Title
Paying the Caring Tax

Journal
Advances in Nursing Science, 43(3)

ISSN
0161-9268

Author
Burton, Candace W

Publication Date
2020-07-01

DOI
10.1097/ans.0000000000000319

Advances in Nursing Science
Vol. 43, No. 3, pp. 266–277

Paying the Caring Tax

The Detrimental Influences of Gender Expectations on the Development of Nursing Education and Science

Candace W. Burton, PhD, RN, AFN-BC, AGN-BC, FNAP

Nursing is not exempt from the social influences that affect other professions, and may in fact be rendered more susceptible thereto. Gender has potential to be such an influence, as its construction is based upon both social and historical factors. Gender has significant implications for nursing. Given that many aspects of the nursing profession remain largely female-dominated, it is sometimes assumed that otherwise common issues of gender bias are not a consideration. In fact, traditional binary gender roles and norms are often imposed and reinforced within nursing education and science, potentially limiting both diversity and innovation in the profession. **Key words:** *caring*, *feminism*, *gender*, *nursing*, *pink-collar work*

THE PROFESSION of nursing is complex and nuanced, encompassing developments within and across practice, science, and education—all of which have far-reaching implications for the field and for health in the broadest sense. It is thus crucial to recognize the dynamics within nursing that influence its trajectory and contribute to or hinder the successful advancement of nurses, nursing, and nursing science. Nursing is not exempt from the social influences that affect other professions, and in some ways may in fact be rendered more susceptible to such influences. This is due to its particular location in historical and professional contexts. Gender has potential to be such an influence, as its construction is based upon both social and historical factors. Gender has significant implications for nursing, not least because the nursing profession remains mainly populated by female-identified individuals. Given this fact, and that nursing itself has been considered a "pink-collar" occupation, it is sometimes assumed that otherwise common issues of gender bias are not a consideration. This article argues that, in fact, the traditional binary male and female gender roles and norms are often imposed and reinforced within nursing education, and science, and that this limits both diversity and innovation in the profession. It first addresses the characterizations of nursing as inherently and necessarily female, then considers how the histories of feminism and gender constructs intersect with nursing, and finally explores the ways in which gender and nursing in the modern academic environment can collude to disempower nursing educators and scientists.

Author Affiliation: *University of California, Irvine.*

The author has disclosed that she has no significant relationships with, or financial interest in, any commercial companies pertaining to this article.

Correspondence: *Candace W. Burton, PhD, RN, AFN-BC, AGN-BC, FNAP, University of California, Irvine, 100B Berk Hall, Irvine, CA 92617 (cwburton@uci.edu).*

DOI: 10.1097/ANS.0000000000000319

GENDERING WORK

The population skew of the nursing workforce at all levels and in all environments contributes to the identification of nursing as a "pink-collar" profession: one that is typically focused on service to or care of others, and which may also be peopled by more

Statement of Significance

What is known, or assumed to be true, about this topic

- Given that many aspects of the nursing profession remain largely female-dominated, and that nursing itself is considered a "pink-collar" occupation, it is sometimes assumed that otherwise common issues of gender bias are not a consideration. Nursing has historically been seen as the mere application of expected or otherwise "natural" nurturing or sacrificing tendencies in women. The implications of this include that participation in nursing—whether as provider, educator, or scientist—is more gendered behavior than true profession, and that because nursing is most often performed by female-identified and thus ostensibly naturally caring individuals, gender biases do not affect the profession. However, the effects of gender norms and expectations are powerful considerations for nursing, given that nurses, whether male- or female-identified, as well as female-identified people more broadly continue to be effectively silenced in academic and scientific discourses as well as vertically segregated away from high-status positions.

