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Original

Intersections of sex, gender, and sexuality in the caregiving practices of Colombian male nurses

Intersecciones de sexo, género y sexualidad en las prácticas de cuidado de enfermeros colombianos

Intersecções de sexo, gênero e sexualidade nas práticas de cuidado de enfermeiros colombianos

Andrés Restrepo-Sánchez[1]

Abstract

Objective: To examine the intersections of sex, gender, and sexuality to understand how privilege and stigma related to these categories influence the caregiving practices and roles of male nurses in Bogotá, Colombia. **Materials and Methods:** Interpretative qualitative research with auto-ethnographic and applied thematic analysis approaches. The study included eleven semi-structured in-depth interviews with Colombian nurses and a systematic review of the author's diary. **Results:** Despite being a numerical minority, cisgender men in nursing enjoy the privilege of their sex and gender identities, which not only allows them to avoid the glass ceiling that women face in male-dominated professions but also places them on a glass escalator of professional advancement. However, the cisgender male nurses in this study who expressed a non-normative sexual orientation at work experienced discrimination, which affected their caregiving practices and roles. In coping with this situation and maintaining their cisgender male privilege, nurses in Bogotá with different sexual orientations confront and attempt to overcome the stereotypes associated with their caregiving practices through cis-heteronormative labor and the strategic use of secrecy regarding their sexual orientation. **Conclusions:** Sex, gender, and sexuality are essential categories for analyzing the experiences of male workers in feminized professions. Intersectionality and the glass escalator are valuable theories for studying these categories. This study contributes to a better understanding of the working conditions for Colombian male nurses and highlights the need for developing diversity, equity, and inclusion policies in the workplace to reduce discrimination and establish protections for labor rights.

Keywords: Intersectionality; Social Privilege; Social Stigma; Professional Role.

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Resumen

Objectivo: Examinar las intersecciones de sexo, género y sexualidad para entender cómo el privilegio y el estigma relacionados con estas categorías influyen en las prácticas y roles de cuidado de los enfermeros en Bogotá, Colombia. **Materiales y métodos:** Investigación cualitativa interpretativa con enfoques autoetnográfico y de análisis temático aplicado. El estudio incluyó once entrevistas semiestructuradas en profundidad con profesionales de enfermería colombianos y una revisión sistemática del diario del autor. **Resultados:** A pesar de ser una minoría numérica, los hombres cisgénero en enfermería disfrutan del privilegio de sus identidades de sexo y género, lo que no solo les permite evitar el techo de cristal que enfrentan las mujeres en profesiones dominadas por hombres, sino que también los coloca en una escalera de cristal de avance profesional. Sin embargo, los enfermeros cisgénero en este estudio que expresaron una orientación sexual no

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normativa en el trabajo experimentaron discriminación, lo que afectó sus prácticas y roles de cuidado. Para hacer frente a esta situación y mantener su privilegio masculino cisgénero, los enfermeros de Bogotá con diferentes orientaciones sexuales enfrentan e intentan superar los estereotipos asociados a sus prácticas de cuidado a través del trabajo cis-heteronormativo y el uso estratégico del secreto sobre su orientación sexual. **Conclusiones:** Sexo, género y sexualidad son categorías esenciales para analizar las experiencias de los trabajadores varones en profesiones feminizadas. La interseccionalidad y la escalera de cristal son teorías valiosas para estudiar estas categorías. Este estudio contribuye a una mejor comprensión de las condiciones laborales de los enfermeros colombianos y resalta la necesidad de desarrollar políticas de diversidad, equidad e inclusión en el lugar de trabajo para reducir la discriminación y establecer protecciones para los derechos laborales.

Palabras clave: Interseccionalidad; Privilegio social; Estigma social; Rol profesional.

Resumo

Objective: Examinar as interseções de sexo, gênero e sexualidade para entender como o privilégio e o estigma relacionados a essas categorias influenciam as práticas e os papéis de cuidado dos enfermeiros em Bogotá, Colômbia. **Materiais e métodos:** Pesquisa qualitativa interpretativa com abordagens autoetnográfica e de análise temática aplicada. O estudo incluiu onze entrevistas semiestruturadas em profundidade com profissionais de enfermagem colombianos e uma revisão sistemática do diário do autor. **Resultados:** Apesar de serem uma minoria numérica, os homens cisgênero na enfermagem desfrutam do privilégio de suas identidades de sexo e gênero, o que não apenas lhes permite evitar o teto de vidro enfrentado pelas mulheres em profissões dominadas por homens, mas também os coloca em uma escada de vidro de avanço na carreira. No entanto, enfermeiros cisgêneros neste estudo que expressaram uma orientação sexual não normativa no trabalho sofreram discriminação, o que afetou suas práticas e funções de cuidado. Para lidar com essa situação e manter seu privilégio masculino cisgênero, enfermeiros de Bogotá com diferentes orientações sexuais confrontam e tentam superar estereótipos associados às suas práticas de cuidado por meio do trabalho cis-heteronormativo e do uso estratégico do sigilo sobre sua orientação sexual. **Conclusões:** Sexo, gênero e sexualidade são categorias essenciais para analisar as experiências de trabalhadores homens em profissões feminizadas. A interseccionalidade e a escada de vidro são teorias valiosas para estudar essas categorias. Este estudo contribui para uma melhor compreensão das condições de trabalho dos enfermeiros colombianos e destaca a necessidade de desenvolver políticas de diversidade, equidade e inclusão no local de trabalho para reduzir a discriminação e estabelecer proteções aos direitos trabalhistas.

