (2007) observed that assessing the subjective concept of dignity can easily take second place to more measurable and quantifiable aspects of care. Woogara (2005) noted that patient dignity is an important principle of holistic care protected by Article 3 and Article 8 of the Human Rights Act 1998, which cover degrading treatment and respect for privacy, respectively. The authors stated that it is nurses’ responsibility to uphold patient dignity and failure to do so is a failure of the duty of care owed to patients (DH 2008). Therefore nurses could find themselves in the invidious position of being gatekeepers of patient dignity via the implementation of various recommendations and exhortations of government and nursing organisations, while struggling with practical considerations including time and financial limitations, understaffing, high patient turnover and the target culture of the NHS (Sadler 2007, RCN 2008b). Jacelon et al (2004) pointed out that dignity, despite being regularly used in health care, remains a poorly understood and defined term. The authors stated that it is an intrinsically human characteristic that can be experienced subjectively as an aspect of oneself and expressed through conduct and attitudes that recognise and respect the humanity of others.

The use of chaperones

Wainwright and Gallagher (2008) observed that ethical concerns in health care generate public attention. In 2006, the case of a former nursing student successfully suing his local trust using the Sex Discrimination Act 1975 was reported in the national media (Carvel 2006). The student alleged that the trust barred him from conducting intimate procedures such as electrocardiogram tests with patients of the opposite sex unless a female chaperone was present, yet the chaperone was not imposed on female students and trained female healthcare staff when providing intimate care for men. Parish (2006) commented that the case highlighted the uncontroversial acceptance of unchaperoned intimate female care of male patients. Perhaps this is because nursing has been a predominantly female practice since the era of Florence Nightingale (Lou et al 2010). Keogh and Gleeson (2006) stated that the adoption of a chaperone policy is prudent. However, there is the possibility that female patients may take offence if a male nurse requests a chaperone be present. This is because the patient might believe she is suspected of being prepared to make false allegations of improper conduct against the nurse. Indeed, the patient might feel that under Article 3 of the Human Rights Act 1998, she is being subjected to humiliating treatment through the perceived insinuation that she is a wilful source of wrongful allegations. Article 3 covers the prohibition of torture but can, by extension, cover treatment that is perceived as degrading (McHale and Gallagher 2003b). Although there is no evidence to indicate that this has occurred, it illustrates how the act could be used.

There are other issues. Riordan (2004) commented that the use of chaperones can unwittingly exhibit the prevailing dominance of heteronormative values and presumptions based on the gender of the patient, so ignoring the
art & science professional issues

sexual orientation of patients who may be homosexual, lesbian or bisexual. Perhaps when informing a patient that a chaperone policy exists, rather than assuming that the chaperone should be of the same sex as the patient, the nurse should enquire whether the patient would prefer a male or female chaperone. Providing such a choice would show recognition of and respect for all sexual orientations.

Hughes (2004) raised questions including whether patients should be empowered to choose the gender of the health professional providing care for them, but also their sexuality. He also asked if the concealment and dissemblance of personal sexuality by the health professional represent breaches of patient consent and autonomy. Nurses are required to provide non-discriminatory care (NMC 2008a), however, homosexual, lesbian, bisexual and transgender patients can experience inequalities in health care because of fear of discrimination by health professionals (DH 2007). A nurse or chaperone who declines to conduct a procedure for a patient on the grounds of an objection to the professed sexuality of the patient could find him or herself open to charges of breaching the Equality Act 2006 and Article 14 of the Human Rights Act 1998, which covers discrimination.

The General Medical Council issued guidelines to doctors in 2006 advising them to use a chaperone when conducting intimate procedures with male and female patients. However, the NMC did not publish similar protocols until 2008 (NMC 2008c). The reason for the delay may lie in the fact that male nurses constitute only 10% of the nursing population and that, historically, it has been a predominantly female vocation (Loughrey 2008).

The shortage of male nursing staff would render same-sex care provision problematic should increasing numbers of male patients demand that male nurses perform their care. Quantitative research by Chur-Hansen (2002) revealed that male and female patients preferred same-sex care for intimate procedures. Using these findings, it could be argued that the low numbers of male nurses in the nursing workforce gives rise to ritualistic practice born out of expediency, whereby men are expected to accept female care. This forced acceptance is reflected in the lack of research on same-sex care (Inoue et al 2006) and ignores how male patients value recognition of their self-respect and dignity (Widäng and Fridlund 2003).

A study by Whitehead and Wheeler (2008) showed how patients valued their personal space and bodily privacy, and wanted these boundaries to be respected during nursing care provision.

For male nurses, the use of chaperones when providing intimate care for female patients is protection against any allegation of sexual impropriety (Keogh and Gleeson 2006). Sexual abuse is a criminal offence for which the offender would expect to be tried under criminal law, as well as being removed from the professional register if found guilty. If a patient declines the offer of a chaperone, this needs to be documented because only through recording the preferences of patients can nurses defend themselves should a patient subsequently object to their treatment (Kärkkäinen et al 2005). The use of chaperones safeguards the interests of practitioner and patient. However, patients may opt to decline the presence of a chaperone because of a perceived further invasion of their privacy, caused by the presence of an additional staff member (Rosenthal et al 2003).

