



Power Dynamics within Icelandic Nursing: Walking the Fine Line¹

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ABSTRACT

Like other Nordic nations, Iceland has a reputation of gender-equality, despite 98% of the country's nursing profession being women. This paper examines power dynamics within the profession. Fifteen semi-structured interviews with nurses were analyzed with a thematic analysis. Our theoretical framework draws on an ecological perspective highlighting nurses' vulnerability to power dynamics, and Allen's work on organizational labor and the invisibility of nurses' 'glue work'. The findings reveal that the nurses experience power imbalances when their autonomy is restricted in cooperation with other professionals, demanding their time and disrespecting their professional workspace, and they miss support from their supervisors. They feel their professionalism is belittled, and that the gender imbalance hinders equality. For coping and meeting norms and expectations, the nurses use silencing, which with time pressure and unclear boundaries preserve and enhance stereotypical images. Attracting more male nurses could enhance equality, but additional effort at multiple levels is needed.

KEYWORDS

Gender equality / management / occupational health / organizational labor / power dynamics / professionalism

Introduction

The shortage of nurses in Iceland is a longstanding situation, even though foreign workers have brought some temporary relief (Icelandic Ministry of Health 2020). The Covid-19 pandemic has brought the issue up again with nurses being called in from their summer break to work in acute hospital wards. Their contribution has been honored and applauded for, but as Wood and Skeggs (2020) argue, the re-evaluation and appreciation of care labor takes more than clapping. The nursing work environment is a challenging one, the strong hierarchical organisational structure of the hospital and chronic retrenchment, with staff shortages and increased workloads, lead to high workloads, occupational stress, poor job satisfaction, burnout, and high turnover rates (Brynjólfssdóttir 2018; Donnelly 2014; Happell et al. 2013; Johnson 2011; Lu et al.

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2019; Marc et al. 2019; Simard & Parent-Lamarche 2021). Within the nursing profession, there has been a call for stronger leadership, mutual trust (Salmi et al. 2020) and supportive and embracing management (Hølge-Hazelton & Berthelsen 2021; Simard & Parent-Lamarche 2021), but the position of nursing within the healthcare field, defined by power imbalances, makes this a challenging task. As trained nurses are sought after in the labor market, they have little difficulty finding alternative employment. In that way, they also get rid of moral distress when facing ethically difficult situations and not having appropriate managerial support when institutional constraints make it impossible to provide the desired patient care (Hart & Warren 2015; Kristoffersen et al. 2016).

Nursing has indeed long been linked to the meaning of vocation and altruism, where the need to help and care for others is considered one of the most salient attributes of the professions' identity (Carter 2014; Kenny 2010). Altruism is then associated with a genuine desire to alleviate another's suffering (Eley et al. 2010), and to put the needs of others before one's own (Kubsch et al. 2021). The concepts of vocation and altruism are still contrasted to professionalism and paid employment today (Slettmyr et al. 2017). Professionalism is commonly established by a list of traits, among which are included *possession of a distinct body of knowledge; esoteric skills; occupational control over qualification; a code of ethics; a corporate body or association; [and] social prestige* (Hugman 1998:180). The more traits the profession lives up to, the higher it can be placed on the ladder of professionalism. The field of nursing has been struggling with creating its own distinct position as it shares the field with the medical profession. This situation, in which vocation and altruism are not recognized as professionalism traits, creates a paradox between the professional self-image of nurses as a key player in the health care system and the public display of nursing through stereotypes (Girvin et al. 2016), such as being trained handmaidens to physicians. While it has been argued that defining nursing as 'new professionalism' could be a solution to this problem (Davies 1995), as long as caring is seen as feminine and professional advancement and assertiveness characterized as masculine, there is a conflict between being in a profession and being a female nurse (Apesoa-Varano 2007; Burton 2020; Zhang & Liu 2016).

The feminised construct of care may also well be what is discouraging men to start a career in nursing, accounting for the low numbers of men in the profession. They are frequently stigmatised and distrusted, by colleagues and clients, and there is the pressure to adapt to the existing female-dominated culture. As they are often considered to lack the necessary female skills for nursing, many of them choose to seek employment elsewhere (Warming 2013).

Attempts to increase the number of male nurse students in Iceland by taking care of their school fee (an experimental project run since 2018) have so far not led to a turnaround (Icelandic Ministry of Health 2020), indicating that the inequality runs deeper than paying the school fee.

Although nurses have gradually come to be viewed as professionals, they have been slow in representing their responsibilities and expertise possibly because of their socialization to the female role (Marquis & Huston 2017). This is considered damaging to their professional identity, status, and societal perception (Gill & Baker 2019), as it keeps the social construct of the nursing identity in place. While hierarchies in health care offer stability, predictability, and productivity, the behaviors can become gender unequal and arrogant. This reinforces the image of nursing as women's work with enduring views of subordination, having no professional mandate, and being in a subservient

role to physicians. It is often a barrier to interdisciplinary collaboration, and can directly affect patient care while undermining the role of the nurse (DiPalma 2004).