What this article adds

- Since caring is among feminine-assigned behaviors, but career advancement and professional assertiveness are often characterized as masculine, nursing education and science exist in an almost paradoxical state of behavioral valuation and professional social discourse. This creates dissonance between the "masculine" behaviors of career achievement and the "feminine" behaviors that supposedly identify caring. There is thus conflict between being in a profession (nursing academia) and in embodying the markers of that profession (nursing). This conflict may lead some in nursing academia to seek other ways of performing caring, which can lead to extreme expectations of some social behaviors associated with caring and femininity. Relationships among colleagues may be expected to be as personal as much as professional, creating unrealistic expectations of work environment interactions. This has been identified as a type of workplace adversity, and one primarily expected of female-identified nurses by other providers and colleagues because of nursing's association with feminine caring. This added burden of situational caring expectations for nurses regardless of work environment can lead to exceptionally disparate workloads both in the physical and emotional realms—a "caring tax," implicitly required as an addition to the nurse's academic and professional activities.

female- than male-identified workers.[1] According to 2017 data from the United States Census Bureau, 88.9% of registered nurses in the United States identified as female[2]—a clear majority. The identification of nursing as pink-collar work speaks to the fact that some

of the specific and unique characteristics of nursing are related to both the service and/or caring orientation as well as to its predominantly female-identified workforce.[3]

What is pink-collar work?

The concept of pink-collar work was described by Louise Howe in the late 1970s, and although this descriptor typically references jobs commonly held by women, it is applicable to both male- and female-identified persons' work. Pink-collar work refers specifically to the *type* of work—usually work that primarily provides care or personal services—which also stands in contrast to blue-collar work. Blue collar connotes work that is physical, labor-intensive, or derived from skilled trades—work historically seen as the province of male-identified individuals.[4] Both also stand in contrast to white-collar work: those professions that impute particular privilege, as well as economic and social standing.[4] The distinction among pink, blue, and white collar types of work also suggests that pink-collar work is both different from and less prestigious than is white collar, and less skilled work than is blue collar. The result for nursing is a connotative distancing from either a skilled profession or a privileged professional career track.

In this context, it is also vital to recognize that there is a socially constructed gender expectation that female-identified individuals will by nature engage in certain types of caring behaviors.[5] Nursing was historically often considered the mere application of expected or otherwise "natural" nurturing or sacrificing tendencies in women.[3,6] The interesting implications of this for nursing include that participation in nursing—whether as provider, educator, or scientist—is seen as more gendered behavior than true profession, and simultaneously that because nursing is most often performed by female-identified and thus ostensibly naturally caring individuals, gender biases do not influence those in the profession. This is clearly not the case, as explorations of the experiences of men in nursing have shown.[3,7] For male-identified nurses, implicit biases that locate nursing in the domain of the feminine can lead to perception of these nurses as deficient: ironically either because they embody a "spoiled" masculinity, or because their maleness implies that they are unable to be truly caring as nurses.[3,8] It is therefore critically important to examine the ways in which gender, its norms, and performative roles have affected the profession throughout history, and to consider how these effects influence the modern discipline of nursing.

GENDER AND FEMINISM: HISTORICOCULTURAL INFLUENCES

The history of feminism and feminist theory necessarily parallels the history of gender constructions to some extent, and both are therefore reflected in the history of the nursing profession. Gender is unquestionably a social construct, influenced by concurrent historical, social, and political factors at any given moment.[9] This is a powerful consideration for nursing given that nurses, whether male- or female-identified, as well as female-identified people more broadly have been and at times continue to be effectively silenced in academic and scientific discourses as well as vertically segregated away from high-status positions.[9] Critical discourses, such as feminist theory, specifically seek to deconstruct the mechanisms of such silencing.

Angels or whores: First-wave feminism and the work of nursing

Feminist theory seeks to challenge how gender is constructed, and to elucidate the features of gender constructs that disempower female-identified persons.[10] The path that feminism and feminist theory have taken to the present epistemological and ontological moment, however, has not always been fully empowering when seen through modern post-positivist, intersectionalist lenses.[11] Early Western constructions of feminism,