Palabras clave: Interseccionalidade; Privilégio Social; Estigma Social; Papel Profissional.

Introduction

Sociologists and other behavioral scientists have employed intersectionality to comprehend how various social locations—such as class, race, gender, ethnicity, age, nationality, religious affiliation, disability, and sexuality—simultaneously influence and shape individuals' experiences in the workplace (1-6). Intersectionality is a social theory rooted in Black feminist activism and practice that identifies how identity markers can evolve into interlocking systems of oppression with multiplicative effects (7). Later popularized in academia by the legal scholar Kimberlé Crenshaw, who examined the experiences of Black women facing sexual violence and discrimination within the American judicial system (8), intersectionality has emerged as a powerful framework for analyzing power, privilege, and oppression in specific social contexts (9-10).

Privilege refers to the condition of advantage, immunity, or special rights one person or group has over others, socially conferred by birthright or a perceived

capacity, ability, or personal merit (11). Those who are privileged often remain unaware of the extent and impact of their privileges, sometimes believing that "those denied power, access, or visibility must, by definition, have earned their exclusion and oppression because of some personal defect" (11. p.243). Although privilege can serve as a powerful and beneficial tool when used appropriately (e.g., mobilizing white privilege to create political spaces for racialized groups), the special advantage granted by privilege is frequently "exercised for the benefit of the recipient and to the exclusion and detriment of others" (11. P.244). In workplace settings, privilege has been typically understood as hierarchical rank or economic advantage, but workplace privilege must also be examined in conjunction with race, sex, gender, and sexuality; "To do otherwise presumes the whiteness of women, the maleness of people of color, and the heterosexuality of everyone" (3. p.442).

This study examines the intersections of sex, gender, and sexuality in the caregiving practices and professional roles of cisgender male nurses in Bogotá, Colombia. Sex (biological descriptors associated with a person's anatomy, reproduction, hormones, and genetics), gender (cultural meanings attached to the sex assigned at birth), and sexuality (the presence or absence of erotic and affective attraction to others) are social categories created and reproduced through human action, constrained by normative discourses, and are always contested, fluid, and unstable (12). In Colombia, as in other Latin American countries, sex, gender, and sexuality operate within a binary framework (i.e., man/woman, masculine/feminine, heterosexual/homosexual), reinforced during colonial times by Catholic morality and traditional European values, which fuel systemic forms of violence (13) and overlook the existence of other identities, such as intersex, queer, gender-fluid, agender, transgender, bisexual, asexual, demisexual, pansexual, two spirits, and others. Societal norms that maintain the status quo of these binarized identity markers have proven to influence power dynamics within health institutions in the country, contributing to incidents of bullying and sexual harassment among health professionals (14-16).

This article demonstrates that homosexuality continues to be stigmatized in the workplace, a foreseeable consequence of the cultural impact of machismo that still exists in the country (17). However, rather than adopting a simplistic victimhood perspective, the analysis presented here reveals that cisgender male nurses have found ways to mobilize their sex and gender privilege to maintain a certain level of advantage over their female colleagues. This is achieved through "cis-heteronormative labor" (18) and the strategic use of sexual identity secrecy, commonly known as "being closeted" (19). The findings from this study build upon a longstanding research tradition that explores privilege and oppression arising from identity markers and social determinants in the workplace (1-2, 6, 14-16, 18).

Among these academics, Williams (1-2) proposed the "glass escalator theory" to explain how sex, gender, and race impact the social status of men entering feminized professions like nursing. According to Williams, "the most compelling evidence of discrimination against men in these professions is related to their dealings with the public" (1. p.261), which includes facing stereotypes of being weak, effeminate, and homosexuals. Men can also face challenges from sex-exclusionary policies and social prejudices that limit their access to care-oriented occupations, such as midwifery and early childhood education (1-2, 20-24). Furthermore, men know that entering a female-dominated occupation often means lowering their wages, social prestige, and power, which would not occur in a traditionally male-oriented occupation (25). As a result, men have not pursued sex-typed work as frequently as women, remaining a numerical minority in fields socially built as feminine (24). Despite these disadvantages, men do not experience the glass ceiling women face in male-dominated fields; instead, "men generally encounter structural advantages in these occupations, which tend to enhance their careers" (1. p.253).

The glass escalator theory employs intersectionality to challenge the idea that numeric minorities (tokens) are always disadvantaged in the workplace, an argument initially proposed by Kanter (6). According to "tokenization theory," social minorities in the workplace are isolated, highly visible, and negatively stereotyped, ultimately facing significant barriers to upward mobility (6). However, Williams demonstrated that tokens are not gender- or race-neutral and that white male workers in feminized professions experience invisible pressures to move ahead and occupy higher positions in the organizational hierarchy, leading them to earn higher wages and hold positions of power (1-2). This research adheres to the intersectional approach and expands the glass escalator theory by including sexuality as an additional

variable that influences privilege and stigma in occupational settings. In doing so, it reveals the limitations of essentialist views on gender privilege, suggesting that sexuality is a crucial category to consider when examining professional advancement, workplace relations, and discrimination.