Cingel and Brouwer (2006) argue that nurses reinforce some of the stereotypes by setting unclear boundaries in their physical and psychological working space, and by simultaneously attempting to control and define their workspace and their role within it as their 'expert' field (Curran 2006). Skeggs (1997) holds that because women in female-dominated and suppressed groups have limited access to power in the gender relations of the organization, they use and stage their femininity as social capital, in tactical rather than strategic ways (Skeggs 1997). Many nurses have been reluctant to participate in that fight with feminists, partly because feminists have kept up the image of nurses as submissive, having ideological problems, and their work as a manifestation of oppression and sustained by hierarchical structures. Therefore, the gendered side of power relations is of importance when investigating institutions and professions (Green 2012). In this article, we will be focusing on power dynamics, which we define as the manner in which power differences display itself within a certain setting, in this case the nursing work environment. Related to this are gender imbalances which Connell (1987) describes as a part of the social norms, historical praxis, and political policies, which are deeply rooted in a society and institutions.

Theoretical perspective

In our theoretical framework, we draw upon an ecological perspective (Johnson 2011), which emphasizes that the profession of nursing is embedded and connected to multiple systems at different levels, which makes it vulnerable to power dynamics. Scholars have identified the nursing profession as 'doubly oppressed' as gender imbalances exist as part of social norms, historical praxis, and political policies that are deeply rooted in society and institutions (Connell 1987) as well as because of their socialization as nurses (Roberts et al. 2009).

Societal, organizational, departmental, and individual factors keep power dynamics in place and contribute to the way in which nurses are experiencing their work environment. A strong hierarchical organizational structure and chronic retrenchment, with staff shortages and increased workloads, are found to negatively effect the work environment (Johnson 2011). Moreover, Hutchinson et al. (2010), by drawing on Clegg's circuit of power framework (1989), explain the complexity of power dynamics within the nursing profession by conceptualizing power as flowing between interacting circuits of microlevel interactions, and organizational routines, rules, regulations, and incentive systems. As a result of the power imbalances, Roberts et al. (2009) have argued that as an oppressed group within the larger system, nurses tend to turn their anger and frustration to their own group members. This behavior has been identified as horizontal violence (Fanon 1967) and is explained by a mixture of inability to confront the authority directly, fear, and low self-esteem. In the same meta analysis (Roberts et al. 2009), nurses are found to use both silencing and passive aggressiveness in order to cope with the oppressive situation and to avoid conflict (DeMarco 2002).

We also draw on Allens's (2015) approach of organizational labor. She argues that while nurses are focal actors in health systems, much of their work is undervalued and invisible due to nursing's gendered nature and power relations in their workplace. Allen



acknowledges and legitimizes organizational labor as a part of nurses' work, and argues like Roberts et al. (2009) that elements of nursing are in need of revision. The focus on nurses' holistic treatment of patients based on the knowledge of individual patient care needs is often contrasted with the centrality of the physicians' 'cure' discourse. When nurses perform tasks that overlap professionally, this work is less visible because of nurses lower status to physicians (Allen 2015:143), although the treatment/care divide is often unclear and more symbolic than functional. Therefore, to conceptualize nursing primarily as care-giving creates an unhelpful identity, as it disempowers the importance of organizing work of nurses. To a significant extent, nurses do organizational work and a wide range of background activities other than direct care delivery (Allen 2015:xi). Coordinating relevant information, network building, and safe patient flows throughout the hospital and beyond is largely invisible and undervalued work (Allen 2015:3). This work is often referred to as the 'glue' in health care systems and has not been noted at a policy or strategic level, considered a bureaucratic exercise or 'paperwork' meant to distance nurses from their 'real jobs'. The aim of this article is then to examine the power dynamics within the Icelandic nursing profession and relate it to existing theoretical perspectives and literature on power imbalances.