identified as first-wave feminism, emerged in part from the Abolitionist movement and brought with them the assumption that female characteristics were temperate and tempering social influences, as well as specific expectations for attaining social respectability among women.[12] In fact, the ideal of the respectable and essentially feminine woman is enshrined in Coventry Patmore's 1854 epic narrative poem *The Angel in the House*, which describes a woman who "is modest, chaste and innocent, she unconditionally loves and supports her husband, submits to him completely and is a caring mother to her children."[13] The imagery here so captured the contemporaneous public imagination that the poem's title became synonymous with the ideal 19th and early 20th-century housewife: one naturally devoted to a caring and nurturing life restricted to the confines of the (private) home, in contrast to "fallen women" who necessarily lived and functioned in more public, male-dominated spaces.[13] In the nursing profession, parallel imagery is found in the "ministering angel" as invoked by Florence Nightingale and the fictional nurse Sarey Gamp of Charles Dickens's 1843 creation.[14] This is reflected in the developing professional constructs of nursing—in Nightingale's own words, "On women we must depend, first and last, for personal and household hygiene–for preventing the race from degenerating in as far as these things are concerned. Would not the true way of infusing the art of preserving its own health into the human race be to teach the female part of it in schools and hospitals, both by practical teaching and by simple experiments . . . ?"[15] The several implications of this statement include an assumption that women's presumed attention to personal and household caring renders them best-suited to the work of nursing. Given the structural inequities of the time that largely prohibited persons of color and/or of low socioeconomic status from most educational institutions, it is also apparent that these archetypes were the provenance of upper class, educated, white women.[16] This is equally manifest in Mary Seacole's autobiography—originally published in 1857—which describes the difficulties she faced as a black woman seeking to work as a nurse during the Crimean War, despite her extensive experience caring for victims of cholera and other illnesses:

> Once again I tried, and had an interview this time with one of Miss Nightingale's companions. She gave me the same reply, and I read in her face the fact that, had there been a vacancy, I should not have been chosen to fill it. . . . The disappointment seemed a cruel one. I was . . . so certain of the service I could render among the sick soldiery, and yet I found it so difficult to convince others of these facts. Doubts and suspicions arose in my heart for the first and last time, thank Heaven. Was it possible that American prejudices against colour had some root here? Did these ladies shrink from accepting my aid because my blood flowed beneath a somewhat duskier skin than theirs? Tears streamed down my foolish cheeks, as I stood in the fast thinning streets; tears of grief that any should doubt my motives—that Heaven should deny me the opportunity that I sought.[17]

Here, intersection of race and gender is prominent, insofar as Seacole identifies racist overtones in these encounters and calls attention to the fact that she has been rejected by "these ladies"—white, formally educated, and presumably as in the case of "Miss Nightingale" specifically devoted to a life in the service of caring.[18]

More than archetypes: Subsequent waves

By the 1960s, the second wave of feminism was attending more to inclusivity within the movement—but this sometimes led to erroneous dependence on presumptions of homogeneity among the population of "women" generally.[19] At the same time, there were splintering influences that positioned "the activities of African American, Chicana, Asian American, American Indian, working-class, and lesbian feminists . . . primarily as reactions to a straight, white, middle-class movement,"[16] and not as vital contributions to the development of feminist ideology, with

influence on trajectories of politics, history, economics, and society. Both the exclusionary stance of the first wave and the isolation-in-reaction of the second wave of US feminism thus privileged a fairly specific and limited ethos of womanhood even in the context of gender equity work. In essence, the implication is that only some women deserved such equity by virtue of having specific and socially valued characteristics.

The third wave of feminism, possibly its most complex, occurred as scholars sought to decipher interactions among social constructs and systems contributing to disempowerment of people of color as well as the female-identified. The resulting bodies of feminist theoretical work radically altered the framing of such work and allowed for differing conceptualizations of femininity, empowerment, and identity as experienced through racial, ethnic, and socioeconomic lenses.[20] Although a potentially positive change, some feminists of color critiqued early third-wave approaches for again homogenizing multiple populations into one monolithic "multicultural" entity, allowing the proliferation of racism and alienation under a mask of tolerance and inclusivity.[21] By collapsing multiple populations into a single "other" of whom to be tolerant, multiculturalist feminism could thus be co-opted into reaffirming the dominance of specific race, gender, and economic characteristics—enforcing discriminatory hierarchies rather than empowering less privileged groups.