Since the beginning of the glass escalator theory, nursing has frequently served as a prime example to analyze the paradoxical role of men engaging in a traditionally feminine activity: caregiving. In the mid-1800s, Florence Nightingale (1820-1910) characterized nursing as a profession most suited for an educated middle-class white woman, highlighting the Victorian gender roles of emotional engagement, empathy, respectability, and lean to care that were presumed inherent to women (23). Nursing was one of the first "respectable" options available to white women who sought or required employment at a time when they were barred from other paid jobs and from accessing formal education (20). According to Nightingale, nurses needed to be obedient and attentively listen to the orders of (male) physicians, who were deemed superior in the healthcare team due to their technical expertise and academic knowledge (23). This unequal dynamic resulted in a disconnection between curing and caring. The treatment plans devised by male physicians were regarded as superior to the vocational caring practices of female nurses (21). Presently, "much of the care provided by nurses is unrecorded, 'invisible' and could be seen as an extension of their role as caregivers" (26. p.2148). Moreover, when nurse practitioners undertake tasks traditionally reserved for physicians, such as evaluating blood tests or conducting physical examinations, they risk being perceived as lesser-skilled physicians rather than proficient nurses (27).

Importantly, the nursing profession did not begin with Nightingale, nor was she the only significant figure in the early definitions of nurses' roles. Lesser-known authors, such as the Catholic Obregonian brother Andrés Fernández and the controversial "doctress" Mary Seacole, are also important figures for nursing historians (28-29). Nevertheless, the popularity and spread of Nightingale's ideas about sex, gender, and race would lay the basis for the curriculum and practices of many nursing schools worldwide, including those emerging in Colombia. According to Suárez, when the first professional nursing programs were established in the country during the 1950s and 1960s, nurses were trained under North American pedagogical models that perpetuated mechanisms for women's subordination and instrumentalization, which were already present in other feminized jobs and tasks (30).

The "gendered hidden curriculum" that conceptualizes nursing as subordinate to physicians and an office of servitude still influences nursing education and practice today (30). As a result, nurses have sought to establish more equitable relationships with the rest of the health team through specialized training, the creation of nursing theories and models, and increased research involvement. Notably, many strategies aimed at gaining social respectability involve reinforcing values traditionally linked to masculinity, such as self-reliance, competitiveness, dominance, control, and toughness, or promoting the recruitment of men into universities and hospitals (22, 31). In Colombia, the integration of men into nursing has been gradual and initially perceived as disruptive due to a prevailing cultural belief that men cannot provide care with the same quality as women (32-33). While sex and gender have been considered in the caregiving experiences of male nurses elsewhere, sexuality remains an underexplored area. Addressing this gap, the aim of this study is to examine the intersections of sex, gender, and sexuality to understand how privilege and stigma related to these categories influence the caregiving practices and roles of male nurses in Bogotá, Colombia.

Materials and Methods

This interpretative study was developed using autoethnographic and Applied Thematic Analysis (ATA) approaches. Autoethnography is a valuable research method that robustly engages with reflexivity and values the epistemic potential of personal experience (34-35). It acknowledges that the researcher's "mind, body, instincts and intuitions, interests, emotions, experiences, perspectives, values, and beliefs" make them an ideal research instrument for providing unique insights into social life on a specific topic (35. p.4). Since the "auto-" refers to the author's subjectivity and research experience, it is important to note that I am a light-skinned, mestizo, middle-class, cisgender, gay male nurse who has worked in clinical settings in Bogotá, Colombia. After being trained as a nurse, I earned master's degrees in cultural studies and anthropology, which included a strong foundation in gender and sexuality studies.

The connection between health and social sciences has enriched my understanding of how nursing care is influenced by gender and sexuality and how these categories have shaped the power dynamics I encountered in the workplace.

A "good autoethnography" not only describes one's subjectivity and personal experiences, but also pushes us outside of and beyond ourselves to "identify, and sometimes challenge, cultural expectations, beliefs, and practices, and then, via 'thick description,' facilitate a nuanced understanding of these cultural phenomena" (35. p.3). To achieve this objective, I wrote and reflected on my own experiences of privilege and stigma while working in the pediatric and newborn units of a private hospital in Bogotá. For two years, I wrote weekly entries in personal physical diaries, which I later transcribed into virtual documents. Each entry began with "My week at the unit," a free writing exercise aimed at capturing the first thoughts and memories that came to mind about my work experiences that week. Then, I responded to questions such as: how did I emotionally feel, how did my body feel, what did I learn, what will I remember, what surprised me, and what challenged me? Lastly, I included an additional open section for "Other thoughts, memories, and comments," which did not always contain information. Diary entries ranged from 1500 to 2000 words, with the longest being 6000.

To complement the autoethnographic exercise, I conducted eleven semi-structured, in-depth interviews with Colombian nurses working in public and private clinical settings in Bogotá, Colombia. The Department of Cultural Studies at Pontificia Universidad Javeriana evaluated and approved this portion of the research. All participants were mentally competent to provide informed consent and freely decided to enroll and take part in the study procedures after reviewing and verbally accepting the consent letter. Their right to withdraw at any time was clearly stated. I conducted all interviews face-to-face, in a setting chosen by the participants where they felt safe and comfortable, ensuring a reasonable level of privacy and no interruptions. The interviews were recorded in audio format and lasted between 60 and 120 minutes. Following the interviews, I performed an emotional assessment to verify the participants' emotional well-being. Psychological first aid and mental health support were available if needed, although no participants required it. Interviewees did not receive financial compensation for their participation, and none dropped out or left the study before it concluded.