The situation in Iceland

Like other Nordic nations, Iceland has a long tradition of democracy and egalitarianism, with women supposedly participating in the workforce in the same way as men. Values of gender equality are important in theory but may be overshadowed by actual behaviors, creating the illusion of equality (Sund 2015), or what Pétursdóttir (2009) has referred to as the aura of gender equality. Recent COVID-19 related studies have indeed been pointing toward a backlash in equality development in Iceland (Iceland's Directorate of Equality 2021). Notably, 2% of nurses in Iceland are males (The University of Akureyri 2021). This is very low in comparison to, for instance, the situation in Norway, where in 2021, about 10% of nurses were men (Statistic Norway 2021). While the literature does not provide many clues on why this is the fact, data from Statistics Iceland (2021) show that Norway invests a higher percentage of its GDP on health care than Iceland does. The same accounts for the UK, which also employs more men (11%) in nursing positions (Farrah 2021) than Iceland. Nursing in Iceland has been taught at the university level since 1973, with a Bachelor of Science degree earned after 4 years or a Master of Science degree after 6 years (The University of Iceland 2021). The places for the program are however limited (The University of Akureyri 2021; The University of Iceland 2021). Iceland's alleged high standard of gender equality in the global context, examined by the Global Gender Gap Index (World Economic Forum 2021), is explained by its successful women's rights movement and solidarity campaign against discrimination (e.g., sexual harassment and abuse) and for women and men sharing power and decision-making. Considering the gender bias in the nursing profession, it is of relevance to keep these Index results in mind when it comes to the equality experiences of nurses in Iceland, not in the least regarding feelings of well-being. Various studies reveal that women value their health condition less than men do, and the traditional attitudes toward gender equality and gender roles may have something to do with this (Tesch-Römer et al. 2008).

Method and data collection

The data are derived from 15 semi-structured interviews with nurses in Iceland conducted in 2019 and 2020. Through the lens of social constructionism, we examine how the professional identities of the participants are constructed and how they give meaning to their gender-related experiences. Social constructs can be so ingrained that they appear as natural constructs instead of being shaped by cultural and historical contexts. According to Crotty (1998), meaning and truth are constructed through our interactions with the world, meaning is created but not discovered. In this way, an agreement is reached on the reality of certain social interactions and contexts. No one meaning is therefore truer than another one and individuals give different meanings to their experience of the same phenomenon. The mutual understanding that develops within the study derives from individual experience, values, culture, and circumstances of both participants and researchers (Crotty 1998).

The study was introduced in two closed Facebook (FB) groups for nurses with about 3500 members each. It was described as a study of the working conditions and health of nurses, and nurses interested in taking part in the study were encouraged to contact one of the researchers through FB Messenger or by phone. Fourteen nurses initially responded of whom 12 participated in an interview. Three more participants were recruited by snowballing. The interviews were conducted outside the workplace, within the participant's or the researcher's home, whatever place was preferred by the participant. It was a part of acknowledging and respecting their contribution to knowledge, and a way for building trust. For some, it was convenient to come to the researcher's home after dayshift, as it is located near their workplace. None had the facility for privacy in their workplaces. Conducting the interviews in the participants' homes was for some because of their health reasons, and others just invited the researcher into their homes, and offered coffee and cakes. The interviews lasted between 1 hour and 2 and a half hours. The interview frame revolved around topics such as why they were interested in taking part in the research, the reasons for going into the nursing profession, career development, the work environment, collaboration, how they thought they managed their professional duties, and working in a female-dominated profession. The interviews were recorded and transcribed verbatim. To protect the participants' anonymity, they were given pseudonyms. In small societies like Iceland, anonymity can be a delicate issue, but the relatively large nursing population in this case reduced the likelihood of being exposed. Only the two researchers had access to the data. The participants gave their written informed consent, and they were informed about their right to withdraw from the study at any time without further explanation.

Ten participants were women and five were men, with an age span between 25 and 65 years (See also Table 1). Twelve participants worked at hospitals and three in related fields. All participants had nursing experience in acute care wards with critically ill patients, and they were all occupied for 60% or more. Ten had management experience, and seven hold master's degrees or other further studies providing a degree. Three nurses were about to retire or change to less straining jobs because of health reasons. At the beginning of the interviews, the participants were asked why they were interested in taking part. All of them, whether they had managerial experience or not, shared that they had some experience of lack of support from their supervisors and wanted to contribute to knowledge by telling about it. A common opinion was that the issue is neglected and should be investigated.



Table 1 An overview of the participants

	Age 25– 30	Age 30– 35	Age 35– 40	Age 45– 50	Age 55– 60	Age 60– 65	Work ratio %	Retiring = R Disability = D Illness = I	Years of work	Master's degree/ diploma	Management experience Before = B Now = N
Annie						X	100	R, D, I	40		
Betty				X			100		20	X	N
Carl					X		100		25		N
Carly		X					60		5		
Dave			X				100		15	X	N
Debbie						X	80		40		
Eve		X					80		10	X	B
Fay						X	100	R, I	40	X	B
Grace					X		80		40	X	B
Helen						X	80	R, I	40	X	B
Irene		X					80		10		
Joe	X						100		5		N
Josie	X						100		2		N
Steve		X					100		5		
Tom						X	80	R	35	X	N