More recently, during what some have termed the fourth wave of feminism, recognition of the intersectionality of female-identified individuals' lives—that is, the specific overlapping identities and characteristics that identify "a" woman rather than "any" or "all" women—has helped to diversify constructions of gender and of feminism itself.[22,23] Awareness of the ways in which intersecting and devalued identities can affect lifetime health and well-being has become a focus for research, intervention, and prevention strategy—perhaps most notably in the elucidation of the many social determinants of health (SDH).[24] The SDH, and with them understanding of how intersectional social constructs and social justice influence individual potentials, seem a natural intersection with the development of the nursing profession—but these subjects are not prioritized in many nursing education programs. These unfortunately often center clinical content and lack educational attention to the diversity of the populations for whom nurses ultimately care.[25] This suggests that while intersectional perspectives in nursing and on the SDH do exist, they are seen as secondary to the "work" of nursing rather than integral to its professional execution. This is the historical moment at which nursing is currently situated, and it is thus important to consider how gender—as only one of many social intersecting constructs—continues to influence this profession, its science, and practice.

GENDER BEHAVIORS IN NURSING

Within each wave of feminist ideology, explications of gender can shift and be refined, but many identifying attributes of what is considered female and feminine have remained static. Given the pink-collar associations of nursing, identifying how these influence the field is critical to consider in developing nursing science and education. Personal and professional identities are not static, being dynamically and constantly constructed and reconstructed in the quest to meet certain milestones, yet certain attributes of the constructed female or feminine persist within the nursing field. The enmeshment of these in the nursing profession may have the additive effect of enforcing what has been described as benevolent sexism, which causes the "scientific contribution, technical skill, and leadership inherent to the unique body of the (nursing) discipline" to be dismissed as irrelevant to broader scientific and educational endeavors.[26]

Nicolson[5] notes that a major difference between the discourses of masculinity and femininity is that masculinity is associated with

independence and autonomy, while femininity is associated with co-operation, dependence, and nurturance—caring. The concept of caring within nursing has been identified as the foundation of the entire profession, and it is telling that it is often identified as part of the moral imperative thereof.[27,28] Given that nurses who pursue advanced education and ultimately enter academia as scientists and/or educators often give up clinical care work to do so, the identifying actions of caring that otherwise frame the nurse identity may be lost. Since caring is among feminine-assigned behaviors, but career advancement and professional assertiveness are often characterized as masculine, nursing education and science exist in an almost paradoxical state of behavioral valuation and professional social discourse. This creates dissonance between the "masculine" behaviors of career achievement and the "feminine" behaviors that supposedly identify caring.[26] There is thus conflict between being in a profession (nursing academia) and in embodying the markers of that profession (nursing). This conflict may lead some in nursing academia to seek other ways of performing "caring," which can lead to extreme expectations of some social behaviors associated with caring and femininity—effectively hegemonic gender enforcement.

Gender hegemonies

Kellet et al[3] posit that the influence of hegemonic masculinities—constructions of male gender that enforce power and dominance of male over female, and preclude association of feminine-identified traits with male-identified persons—may marginalize or emasculate some nursing care activities by situating men as sexual aggressors, enforcing patriarchal structures, and subjugating nursing practice to physician practice.[29] In an exploration of gender as a factor in professional complaints against nurses from 1999-2006, Chiarella and Adrian[7] found that intimate touch activities such as bathing and toileting assistance resulted in fewer and less significant complaints against female than against male nurses. This implies that such contact is more acceptable if performed by a woman, perhaps in part because such actions are inherently private and thus identified as "feminine": relegated away from the public gaze.