The inclusion criteria for the interviewees comprised professional nurses of any sexual identity, sexual orientation, and gender identity working in clinical settings in Bogotá who were older than 18 years old and could follow an oral interview. The research employed a purposive sampling technique to deliberately select participants with the aforementioned characteristics who could share insights about their working experience as nurses. They were chosen based on their varied ages, professional experiences, educational backgrounds, and sex, gender, and sexuality identities.

The study was developed in Bogotá, the capital city of Colombia, because it has the largest number of accredited health institutions in the country (36) and congregates professionals born and trained in different cities, providing a more culturally diverse participant sample for the research. The interviews included open-ended questions that explored the informants' past and present experiences in nursing school and the workplace, their challenges and opportunities as healthcare workers in the city, and their definitions of nursing care, sex, gender, and sexuality. I transcribed the audio recordings verbatim and shared the document with the participants, allowing them to clarify, add, or remove any statements. All participants approved the transcription in its original form, and their identities were anonymized using Roman numerals from I to XI in the order that the interviews were completed. I also translated the reflexive diary entries and interview quotes used in this article from Spanish to English.

The interview transcripts and the investigator's diary notes were coded and analyzed using ATA and the assistance of MaxQDA software (37). "Thematic analyses move beyond counting explicit words or phrases and focus on identifying and describing both implicit and explicit ideas within the data, that is, themes" (38. p.10). With the researcher's active involvement and interpretation, "Codes are then typically developed to represent the identified themes and applied or linked to raw data as summary markers for later analysis" (38. p.10). ATA involves the same first three steps of grounded theory: 1) read verbatim transcripts, 2) identify possible themes, and 3) compare and contrast themes, identifying structure among them (39). The fourth step, 4) to build theoretical models, constantly checking them against the data, is partially applied because not

all ATA leads to the production of new theories, though that does not mean that theory is not applied during data analysis.

For this study, I read all verbatim transcripts of autoethnographic diaries and interviews at least twice. Then, I organized the data into five broad themes (i.e., sex, gender, sexuality, social class, and race) based on the identity markers commonly used in intersectionality. Through comparing and contrasting this initial classification, twenty-five sub-themes emerged, with the most significant information derived from the themes of sex, gender, and sexuality. Although the results regarding social class and race are not fully detailed in this article, they contributed to the general analysis. The homogeneity of the sample on these variables may account for the limited information on these aspects (all participants self-identified as mestizos/as and came from a middle-class background). Lastly, using intersectionality and the glass escalator as guiding theories, I restructured the findings relating to sex, gender, and sexuality into four major themes for this article: 1) Homophobia in the workplace, 2) Secrecy and disclosure of sexual identity, 3) Cis-heteronormative labor, and 4) The hypersexualization of male nurses. An initial interpretation of the data is published in the author's master's thesis in Cultural Studies at the Pontificia Universidad Javeriana titled: "Nightingale's Bastard Sons: Sex, Gender, and Sexuality in Male Nursing Care Practice."

Results

Sociodemographic Information

The research sample was twelve participants, including the author (n=12). At the time of the interview, the age mean was 36 years old, with 66.6% of participants being in the age range between 26 and 45 years old. Most were born in cities like Bogotá (41.7%) and Medellín (25%), with only one participant coming from Barranquilla, Ocaña, Manizales, and Cali. The majority held only a professional nursing degree (66.7%), but two participants had specializations (16.7%), and two had master's degrees (16.7%) in nursing or health-related areas (i.e., health administration). Eight participants self-reported their sex as men (66.7%) and four as women (33.3%). All participants reported their gender identity as cisgender (100%). Half of the participants reported being heterosexual (50%), and the rest reported being homosexual (33.3%) or bisexual (16.7%). Despite being provided as options and explained at the time of the interview, none reported other sex, gender, or sexual identities like intersexual, non-binary, agender, transgender, gender-fluid, queer, asexual, demisexual, or pansexual. As mentioned in the previous section, all participants self-identified as mestizos/as and from a middle-class background (which in Colombia includes the socio-economic stratum 3 and 4).

Homophobia in the workplace

Study participants shared multiple instances of homophobia (discrimination against homosexual individuals) exhibited by physicians, patients, and colleagues. For instance, a female heterosexual nurse recounted the experience of one of her gay colleagues: "The other nurses used to laugh at him, calling him bad names like sissy or faggot" (IX) However, homophobia was not always expressed through violent language or slurs. I noted in one of my diaries: "I had been caring for this teenage boy for about a month without any issues. I recently disclosed to him that I had a boyfriend during a blood draw when he asked about my relationships. Since then, the patient has refused to let me perform any procedures or care tasks that I used to do and always requests a female nurse. I feel sad about his attitude."

Other interviewees reported discrimination during the recruitment process for new jobs. A gay male nurse who described himself as effeminate stated, "They [the recruitment team] never tell you why you're not continuing in the process. You do well in the interview and meet the job description, but you're doomed when the psychologist looks at you. My theory is that they think, 'I'm not hiring him because he is clearly gay, and he will give me problems'" (VI). The emphasis on the looks of others coincides with one of my interactions with the nurse coordinator who hired me for my first job in the newborn unit. The coordinator mentioned she liked me because I acted like a "serious nurse," which can be interpreted as conforming to a cisgender masculine persona. In contrast, the effeminate gay nurse in the previous quote was rejected for appearing "clearly gay." These statements highlight the different ways nurses perform their sexual and gender identities in the workplace and how others perceive them.