Data analysis

The data were analyzed using thematic analysis in six steps, outlined by Braun and Clarke (2006). The purpose was to look for core expressions and themes, describing participants’ shared experiences, keeping in mind the research aim and theoretical framework. For analyzing qualitative data, thematic analysis is a useful research tool, as it offers an accessible and theoretically flexible approach to analysing and has the ‘potential to provide a rich and detailed, yet complex account of data’ (Braun & Clarke 2006:78). The transcribed interviews were read with focus on becoming familiar with them and to look for possible patterns, and writing down first ideas. Codes of interest for the purpose of the article were created from the participants’ stories. There was also a progress in the interviews; the first interviews gave rich information of interactions with other professionals, and codes identified were, for instance, *interruptions*, *work-load*, and *devaluation*. Although these concepts occurred more or less in all of the interviews, they became more focused on strategies the nurses use for setting boundaries and defending their working space, literally and metaphorically. This gave codes like *enduring* and *compromising*. Themes were gradually formed, refined, given names, and reviewed to examine how they support data (the experiences of the participants) and



whether the analysis was in line with the research question and theoretical perspective. Power dynamics turned out to be a recurrent theme, manifested in how nurses prioritise their work and try to make compromises to keep the peace, and adapt to the working culture. This will be discussed in the finding section through the following subthemes: time management, space as a disciplinary tool, lack of support and advocacy, the invisibility of the profession, gender imbalances as a disability, and compromising and enduring the traditions.

The study can be labeled as intimate research (Taylor 2011), as Klara has an extensive background in the nursing profession. For investigator triangulation, the role of Thamar was to apply a more detached mode to the data analysis. In this way, we believe we are optimizing the credibility of the study.

Findings

As being part of a female-dominated profession, the nurses experience that they are caught up in power relations stifling their professionalism. Fighting against this situation is perceived as extra workload and a contrast between the nurses' professional vision and the working culture. They experience power dynamics regarding time management, their actual physical working space, a lack of support and advocacy, and the invisibility of much of the gluework they take care of as a profession. The participants also describe how they prioritize their work in the busy environment to defend their professional and ethical obligations, and compromise to fit accepted gendered organizational norms and expectations. This can happen against their own sense of justice. Being conscious of these contradictions, they try to resist these, while anticipating gender equality. It can be tricky to navigate through the day in this complex system of hierarchies and traditions. Table 2 gives an overview of the themes, codes, and quote example, while these will also be discussed in more detail here below.

Table 2 Themes, codes, and quote examples

Theme	Definition	Codes	Quote examples
Time management	Not having enough time to meet professional standards, unreasonable demands and daily work circumstances force the nurses to prioritise their clients' safety and neglect other duties	Danger, anxiety, workload, exhaustion, powerless	– I have to keep danger away, there is nobody else – We eat on the run – Like the whole hospital is a slow-motion train crash – There is always something left
Space as a disciplinary tool	The nurses' working space is not clearly recognised by other professions, nurses are seen as accessible and responsive at all times	Interruptions, strain, mistakes, distraction, disrespect, frustration	– Like it is always okay to interrupt you – I am still learning to build up the courage to say no

(Continued)



Table 2 (Continued)

Theme	Definition	Codes	Quote examples
Missing support and advocacy	The participants love their job and care for their clients, but miss having a trusting relationship with their supervisors. This increases the sense of being rejected and not worth much	Sadness, rejection, disloyalty	– I can't let it destroy me. So, I quit – I just feel that I made a terrible mistake reporting it
The invisibility of the profession	The nurses' academic discipline and professional opinion is not always recognised or appreciated	Justifying, defending, prejudice, belittled	– I know nurses who have been asked if they did not have the ability or brains to be a doctor. – I was so naïve to believe that my supervisor and the manager were idealists, thirsty for new knowledge
The gender imbalance as a disability	A female-dominated profession is seen as having flaws and hindrances for development and for the team spirit. Fixing the gender imbalance is considered crucial for a healthier working culture and to empower the profession	Complaining, gossiping, backstabbing, female sacrifice, oppressed, avoid conflicts	– Somehow, the men have the freedom and licence to express themselves more uninhibitedly than women have
Compromising and enduring the traditions	The nurses realise that they must adjust and compromise, often against their own sense of justice; a conscious strategy meant to save energy, protect professionalism, create a positive mood, and avoid conflicts	Compromising, saving energy, balancing	– The biggest challenge is to keep up the positive energy and professional interactions with dignity – This is not my job