The potential for such enactment of hegemonic masculinity in nursing implies that there is also the implicit—and at times explicit—performance of hegemonic femininity. This should not be construed to mean that the latter exists only insofar as it is the opposite or "other" of the former or that it cannot exist where there is no apparent presence of hegemonic masculinity. Hegemonic femininity more accurately implies reinforcement of feminine norms such that any masculine-associated traits and/or behaviors are deemed inappropriate.[30]

Hegemonic femininity within nursing might best be identified as the enforcement of feminine-associated behavioral norms regardless of environment, often resulting in horizontal oppression.[14,30] Horizontal oppression, as is identified in nursing by the colloquialism that "nurses eat their young," is perpetrated by persons who are part of a disempowered group (ie, nurses, female-identified persons) toward other members of the same group in an effort to enforce a specific power structure.[31] Within nursing, horizontal oppression may thus be the performative result of hegemonic feminine influences that contribute to a professional environment, which demands performance of certain gender-assigned behaviors. This is particularly interesting in light of nursing scholarship, which posits that nurses may exhibit behaviors that are characteristic of oppressed groups. Oppressed group behaviors can include both seeking to assimilate to an apparently more dominant group (ie, physicians or administrators) and the direction of aggression toward other members of the same group—as in the case that "nurses eat their young."[32] In such cases, workplace incivility among nurses may be perpetuated if those new to the workplace seek to assimilate to the more experienced and re-enact their

experiences of oppression.[33] This may occur in both clinical and educational settings, such that some nurses never experience any culture but that of oppression. Peters[34] explored the enactment of horizontal violence among nursing faculty, finding that new nursing faculty experienced frequent rejection from senior colleagues. This rejection included experiences of being belittled or "being treated like a child," of intimidation or aggression, and of feeling disempowered, as they were forced to avoid any appearance of behaving uncivilly toward those same colleagues.

Walker[35] refers to this as a "tyranny of niceness," in which "overt conflict must be avoided wherever and whenever possible. This sensibility is sanctified in our culture in the notion that a good woman does not contradict and a nice woman does what she is told," and in consequence, so must the good and nice nurse.[35] For example, in writing about the transition from clinical to academic nursing work, McDonald[36] stresses the importance of meeting the "social norms and expectations" of the academic unit, as well as establishment of "camaraderie among . . . faculty."[36] This implies that incumbent nursing faculty should seek to align themselves with the behavioral expectations of the new environment and to be seen as comrades or companions rather than as colleagues or coworkers—they should, in essence, be "nice" to assure positive and reciprocal interactions with others.

Further, because of the dearth of men in nursing, the traditional divisions of male-identified as powerful and female-identified as subjugate may be reinforced when men are recruited into nursing: offered higher salaries, allowed more academic and professional freedom and voice, and encouraged to move quickly up the career ladder. This may reinforce divisions in valuation between male- and female-identified nurses, such that the apparent value for the latter of participating in a pink-collar profession is completely negated. Even if the male-identified in question do not intend to take advantage of or even intentionally seek to push back against this preferential treatment, the reinforcement thereof by senior personnel—the vast majority of whom are women—can demonstrate to others in the environment that they must act in accord with these gendered constructs: male-identified are allowed to be openly challenging and ambitious; female-identified are valued more for their capacity to be caring, subservient, and holding the positive opinion of those around them. Such social demands create a specific stress burden, which has been shown to affect female-identified individuals more than male-identified, contributing to decreased self-esteem, poor self-concept, depression, and less coherence in sense of self.[10] When imputed to the nursing workplace, this stress is compounded by the need to be both professional and gender-appropriate, which means that many nurses have to meet benchmarks of both the more masculine-aligned career achievement and feminine-aligned caring achievements. The relative professional power that should come with the achievement of career-based milestones is thus filtered through the lens of caring, and ultimately may be accorded by how "caring" the nurse is or appears in the academic or research environment.

Gender in a caring profession

The hegemonic feminine may also play out in some workspaces by familial structure replication, because this is often a reference point for experiences of caring. Enforcement of ostensibly feminine behaviors can call forth "motherly" expectations of women in the workplace, and turns the professional organization into a decidedly nonprofessional family. As Nicolson[5] reflects, this leads to the expectation—by both male- and female-identified people—that the female-identified individual will necessarily behave in a "motherly" way regardless of context. For female-identified persons, the expectation is often that this "motherly" behavior extends into the professional milieu. This is suggested by the results of a study comparing the service workloads of male- to female-identified faculty,