For the participants of this research, the homosexual identity (being gay) was not as problematic as the performance of mannerisms associated with femininity or

flamboyant gayness, sometimes interpreted as queerness. Referencing the case of a gay student, a female nursing professor described: "Some classmates found it very difficult to tolerate his gestures, his comments, his flourishes, his mannerisms. Patients are shocked when gay students are too effeminate; this complicates their caregiving tasks" (III). The same professor mentioned that one of her male, cisgender students "used to go to the restroom to put on some makeup after clinical practice. I told my colleagues at the time: If this had happened to me ten years ago, I think I would have beaten him up" (III). Openly gay nurses or those who perform traditionally feminine activities, such as wearing makeup, can face restrictions when performing tasks that involve touching the body, like helping someone shower or inserting bladder catheters. For example, a gay nurse narrates: "They [the nurse coordinators] told me that there was a memo from the institution stating that male nurses like me [effeminate males] could not insert [bladder] catheters in pediatrics" (II). The nurse's situation not only represents a case of discrimination but also reinforces the idea that the male nursing touch carries sexual implications, which is explained later.

As previous testimonies reveal, homophobia in the workplace can manifest as either direct or indirect discrimination. Direct forms include standardized procedures that restrict work activities, deny promotions, terminate contracts, or prevent the hiring of individuals based on their sexual orientation. Indirect discrimination may occur through a loss of credibility, acceptance, or respect from coworkers and supervisors due to sexual orientation (40). Notably, not all informants reported experiencing homophobia in the workplace. In contrast to earlier informants, a female nurse stated: "Currently, at my hospital, there has been more respect for gender differences. I have never encountered a situation where a patient says: 'Don't assign me that faggot or that mannered man to care for me today'" (I), which may indicate increasing acceptance of non-normative gender and sexual identities at some institutions.

Secrecy and disclosure of sexual identity

"Coming out" in the workplace entails a contextual and rational decision-making process that involves assessing potential benefits and risks (41). As discussed in the previous section, revealing one's homosexuality or expressing femininity can heighten the risk for male nurses of facing discrimination, job loss, verbal assaults, and physical threats. Consequently, some gay nurses may choose to "stay closeted" during work hours. For instance, one gay nurse who prefers to remain closeted stated: "I do not feel that sexual orientation should influence anything at work. It feels more like something very private that you should not bring to the ward" (V). This nurse not only advocates for separating sexuality from the workplace but also views sexual orientation as a private matter that should not be disclosed at work.

Paradoxically, the sexuality of gay nurses often remains an "open secret" due to the persistent homosexual stereotype in the profession. As one gay informant recalls: "I think the association between nursing and being gay exists because of the cultural belief that women are the ones used to care. Thus, people don't expect a man to care for others" (II). Femininity in men is frequently equated with homosexuality, although this is not necessarily accurate. As one female nurse recounted: "I asked my supervisor about the shortage of personnel in the unit. She told me they had interviewed the male nurse I recommended, but, unfortunately, he was 'too gay.' I asked her what she meant by that, and she answered: 'You know, he is very mannered, very feminine. I'm worried that surgeons won't take him seriously.' I was shocked and replied: 'You know he's married to a woman and has two kids, right?'" (VI).

The closet is not only a space where homosexuals have been marginalized and erased by binary gender politics. Darkness, silence, and secrecy can also serve as strategic tools for living alternative sexualities in the workplace, avoiding the challenges tied to exposure (42). Areas in hospitals where patients are less likely to scrutinize their caregivers—such as sedated patients in intensive care units or non-verbal patients in mental health or newborn units—can provide a refuge for gay men. One of my diary entries reads as follows: "I think I enjoy the newborn unit so much because babies have not yet learned to be homophobic. I do not feel judged while doing my job." Additionally, nursing can offer gay men the chance to engage in care labor that might face judgment in a more masculine work environment. A straight male nurse noted: "It may be that, for gay men, identifying with femininity in nursing helps them feel good about their profession. If they enjoy caring for others, they should have a space to do it" (X).

Cis-heteronormative labor

Besides staying closeted, gay nurses may combat wor-

kplace homophobia by engaging in cis-heteronormative labor, which is defined as "work performed in order to strategically manage [cisgender and] heteronormative expectations through discursive, cognitive, and emotional strategies" (18. p.535). This type of labor aligns with and reinforces the "hegemonic masculinity" expected of men in the workplace, a concept introduced by Raewyn Connell that describes a form of masculinity culturally dominant in a specific context (43). Cis-heteronormative labor in male nursing encompasses avoiding examinations of female patients, delegating tasks involving contact with women's genital areas or breasts, and refraining from visual contact or conversation with male patients while performing procedures on their genitals or during activities like assisted baths, where their bodies may be exposed (18).