Time management

Allen (2015) argues that nurses are focal actors in health systems, but emphasizes their tough and long-lasting undervaluation due to power relations in their workplace. This becomes apparent when the participants describe the scope they have for fulfilling their professional standards, which is limited by lack of time. Daily work circumstances force the nurses to prioritize their clients' safety and neglect other duties: 'Even though I just do the necessary things, there is always something left' (Carly). As Johnson (2011)

explains, the way the nurses' work is organized, their placement in the system, and their connecting role makes them vulnerable to expectations and escalating workload. Some participants have tried to address the workload with their supervisors, but often hit a dead end, as complaints of working conditions are disregarded: 'It is extremely difficult to be the one who swims upstream and speaks the truth; such a nurse is too difficult for the supervisor' (Eve). While the organizational culture neglects the nurses' professional mandate and obligations, the nurses are caught between management decisions and work ethics. They consider the psychological contract (Gupta et al. 2016) a breach, and not a mutual obligation, where there should be given respect and develop mutual trust with their employer. Roberts et al. (2009), however, explain the marginal position nurses in management positions find themselves in. In order to create the change, they feel they need to identify with the dominant group, but by doing so, they create a distance between themselves and the other nurses, which leads to what some of the participants describe as breach.

Due to staffing shortage, the nurses prioritize their clients' needs over their own, which literally eats up their time: 'We eat on the run, and sometimes not at all. There is no time' (Josie). The nurses describe how they cannot go to the bathroom for hours and feel their blood sugar going down because they cannot leave the patients and grab a bite. Working shifts affect the ability to recharge: 'The only days I feel well rested when I show up for work is when I have had a couple of days off' (Annie). The organization's expectations take their toll on the nurses' health and well-being. Attending to lectures and refresher training is a rare opportunity. Irene describes the overwhelming and unreal effects of the workload: 'Because you meet unreasonable and absurd demands each day, you feel like: I have to keep danger away, there is nobody else'. The destiny of the clients seems to depend on individual nurses' judgment and ability rather than the hospital management. Irene adds: 'When you have a human life in your hands, it is like the whole hospital is a slow-motion train crash, and nobody seems to be doing anything about it'.

These stories do not conform to what DiPalma (2004) reports about collaboration, which is carried out outside of hierarchical expectations, and gives most job satisfaction and positive outcomes for patients. Even though workload and demands can be exhausting, a supportive management is likely to prevent nurses from quitting the job (Hølge-Hazelton & Berthelsen 2021).

Space as a disciplinary tool

Distribution and access to space in the working environment reflects power relations and is a situation the participants describe as restricting their autonomy, or the control they have over their work. Their own working space is not clearly recognized by other professions: 'There is always someone interrupting, even if you are in the middle of some delicate matter with your clients' (Betty). Interactions like this are a constant challenge. Defending professional territory and clients' rights for privacy is a daily challenge and a sign of the discrepancy between the nurses' expertise and their status as submissive assistants. It has been argued that nurses themselves reinforce some of the stereotypes by setting unclear boundaries (Cingel & Brouwer 2006). These blurred working boundaries have been explained by the traditional view of nursing as woman's work (Allen 2015; Slettmyr et al. 2017), the hierarchical order which reinforces this image and of having



no professional mandate (DiPalma 2004), and by Johnson (2011) on the vulnerability of being multiconnected. It can take years to learn to handle interruptions from co-workers: ‘They were always barging in. There was never any, “Am I interrupting you?” But of course, I should have done something about it, and as years go by, you learn to deal with it’. (Fay). The participants have not had formal training in setting boundaries with co-workers, and their access to defined working space reflects the symbolic image of being accessible and responsive at all times for others’ needs and demands, as pictured by Carly: ‘It is like everyone expects me to be available all the time, and I don’t have any kind of sacred time, whether I am eating, preparing medicine doses or concentrating on something, like it is always okay to disturb you’.

The nurses admit going along to a certain extent, as some find this easier than adding quarrels to the workload. The ethical aspect of protecting their clients and positive work atmosphere creates emotional strain when facing organizational expectations, which are at times impossible to identify with. Energy and time is spent on responding to the image of them as tireless and self-sacrificing. When Josie started to work after graduation, she was shocked about how much extra work it was for her to respond to co-workers’ interruptions and how complicated it turned out to be for her to keep focus on her own duties. She admits that her own boundaries are unclear and how she is a part of the culture as being always accessible, and that she lacks the skills to keep professional boundaries that are safe and healthy for her and her clients, as this is a source of strain:

I am still learning to build up the courage to say no, or wait, like today, you know, I was busy with something, and a co-worker came and said, ‘Can you help me with something?’ And I just said yes, and then I got distracted and was too late with the other task. But it is still, hey, I must run and do something else, so you are stacking things on you. Yes, it builds up stress in me, and I am not surprised that many accidents happen in this turmoil.

What Josie describes can be related to what Johnson (2011) depicts as being the one of many in a system. In her working space, she is stuck in the hierarchical organizational structure and she is on the verge of being unable to handle the tasks.

Another manifestation of power-related access to space is related to the long-standing staff shortage. Most of the participants are obliged to stay on their wards the whole shifts, missing opportunities to attend to lunch-break lectures which other professions attend, or to have a rest break. This adds to their professional isolation and lack of well-being.