which indicated both that female-identified faculty tended to have heavier service loads and that those loads were less likely to include prestigious leadership positions or be outside the individual's academic unit.[37] The study authors suggest that this inequity may be a result of female-identified faculty "shouldering a disproportionately large part of the burden of 'taking care of the academic family,' so to speak."[37] Another study found that students tended to make more demands of female-identified professors, including special favor requests such as extended time or grade changes for assignments, and that female-identified faculty also reported more emotional labor demands in the workplace than did their male-identified colleagues.[38] The authors of that study posited that a similar demand for female-identified faculty to engage in nurturance and friendship-like interactions by colleagues and staff members would further exacerbate the burdens thereof. Further, those from underrepresented minority populations may experience the intersectional burdens of the nurturing, caring expectation and of representing their entire race or ethnic group in the eyes of others—this can lead to excessive demands for service on committees, as well to role model or mentor students of the same background.[39] Such familial, caring constructs in the academic nursing workplace place an added emotional labor burden on female-identified faculty to maintain peace in the "family" and to make others feel cared for even at the expense of their own well-being.

As a result, unprofessional and uncivil behaviors such as horizontal violence, favoritism, boundary violations, and outright bullying may be tolerated and accepted by leadership as well as by staff.[40] Relationships among colleagues may be expected to be as personal as much as professional, creating unrealistic expectations of how those in the work environment interact. Delgado et al[41] identify this as a type of workplace adversity, and note that it is primarily expected of female-identified nurses by other providers and colleagues because of its association with feminine behavior and acting in a caring profession.

The caring tax

This added burden of situational caring expectations for nurses regardless of work environment can lead to exceptionally disparate workloads both in the physical and emotional realms—a "caring tax," in that it is implicitly required as an addition to the nurse's academic and professional activities. The tax may be exacted in a variety of ways depending on the unit. Among nursing faculty, caring may be taxed by the expectations of students that faculty will behave in gender-appropriate ways: acting as mother confessors or extending greater compassion for student needs than would faculty in other disciplines.[42] Nurses in any work unit may encounter the caring tax in the context of being expected to avoid any appearance of conflict with colleagues and/or supervisors, even in the event that they perceive errors or patient endangerment.[31] The caring tax may also manifest specifically when nurses make the decision to have children. For those seeking to move up the career ladder, the dissonance between masculine-associated career achievement (ie, promotion and tenure) and female-associated caring achievement (ie, child birth and rearing) becomes more striking and in fact can render the "ideal" of femininity and motherhood a double-edged sword. Taking time away from the professional environment to attend to the needs of a child strains the bounds of career potential and may result in decelerated career progression. The parent who stays at home is "taxed" with decreased professional attainment. This unfortunately often creates a power gradient that favors male-identified nurses, because female-identified individuals continue to be the primary providers of needed unpaid care work in many families even when they are also employed outside the home.[5,43]

This power gradient and the associated caring tax is worsened by the scarcity of male-identified nurses, such that although they

are a professional minority, these nurses may have more capacity for advancement and more opportunity to assume leadership positions. In fact, one study suggested that some male-identified nurses specifically sought out advancement to distance themselves from the otherwise feminine-identified work of caring and nurturing associated with the nursing profession.[8] This may push female-identified nurses even further from positions of power and serve to strengthen and enforce the disparity of gender valuation between male- and female-identified individuals within the nursing profession. Additionally, male-identified nurses may be allowed more leeway in professional relationships because they are viewed as engaging in masculine-appropriate behaviors—assertive communication, boundary maintenance, and compensation requests.[3] Female-identified nurses are viewed more critically if they engage in these kinds of behaviors and may be characterized as uncaring, therefore more stringently taxed to demonstrate their caring abilities—reinforcing both masculine and feminine hegemonies.