Cis-heteronormative labor also encompasses activities associated with a traditional and normative sexual division of work; for example, when men engage in tasks that require physical strength while women offer emotional care and nurturing. Some examples shared by the participants include: "They look for us [male nurses] to do the physical tasks like moving stretchers, patients, and equipment, that kind of thing" (II); "I remember when I was working in the mental health clinic, they [the coordinators] selected only men to perform the clinical practice there. They preferred men for restraining patients; there were nearly no women" (IX); "In surgery, the chief nurse was a man. He managed all the administrative tasks. I believe [male] bosses are more effective at administrative work because they are better leaders [than women]" (V). The marked sexual division of labor in clinical settings may complicate nurse coordinators' efforts to assign personnel and distribute care work fairly among the health team, especially in highly sexualized tasks or areas. These findings also align with other studies investigating the distribution of male and female nurses in leadership roles elsewhere. In Spain, for instance, a descriptive study on the personnel distribution by sex in regional public health service hospitals found that despite women being the majority, their representation in higher responsibility and decision-making positions is very limited (44).

The hypersexualization of male nurses

The transfer of activities typical of heteronormative labor often fuels the misconception that a male touch always carries a sexual intention. This phenomenon is called the hypersexualization of men's touch (45). Consequently, female patients may feel uneasy about allowing physical contact with their male caregivers. When I asked a bisexual male nurse about his experiences with female patients, he stated: "When I was a student in the obstetrics and gynecology department, I had two patients who preferred a female nurse for the physical examination. We [the male nurses] were not allowed to perform vaginal examinations on pregnant women" (IV). Additionally, some patients might misinterpret routine care practices as inappropriate sexual behavior, resulting in accusations against the healthcare team and potential sanctions for male caregivers (45). Interestingly, female patients sometimes view the touch of married or older male nurses as safer than that of younger, single professionals (45), as confirmed by one of the male nurses in this study: "Female patients prefer older male nurses, maybe because of their experience, or perhaps because younger males seem like a threat to them" (X).

To avoid negative reactions in their care practice resulting from hypersexualization, cisgender male nurses become especially self-vigilant and sometimes abstain from activities involving physical touch, as one interviewee mentioned: "I decided to work in the administrative area of the hospital. As a man, you always have problems providing direct care to patients, especially women and children who may feel threatened by you. In the office, I don't have to touch anyone!" (XI). A male nurse mentioned that an elderly female patient once rejected his care because it would feel like "cheating on her deceased husband" (VIII), equating the nurse-patient interaction to a sexual or romantic encounter. Nevertheless, the sexualization of male nurses is not always perceived as threatening or harmful, as one female nurse mentioned: "Male nurses provide special care. I associate it with the moments they are courting a woman. They are more tender, detail-oriented, and gentlemanly, especially if the patient allows them to be like that" (VII).

Heteronormative labor is a tactic some male nurses use to reinforce their hegemonic masculinity and combat the stigma associated with homosexuality in the workplace. However, it often comes at the cost of hypersexualizing their touch, which creates challenges in performing basic care tasks. Importantly, hypersexualization increases when it intersects with race. For instance, Black individuals are often perceived as hypersexual and sexually threatening. In Colombia,

Afro-descendants are frequently portrayed as hypersexual and licentious, jovial, uninhibited and libertine, primitive (folklorized), and violent (46). While all participants in this study identified as mestizos, some noted that Afro-Colombian nurses might face additional challenges when caring for white female patients. These findings should be further explored with a more diverse sample. A summary of the main themes and significant quotes derived from the categories of sex, gender, and sexuality can be found in Table 1.

Table 1. Sex, gender, and sexuality main results

Major Theme	Significant Quotes
Homophobia in the workplace	• "I have never encountered a situation where a patient says: 'Don't assign me that faggot or that mannered man to care for me today'" (I. Straight female nurse born in Cali and working in the Surgical Department) • "Some classmates found it very difficult to tolerate his gestures, his comments, his flourishes, his mannerisms. Patients are shocked when gay students are too effeminate; this complicates their caregiving tasks" (III. Straight female nurse born in Medellín working as a teacher) • "If this [a male student using makeup] had happened to me ten years ago, I think I would have beaten him up" (III. Straight female nurse born in Medellín working as a teacher) • "My theory is that they think, 'I'm not hiring him because he is clearly gay, and he will give me problems'" (VI. Gay male nurse born in Ocaña and working in the Emergency Room) • "The other nurses used to laugh at him, calling him bad names like sissy or faggot (IX. Straight female nurse born in Bogotá and working in mental health) • "[Since I told him I was gay] the patient has refused to let me perform any procedures or care tasks that I used to do and always requests a female nurse. I feel sad about his attitude" (Author's field diary)
Secrecy and disclosure of sexual identity	• "I think the association between nursing and being gay exists because of the cultural belief that women are the ones used to care" (II. Gay male nurse born in Bogotá working in adult care) • "I do not feel that sexual orientation should influence anything at work. It feels more like something very private that you should not bring to the ward" (V. Gay male nurse born in Bogotá working in the Intensive Care Unit) • "She [my supervisor] told me they had interviewed the male nurse I recommended, but, unfortunately, he was 'too gay.' I asked her what she meant by that, and she answered: 'You know, he is very mannered, very feminine. I'm worried that surgeons won't take him seriously'" (VI. Gay male nurse born in Ocaña working in the Emergency Room) • "It may be that, for gay men, identifying with femininity in nursing helps them feel good about their profession. If they enjoy caring for others, they should have a space to do it" (X. Straight male nurse born in Medellín working in orthopedics) • "I think I enjoy the newborn unit so much because babies have not yet learned to be homophobic. I do not feel judged while doing my job" (Author's field diary)