Missing support and advocacy

When starting their jobs, the nurses expect a workplace well-being policy in their favor. However, the participants share stories of their supervisors being unsupportive and distant when they voice concerns or seek support. Their well-being is subordinate to their work, and there has been a breach of the psychological contract (Gupta et al. 2016). Eve describes the consequences when she told her supervisor about a sexual assault she suffered from a co-worker:

Ever since then, she has been freezing me out, this has really destroyed the opportunities I have had in my work and has seriously disturbed my job satisfaction. I just feel that I made a terrible mistake reporting it. It made it all worse for me. ...You don't see much caring for us, to help us flourish at work. This is such a huge part of your life. If you don't feel well in the working place, it affects your private life, and the other way round – a complete interplay. If I am happy at work, somehow everything else solves itself.

Eve experienced assault again when she was expecting support from her supervisor. When Dave was sexually harassed at work, he reported it to his supervisor: 'And she just laughed, nothing else, but I could hardly drive home after work, I was so numb'. In his case, having been harassed is seen as something he should take 'as a man' and get over. Eve, on the other hand, was punished for what happened to her. While this behavior seems absurd and goes against any rules and regulations, identified as horizontal violence (Fanon 1967), rather than backing each other up, frustrations due to experienced powerlessness are sometimes projected at own group members.

To quit the job is a way out, and is a common consequence of unsupportive and disrespectful management styles (Brynjólfsdóttir 2018; Donnelly 2014; Happell et al. 2013; Lu et al. 2019; Marc et al. 2019; Simard & Parent-Lamarche 2021). Annie took a half-year sick leave after exhaustion and a work-related accident: 'There was not even a goodbye when I left for home. This is what makes me sad and tired and has forced me to leave my job many times'. Although the participants love their job and care for their clients, they miss having a good and trusting relationship with their supervisors. This increases the sense of being rejected and not worth much. Fay chose to prioritize her own well-being: 'For years, I fought against leaving because I loved my job, and I am a competent nurse. Then, I thought, "No, I can't let it destroy me." So, I quit. If you can't trust that you are cared for, you don't want to be there'. Irene told of a situation in a job interview with her supervisor:

I said, 'You know, the workload has increased immensely, and it is getting very demanding for me.' And then, she just said, 'What? You are the only one complaining about it. What is going on with you?' And that I should not take up too much space because I was so ... when I was commenting on how strenuous the work was now when others were listening. And then, she gave me a long lecture about how everyone has to take their share: 'They all have. Are you really going to be the only one not taking your share of the load?'

When Irene discussed this with other nurses on the ward, some said they also had complained to the same supervisor about the situation. This reveals expectations of nurses by their supervisors as obedient and sacrificial and this hinders well-being. If there are troubles, the nurses get the message to look for reasons within themselves and find the fault there, instead of in the workplace. This reflects lack of recognizing the nurses' professional mandate, and of how hierarchies in the health care can become gender unequal and arrogant, as described by DiPalma (2004).

The invisibility of the profession

It is the nurses' responsibility to monitor their patients' situation, but their professional opinion is not always recognized or appreciated by other professions. Josie recalled when she asked a doctor to examine a patient she was worried about:



I had a patient with pneumonia symptoms, and the doctor just said, ‘Come on, this is probably just a nursing infection.’ Like I was dramatising, you see. I find it insulting because I am with the patient the whole shift, and whether a change in the patient’s condition is serious or not, you must make sure.

The invisibility of nursing as an academic discipline presents itself in the participants’ feeling that their education, scope of work, and skills are not valued from a professional point of view. That nurses are an important link in the working environment, but their work, which is still stereotypically seen as one for which few skills are required (Smith 2019; Wolfenden 2011), is explained by Allen (2015:4–5) with long-lasting views of caring as natural for women; work that is not direct caring is not clearly seen. Subsequently, the nurses feel silenced and devalued and feel a gap between themselves and the institutional management. In addition, justifying and defending the importance of their profession and their choice to enter nursing is a part of the nurses’ daily reality as well, reflecting hierarchial expectations (DiPalma 2004). Most of the participants have been asked why they did not study medicine instead, and they have had to defend their choice. Carly said, ‘I always have to speak up and make myself clear when people start asking me about my choice, and I have even been asked, “And then you are going to study medicine?”’ To meet such attitudes and lack of knowledge of one’s own profession can be frustrating, as Betty explained,

I know nurses who have been asked if they did not have the ability or brains to be a doctor. In my opinion, it is the rudest and most hurtful thing to say to us nurses. And I am completely convinced that if nurses had more opportunities to give the clients emotional support – that is why many of us enter the profession, for the emotional attachment – then not so many of us would leave the job and burn out.