Although a somewhat dated reference, Naomi Wolf's *The Beauty Myth*[44] describes a culture of hegemonic beauty ideals such that "women" become less "womanly" as their beauty fades—the parallel idea being that nurses become less useful as nurses if their apparent performance of caring fades. In the academic environment, this can translate into the enforcement of near-toxic levels of behaviors often associated with caring and femininity: politeness, deference, passivity (often in the form of passive-aggressiveness), nurturing, and prioritizing positive interpersonal relations. In the academic nursing environment, power is to some extent accorded to those who have already demonstrated their ability to perform caring work and in doing so attained senior status—the early-career PhD is supposed superior to the bedside nurse, and the established scholar supposed superior to those early in their careers, without regard for the quality or context in which their work is produced. The senior person in the academic nursing environment may therefore dictate the "appropriateness" of others' behavior within education and science, despite the fact that the actual, socially determined appropriateness of such behavior may be perceived in wildly different ways between groups. As a result, female-identified faculty may be expected and even pressured to double down on caring performances: engaging in overly solicitous or even coddling behaviors toward students, enacting female bonding rituals in the work environment, functioning as stewards of "community" among faculty and students.

This may be especially problematic for faculty of color. Many nursing schools have struggled to establish effective diversity among both faculty and students, and representation of minority and other vulnerable populations remains lacking—particularly at the leadership level.[45] For faculty identified with these groups, the "appropriate" behaviors constructed to signify caring in the academic nursing environment may effectively erase other, intersectional aspects of identity. Alarmingly, this may mean that to some extent the angelic (respectable, and white) archetype of nurse continues to influence priorities within the discipline. Pertinent here is an ongoing lack of emphasis on social justice issues in much of nursing academia. Social justice, the equalizing of gradients of opportunity or options available to different individuals based on their location socially, economically, and even politically, has been identified as a significant source of potential for developments in nursing science and practice, but there has been little uptake of intersectional approaches to either.[46-48] In fact, while social justice is often identified as a fundamental pillar of the nursing profession, it is also often a functionally ambiguous term not well defined within the field.[49] It may be that increased attention to social justice, especially insofar as it may be "achieved through the recognition and acknowledgment of social oppression and inequity and nurses' caring actions toward social reform,"[49] could offer nursing education and science critical opportunities

to improve the intersectional state of the profession and reduce power gradients across gender and other identities.

Such attention could reduce tendencies among nursing faculty to engage in oppressed group behaviors by creating opportunities to interrogate areas of social injustice in the academic environment, both in faculty-student interactions and interactions among faculty. Friend[33] also notes that administrators can play a significant role in fostering a sense of empowerment among faculty through effective communication, attending to the relative weights of workload for each individual, and demonstrating commitment to the fostering of leadership among all faculty. Finally, Walter[50] posits a model of emancipatory nursing praxis that encourages nurses at all levels to interrogate the depth and character of their social privileges while simultaneously and reflexively seeking out ways to challenge workplace status quo. Providing both group and individual opportunities to engage in such emancipatory work may allow faculty, students, and clinicians in nursing to deconstruct the hegemonic influences of social constructs—such as gender—that constrain innovation in the profession. Focus on creating socially just workplaces for nurses could thus enhance professional efficacy, student and patient outcomes, and reduce or eliminate the effect of the caring tax within the profession.

CONCLUSION

The history of gender roles and the feminist interrogation thereof is reflected and easily identified in the social construction of the nursing profession, which is in turn heavily influenced by the constructions and identifications of gender and gender-appropriate behaviors and attributes. Recognizing how the centrality of caring to the work of nursing can be co-opted to reinforce and substantiate binary gender divisions is critical to the development of the profession and to its growth among a diverse population. The concept of a caring tax offers new insights into how gender is framed and valued in the profession of nursing. Managers, supervisors, and senior academics in the nursing profession must account for the subtle and even unconscious ways in which gender can influence expectations of professional conduct in all nursing work environs and take steps to create truly gender-neutral and socially just workplaces.