Cis-heteronormative labor	• "They look for us [male nurses] to do the physical tasks like moving stretchers, patients, and equipment, that kind of thing" (II. Gay male nurse born in Bogotá working in adult care) • "In surgery, the chief nurse was a man. He managed all the administrative tasks. I believe [male] bosses are more effective at administrative work because they are better leaders [than women]" (V. Gay male nurse born in Bogotá working in the Intensive Care Unit) • "I remember when I was working in the mental health clinic, they [the coordinators] selected only men to perform the clinical practice there. They preferred men for restraining patients; there were nearly no women" (IX. Straight female nurse born in Bogotá working in mental health) •"I was always assigned to teach fathers about how to care of their babies. The female collages were in charge of teaching moms about breastfeeding. It didn't matter that I was also trained in breastfeeding counseling, this was an implicit female-only task in the newborn unit" (Author's field diary)
Hypersexualization of male nurses	• "I had two patients who preferred a female nurse for the physical examination. We [the male nurses] were not allowed to perform vaginal examinations on pregnant women" (IV. Bisexual male nurse born in Manizales working in maternity care) • "I associate it [male nursing care with the moments they are courting a woman. They are more tender, detail-oriented, and gentlemanly, especially if the patient allows them to be like that" (VII. Bisexual female nurse born in Bogotá working in epidemiology). • "An elderly female once rejected my care because, according to her, it would be like cheating on her deceased husband" (VIII. Straight male nurse born in Bogotá working in adult care) • "Female patients prefer older male nurses, maybe because of their experience, or perhaps because younger males seem like a threat to them" (X. Straight male nurse born in Medellín working in orthopedics) •"As a man, you always have problems providing direct care to patients, especially women and children who may feel threatened by you" (XI. Bisexual male nurse born in Bogotá)

Discussion

This study examined the intersections of sex, gender, and sexuality to understand how privilege and stigma influence the caregiving practices and roles of male nurses in Bogotá, Colombia. Despite being essential categories for understanding social dynamics in the workplace, studies on gender and sexuality focused on men have been neglected and underdeveloped in Colombian nursing research, with a few exceptions of peer-reviewed articles (32-33, 47) and theses (15-16). In addressing the case of male nurses, some argue that men face discrimination for being a numerical minority in a highly feminized profession. However, reviews on the issue suggest otherwise (48). When applying the glass escalator theory, it becomes clear that cisgender male nurses with different sexual orientations maintain their masculine privilege and benefit from it. Contrary to Kanter's tokenism theory, "While women tokens find that their visibility hinders their ability to blend in and work productively, men tokens find that their conspicuousness can lead to greater opportunities for leadership and choice assignments" (6. p.7). In Colombia, for example, male nurses make up less than 10% of the nursing workforce (49) yet disproportionately occupy leadership roles and earn higher wages, as also occurs in other countries (44, 50).

The advantages that cisgender male nurses reported

from their masculine privilege were similar to those identified in other studies. These include easier interactions with patients and coworkers, an assumption of greater competence and skills compared to their female colleagues, and the ability to avoid "dirty work" typically assigned to lower-ranking female nurse assistants (23). Men also tend to take fewer breaks during their careers due to family obligations, making them more favorable for career advancement. In contrast, women reported utilizing flexible work arrangements to manage motherhood, household responsibilities, and family obligations, which has been documented in other studies (51). This situation undermines women's career prospects and renders them less competitive for promotions.

As described in the introduction, studies on male privilege in nursing and other feminized professions have often focused on sexual and gender identity, overlooking how other variables like race, social class, or sexuality operate in the workplace. This research showed that sexual orientation is crucial to analyze next to sex and gender expressions for a better understanding of male privilege and stigma in the workplace. Like other investigations, this study found that societal expectations for hegemonic masculinity are not limited to cisgender heterosexual men. Proof of that is that some participants, including gay men and women, reported negative attitudes toward effeminacy and femininity, rejecting the possibility of men performing activities and roles traditionally associated with women in Western societies (52). Tim Bergling defines this rejection of femininity as "femiphobia" or "sissyphobia," a situation equally found in men of various sexual orientations and racial backgrounds (52). Sissyphobia, also present in this study, should be considered part of a structural system of homophobic practices in the workplace, which includes differences in wages, experiences of continual harassment, and challenges in accessing fundamental employment rights (40, 53-54).

To multiplicate the benefits and privileges of cisgender masculinity, avoid discrimination, and maintain their position on the glass escalator of professional advancement, male nurses participating in this study —including those with non-normative sexual orientations (i.e., bisexual and homosexual)— developed strategies to separate themselves from femininity and align with cisgender masculine heteronormativity. These strategies included performing heavier physical work, leading administrative tasks, and distancing themselves from areas commonly associated with women, such as obstetrics, pediatrics, and newborn care, which are common findings in similar studies (3, 6, 55). This research also showed that these efforts to manage the stigma associated with non-normative sexual orientations and gender expressions contribute to an unequal distribution of labor and specific placement of nurses within the hospital. The gendered and sexualized geographies that emerge from this phenomenon warrant further analysis, particularly using quantitative methods to examine the distribution of male nurses in various hospital areas and roles (22, 25, 44).