That emotional work is often underestimated is one important part of Allen’s (2015) approach. Another sign of nursing’s invisibility is related to their academic knowledge. Grace wants to have the opportunity to do some research on her ward, but has not received encouragement or the opportunity to put that into practice: ‘I was so naïve to believe that my supervisor and the manager were idealists, thirsty for new knowledge to make the world a better place’. The hierarchical order (Allen 2015; DiPalma 2004) is still ranking the nursing discipline-specific knowledge lower than medicine. The nurses describe this situation as one of the main reasons for their discomfort and stress at work, and as Godsey et al. (2020) argue, this detains professional development.

The gender imbalance as a disability

In the nurses’ opinion, being a part of a female-dominated profession has certain flaws and hindrances for their development and opportunities and affects the team spirit. When male nurses are a part of the team, differences become visible in many ways.

Just having a guy working with you, it changes the interactions in the workplace. Somehow, the men have the freedom and licence to express themselves more uninhibitedly than women have, and that transmits into the environment. They take more risks, do and say

things, but we women are more oppressed. And the guys get away with behavior we would not, and they are respected for it. It would be positive for both patients and staff if there were more guys, for the working spirit. (Eve)

A more balanced gender ratio is described by the nurses as a liberating experience: 'You get rid of the backstabbing and gossip; the communication is much more open and cheerful' (Debbie). This may reflect what scholars have identified as being 'doubly oppressed' because nurses are socialized as both nurses and women, and nursing is considered woman's work (Allen 2015), and views of subordination and traditions of being in a subservient role to physicians have been enduring (DiPalma 2004; Johnson 2011). Hierarchy and traditions are strong, and Cingel and Brouwer (2006) have argued that nurses themselves strengthen some of the stereotypes by setting unclear boundaries. The female nurses argue that men are more assertive and claiming better working conditions and that they are used to their male status: 'It is of huge importance that they enter nursing; then, all this female sacrifice would end' (Grace). In the nurses' opinion, inequality in nursing came to expression by the two-sided hindrance for equality: that many men avoid nursing because of its stereotypical and feminized construct of caring. This is consistent with a significant amount of research on men in nursing, for instance, works of Sasa (2019); Meadus and Twomey (2011); Sedgwick and Kellett (2015).

The men are believed to be able to serve as role models for the female nurses when it comes to dealing with disagreements. 'If there are conflicts in the cooperation between female nurses, then the guys do not listen to it. They can't be bothered to' (Fay). Steve echoes experiences of other male participants of how the working culture does not allow for opportunities for the female nurses to solve agreements or to act out: 'They are complaining and gossiping over a cup of coffee, but they do not stick together, and they really are oppressed, but if you discuss it with them, they do not agree'. But when Betty started to set clear boundaries to her coworkers, she was asked why she was always getting everyone against her. There is a general presumption among the nurses that fixing the gender imbalance is crucial for a healthier working culture and to empower the profession. In their opinion, the idea of femininity and deep-rooted cultural meanings chase the men away from the profession, as many of them seek work opportunities within fields with more traditional masculine emphasis. 'It has to do with their distorted ideas of nursing before they try to find out what it is. It may not match their self-image and can hurt their ideas of masculinity' (Eve). Many of the participants echoed her sentiment, realizing that changes in cultural values is a slow social process.

Compromising and enduring the traditions

Being a link in a large chain, the nurses realize that they must adjust and compromise, often against their own sense of justice, while hoping for changes in interactions and expectations. This is a conscious strategy meant to save energy, protect professionalism, create a positive mood, and avoid conflicts. This appeared in several ways in the interviews, and may be understood as an endurance, and that the nurses, mostly women, are staging their femininity as social capital (Skeggs 1997), typical for women, which have



limited access to power in the gender relations of the organization. Johnson's (2011) emphasis on the multileveled and complicated connections in nurses' work, as well as their socialization, explains the slowness and deep-rooted traditions that detain the equality development.

The pressure to adjust to the working culture contrasts with the nurses' professional identity and commitments. Irene has been met with attitude when prioritizing her own responsibilities: 'If you say, "I can't do it now", you often get that look of, "Okay, uhm, she is one of the difficult ones"'. The nurses understand the deep-rooted ways of interactions between the professions that help with tolerating unreasonable expectations of nurses as doctors' assistants. They know that the older doctors 'were trained to have the upper hand'. Fay described her ways of refusing to be an 'errand boy' for the doctors:

I have answered, 'I am busy, and this is not my job.' And then, they just respect that and go themselves. You know, you don't run around the house for the doctor to find some bandage or stuff; he knows where to find it.