Difficulties facing male nurses providing intimate care

Inoue et al (2006) reported that female patients experience stress when undergoing intimate care provided by male nurses. Although the presence of a chaperone is viewed as a sign of respect and protection (Sinha et al 2009), Inoue et al (2006) revealed that female patients would much prefer a female nurse to provide care. However, on some occasions this may not be an option. Dierckx de Casterlé et al (2008) commented that hospital wards are often understaffed and insufficiently resourced. Consequently, nursing considerations are adversely affected by time constraints and conflicting priorities. A request by a female patient for a female nurse may create problems for a male nurse if a female colleague cannot be found. The presence of a male nurse in a nursing team can create problems for a lead nurse when allocating duties (MacDonald 2007). However, the male nurse might reasonably argue that by seeking a female carer, he is acting as an advocate, representing the patient and advancing his or her wishes.

Duffin (2009) broached the question of whether an increase in the number of male nurses would benefit the profession. It could be argued that there is no straightforward answer, not until the ethical and legal issues surrounding male care and its impact on the running of a ward are examined. However, an increase in male nurses may create a cultural change in the profession, for example less emphasis on...
task-orientated routines and the creation of a more ethically sensitive and empathetic mode of nursing that responds holistically to the wishes of male and female patients. The move to single-sex wards further begs the question whether it would be ethically preferable and legally prudent to prohibit men from working on female-only wards.

A male nurse may find himself charged with the duty of performing intimate care for a female patient when a chaperone and female nurse is unavailable. Should a male nurse endeavour to perform the care for the female patient without offering a chaperone, he would be contravening NMC guidelines (2008c), which may then challenge his fitness to practise. Such a situation can lead to what McCarthy and Deady (2008) described as moral distress. This is where the nurse either knows that his care would be inappropriate but still attempts to perform it, or knowingly does something he recognises to be wrong due to time limitations and the task-orientated requirement to get the job done (Dierckx de Casterlé et al 2008).

Healthcare professionals are not permitted to pressurise patients to consent to treatment and procedures. Consent must be given freely on the basis of informed choice, no matter how time consuming and busy the working environment (McHale 2002). Communication with patients must be conducted in a non-paternalistic manner, which respects patients’ autonomy in decision making, thereby promoting and protecting patient dignity (Randers and Mattiasson 2004).

If a male nurse withheld the offer of a chaperone to a female patient when proposing to perform an intimate procedure, he could face a charge of battery in a civil court. This is because ‘consent’ obtained in a fraudulent or coerced manner is not valid or ethical and in this instance would lead to a form of non-consensual touching and trespass should the nurse proceed with the procedure (Miola 2009). A case against the nurse might be brought because of the causal link between the distress experienced by the patient and the wilful breach of duty by the nurse (Dimond 2008a). If the trust has a chaperone policy, the nurse would also be in breach of contract and face internal disciplinary action (Dimond 2008b). If taken to court by the patient, the nurse might try and use the Bolam Test (Bolam vs Friern Barnet HMC [1957]) to prove his or her innocence.

The Bolam Test is an assessment of culpability based on the judgement that a professional, using his or her skills in a given clinical situation, acted either in accordance with or fell short of the professional standards of their peers (Dimond 2008c). A defence of a care intervention by a male nurse which cited a lack of available female staff would be unsuccessful because a lack of resources or understaffing is insufficient grounds for defence (Lee 2002).

A male nurse who voices misgivings about his duties, working in a culture of staff shortages, heavy workloads and time limitations, could be at risk professionally (Hyland 2002). MacDonald (2007) remarked that the competing demands of a work environment can affect the moral integrity of a nurse. However, under the tenets of the Human Rights Act 1998, nurses would have the right to decline tasks by appealing to the principle of conscientious objection (McHale et al 2001).

In a situation where a procedure such as a catheterisation must be performed as a matter of urgency, and obtaining consent is impossible because the patient is unconscious, a male nurse who performed the task because there was no qualified female staff available could argue that he acted in good faith – he sought to benefit the patient by performing the procedure (Varcoe et al 2004). The nurse could use the same defence, if the patient was deemed to lack the mental capacity to make his or her own decisions under the Mental Capacity Act 2005, in response to a civil action brought on behalf of the patient by the person who had lasting power of attorney and was seeking to protect the patient’s welfare (Dimond 2008d).

If the patient belonged to a specific cultural or ethnic group which held the belief that male care of female patients is prohibited, the care provided by the male nurse would offend the cultural values held by the patient and her relatives (Davidson et al 2008). This could expose the male nurse to being accused of contravening Article 9 of the Human Rights Act 1998 as well as the Race Relations Act 1976.

Conclusion

The context in which nurses deliver care on a daily basis, in a wide range of care settings, changes constantly due to technological advances, government policy, social and cultural change, the growth in litigation, professional accountability and the need to adhere to the Human Rights Act 1998. Nurses must be aware of their professional, legal and ethical responsibilities towards the patients in their care more than ever before. The onus is on nurses to acknowledge and understand these changes and to develop their awareness of the ethical challenges that increasingly encroach and impinge on their practice.

Male nurses in particular encounter ethical problems in their practice due to their gender and...
the stereotypes that surround the delivery of care, which can act as a barrier to their duty of care. Male nurses and male nursing students are keenly aware of their predicament in relation to their gender and provision of care for female patients. The provision of guidance and support at pre-registration level regarding caring for female patients would be invaluable. Dignity should be an inviolable principle in health care and be respected regardless of the gender or sexuality of the patient. Only then can all nurses honour their duty of care and provide holistic care for patients.

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