Cisgender men experience barriers when attempting to advance in the glass escalator that are derived from their race, sexual orientation, or socioeconomic level. This situation underscores that intersectionality is vital when analyzing their workplace status. Some gay and bisexual men in this study concealed their sexual orientation to shield themselves from discrimination and "pass" as cisgender heteronormative male individuals, a strategy that Black male nurses in Wingfield's study could not adopt with their race (6). Gay and bisexual male nurses constantly grappled with the decision of whether to be in or out of the closet at work, an exhausting process that other authors have termed "the queer battle fatigue" (56). The closet has been characterized as the structure that defines gay oppression in this century (19), a space that normalizes and confines sexuality, perpetuating heteronormativity and imposing emotional, health, and cognitive burdens (57). For some nurses, the closet may not even be a viable option, as there is a prevalent cultural association in Colombia between male caregivers and homosexuality.

Notably, some of the gay participants who openly displayed a non-normative sexual orientation faced workplace discrimination, challenges in forming connections with colleagues and supervisors, and were viewed as less capable of providing qualified care, ultimately diminishing the benefits of the glass escalator they hold as cisgender men. Discrimination based on sexual orientation is always context-specific, and in Colombia, it is driven by machismo and traditional gendered divisions of labor (13, 17). This situation may not be applicable in other countries, which highlights the need to replicate this study in different geographical and cultural contexts. Additionally, further research should examine how social class, ethnicity, nationality, and

other social identities are contested, obscured, and embraced in nursing training and practice, and how these intersections impede or facilitate professional advancement.

Similar to other studies, cisgender male nurses in this research reported that patients might misinterpret their care practices as sexual threats. This perception stems from cultural conceptions of hegemonic masculinity as violent, libidinous, and possessive —traits that are amplified when associated with specific racial and socioeconomic backgrounds, as previously noted (14, 45-46). In this context, Evans (45) outlines six strategies that cisgender male nurses utilize to navigate heteronormative labor demands: 1. Taking time to build trust before touching; 2. Maintaining a degree of formality; 3. Projecting a "traditional" image of nursing (including the white uniform); 4. Working along with female nurses; 5. Delegating tasks that require intimate contact with female patients; and 6. Modifying procedural techniques to minimize patient exposure and intimate touch. Notably, these strategies originated from a study on Canadian nurses and may not always be effective in the Colombian context, where nurses face work overload and burnout conditions that limit their time and flexibility during nurse-patient interactions (58).

Ideally, further research on male privilege and discrimination at the organizational level should encompass a wider sample with increased diversity in sexual identity, gender expression, sexual orientation, social class, educational level, race, and ethnicity. This study's limitations include the absence of perspectives from additional non-normative sexual identities, gender expressions, and sexual orientations, such as intersex, transgender, and asexual individuals. The sample's homogeneity concerning socioeconomic background and race also limited the ability to perform a more thorough intersectional analysis that would include these social categories. Future studies should examine how and why individuals select one professional path over another and the various stereotypes that influence those decisions and subsequent work experiences. Finally, since "the glass escalator effect may be a complicated amalgam of racial, gendered, and sexual expectations and stereotypes" (6. p.23) and intersectionality always allows us to make new theoretical connections, additional studies are essential to broaden and apply these theories.

Conclusions

Studies like the one presented here contribute to informing inclusive and respectful nursing care practices and orient the development of diversity, equity, and inclusion (DEI) policies in the workplace. These policies are essential for establishing labor rights protections and reducing discrimination based on sex, gender, sexuality, race, social class, and other identity markers. Privilege in nursing work environments often enables the advancement of some groups at the expense of others, which can lead to discrimination and emotional distress for certain workers, ultimately diminishing the quality of care provided in clinical settings. Discrimination in the workplace and the negative use of privilege also harm patients by creating emotional distance between them and their caregivers, imposing restrictions on who can perform specific caring tasks, and fostering a tense recovery environment.

This study showed that cisgender male nurses who openly express a non-normative sexual orientation at work risk losing the privileges associated with hegemonic masculinity, which would otherwise facilitate their movement along the glass escalator of professional advancement, even when they are a numerical minority in the discipline. To avoid the glass barriers and the stigma stemming from this situation, the male nurses in this study strategically used the closet and performed cis-heteronormative labor. These mechanisms allowed them to continue enjoying some of the privileges of hegemonic masculinity in the workplace while maintaining an authoritative cisgender masculine heterosexual presence. However, some of these practices directly impacted their caregiving practices, roles, and opportunities within the health team. Negative consequences included the hypersexualization of their touch, the unequal sexual and gender distribution of labor, and the inability to establish closer emotional relationships with their patients.

Colombian male nurses who identify as members of the LGBTQ+ community engage in complex processes of self-advocacy and identity negotiation, navigating multiple layers of social, cultural, and professional dynamics. These nurses challenge traditional gender norms and strive to redefine their roles within both the healthcare system and society at large, advocating for inclusion and equity through both overt actions and

subtle, everyday interactions. Their experiences illustrate that identities are not fixed; rather, they are fluid and continuously reshaped by factors such as time, space, and context. The intersectionality of their sex, gender, sexuality, and professional identities evolves in response to societal attitudes, workplace policies, and personal experiences, underscoring the need for a dynamic understanding of how marginalized groups assert their rights and negotiate their place in the world. As such, the identities of Colombian nurses must be viewed as a process of ongoing transformation, one that reflects the interplay between individual agency and structural influences.

Conflicts of interest

The author declares no conflicts of interest related to the publication of this article.

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