To endure deep-rooted traditions, Betty prepares herself mentally and emotionally for interactions with other professionals who do not view nursing as an academic discipline. She plans her interactions carefully to get successfully through the day:

The biggest challenge is to keep up the positive energy and professional interactions with dignity with other groups, to set the starting point for the day, holding on to warmth, joy, and courtesy, even if you do not get it in return, and do not let others' bad temper ruin my relationships or my nursing. Sometimes, I get so exhausted from this, always having to guard my own territory to be able to do what I was employed to do. The price I pay for this is keeping everybody happy.

Enduring possible conflicts and finding the balance adds an extra workload. A generation shift is visible in the interactions between nurses and doctors. Betty described her strategy of softening and easing the process of change:

Women are now most of the doctors, and they interrupt me just as much as others do. So, it has nothing to do with gender. But I bother them just as much as they interrupt me, but I interrupt the male doctors less. The female doctors are more tolerant and patient than the men when being interrupted.

Balanced and mutual interruptions between the professional groups are seen as a sign of increased equality and reciprocal respect. Being conscious of ruling expectations and making compromises as needed, walking the fine line, the nurses feel they have developed a way for advancement while defending their professionalism. Still, there seems to be a long way to go to the visibility and legitimizing of nurses' work as central to the health care system as presented by Allen (2015:44–45). As compromising is considered a way to get through the day, there is also the risk of lowering professional standards, maintaining hierarchy, putting a lot of pressure on nurses, and taking its toll on their well-being, and as a result, the well-being and safety of clients is jeopardized. Besides, it enhances the image of nurses as selfless and at all times available.

Conclusion

This article set out to examine the power dynamics within the Icelandic nursing profession and relate it to existing theoretical perspectives and literature on power imbalances. In the participants' stories, factors emerge that prevent them to fulfill their professional obligations, as they are constantly striving to find a balance between their professional conviction and the hierarcical expectations of the organization. This is closely connected to longstanding staffing shortage, with high workload as result. Sacrifices are made, as the nurses' physical and psychological health and the clients' safety is sometimes jeopardized. Therefore, the consequences of this can in some ways be described as a devaluation of professionalism. Working conditions of nurses in this paper reflect multifaceted financial and managerial angles. One is the relationships the participants describe they have with their supervisors, they experience a gap between themselves and the institutional management, a lack of support, and sometimes an attitude characterized by blaming the victim. Whether it is categorized as horizontal violence, or just poor leadership skills, there is something in the culture, which allows such conduct to take place. The consequences not only affect the nurses' and clients' wellbeing, but the entire institution, with workforce reduction and increased costs. Such circumstances must change, with honest institutional introspection and dialogue.

For more gender-equal nursing profession, changing stereotypes surrounding nursing and how nursing is viewed by the public is important. The conception that nursing is better suited to women due to innate abilities can be well eradicated with strong male role models, promoting and emphasizing the interpersonal caring aspect of nursing and highlighting that the profession should reflect diversity of society. This is not only the responsibility of the education system but also the media. Counseling and training for nursing students may be a helpful tool to make the equality topic more widely discussable. Introducing gender studies and the comprehensive research literature into both nursing education and the workplace could further help to shed light on the underlying power structures and ideally make nursing a more gender-equal profession to work in.

This study is not without limitations. It may well be that the nurses who were ready to participate were the ones with most on their plates and with an urgent need to ventilate on the matter. Nevertheless, their experiences bring useful insights into the power dynamics still occurring within the nursing profession. While the nurses in the study may have been more aware of power dynamics and gender issues because of Iceland's position on the Global Gap Gender Report Index, there appears to be enough room for improvement when it comes to these issues. Judging from their stories, many nurses suffer from working situations, which are both health-threatening and often professionally unacceptable.

Future research in the field could help to explain why men are only 2% of the nursing profession. It is also relevant to study from a viewpoint of gender studies how individuals make their choice to enter nursing and how nursing is promoted to attract young people. Exploring how individual's background and life events affect the choice of nursing as a career is also of interest.

To conclude, it is disappointing that Iceland's rank on the Global Gender Gap Report and having nursing education taught at the tertiary level, is not reflecting itself by means of a more gender-equal work culture even though theoretical work on power imbalances largely explains why this is. The effect that power dynamics and stereotypical views have



on the nurses' health, wellbeing, and job satisfaction is worrisome and paradoxical, as working in health care apparently does not necessarily relate to working in a healthy work environment. Instead, what this study has shown is that the gender imbalances prevent the nurses' working place from becoming more healthy, as it is gets caught up in a negative spiral that is difficult, although not impossible, to turn around. This study reveals the importance of supervisors and managers being aware of their own position within the larger system and the impact that negative working conditions have on the welfare of nurses and their clients. Moreover, from the situation in Norway and UK, it can be extrapolated that it is possible to attract more men to the nursing profession. This then in turn can contribute to diminishing gender imbalances within the nursing profession, although the study findings show that quite a bit more effort, at multiple levels, is needed for a change to actually take place.

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