REFERENCES

1. Basu S, Ratcliffe G, Green M. Health and pink-collar work. *Occup Med (Lond)*. 2015;65(7):529-534.
2. Data USA. Registered nurses. https://datausa.io/profile/soc/291141/#about. Published 2019. Accessed May 21, 2019.
3. Kellett P, Gregory DM, Evans J. Patriarchal paradox: gender performance and men's nursing careers. *Gen Manag An Int J*. 2014;29(2):77-90.
4. Lips-Wiersma M, Wright S, Dik B. Meaningful work: differences among blue-, pink-, and white-collar occupations. *Career Dev Int*. 2016;21(5):534-551.
5. Nicolson P. *Gender, Power and Organization: A Psychological Perspective on Life at Work*. London, England: Routledge; 2015.
6. Rickett B. Working without sacrifice: acceptance and resistance to dominant discourse around women's occupational risk. *Fem Psychol*. 2010;20(2):260-266.
7. Chiarella M, Adrian A. Boundary violations, gender and the nature of nursing work. *Nurs Ethics*. 2013;21(3):267-277.
8. O'Connor T. Men choosing nursing: negotiating a masculine identity in a feminine world. *J Men's Stud*. 2015;23(2):194-211.
9. Artazcoz L, Cortes-Franch I, Escriba-Aguir V. Gender, work and health: a step forward in women's occupational health. In: Gideon J, ed. *Handbook on Gender and Health*. Northampton, MA: Edward Elgar; 2016:165-188.
10. Burton CW. The health needs of young women: applying a feminist philosophical lens to nursing science and practice. *Adv Nurs Sci*. 2016;39(2):108-118.
11. Collins PH, Bilge S. *Intersectionality*. New York, NY: John Wiley & Sons; 2016.
12. Eisenstein H. Feminism seduced: globalisation and the uses of gender. *Australian Fem Stud*. 2010; 25(66):413-431.

13. Kühl S. *The Angel in the House and Fallen Women: Assigning Women Their Places in Victorian Society*. Open Educational Resources, University of Oxford: 2016:14.
14. Chiarella M, McInnes E. Legality, morality and reality—the role of the nurse in maintaining standards of care. *Australian J Adv Nurs*. 2008;26(1):77-83.
15. Nightingale F. *Notes on Nursing: What It Is and What It Is Not*. London, England: Harrison and Sons; 1860.
16. Hewitt NA. Feminist frequencies: regenerating the wave metaphor. *Fem Stud*. 2012;38(3):658-680.
17. Seacole M. *Wonderful Adventures of Mrs. Seacole in Many Lands*. In: London, England: Penguin; 2007. http://www.gutenberg.org/files/23031/23031-h/23031-h.htm.
18. Rakoczy S. Florence Nightingale: discernment as trusting experience. *HTS Theolog Stud*. 2018;74(3):1-8.
19. Kumar R, Birn AE, McDonough P. Agenda-setting in women's health: critical analysis of a quarter-century of paradigm shifts in international and global health. In: Gideon J, ed. *Handbook on Gender and Health*. Northampton, MA: Edward Elgar; 2016:25-44.
20. Fernandes L. Unsettling "third wave feminism": feminist waves, intersectionality, and identity politics in retrospect. In: Hewitt NA, ed. *No Permanent Waves: Recasting Histories of US Feminism*. New Brunswick, NJ: Rutgers University Press; 2010:98-118.
21. Rudge T. The violence of tolerance in a multicultural workplace: examples from nursing. In: Holmes D, Rudge T, Perron A, eds. *(Re)Thinking Violence in Health Care Settings*. London, England: Routledge; 2016:55-70.
22. Munro E. Feminism: a fourth wave? *Political Insight*. 2013;4(2):22-25.
23. Crenshaw K. Demarginalizing the intersection of race and sex: a black feminist critique of antidiscrimination doctrine, feminist theory and antiracist politics. *U Chi Legal Forum*. 1989;1989:8.
24. Braveman P, Gottlieb L. The social determinants of health: it's time to consider the causes of the causes. *Public Health Rep*. 2014;129(1, suppl 2):19-31.
25. Young S, Guo KL. Cultural diversity training: the necessity of cultural competence for health care providers and in nursing practice. *Health Care Manager*. 2016;35(2):94-102.
26. Castner J. Healthy environments for women in academic nursing: addressing sexual harassment and gender discrimination. *Online J Issues Nurs*. 2019;24(1):6.
27. Watson, J. Nursing: human science and human care. A theory of nursing. *NLN Publ*. 1988;(15-2236):1-104.
28. Papastavrou E, Efstathiou G, Tsangari H, et al. Patients' and nurses' perceptions of respect and human presence through caring behaviours: a comparative study. *Nurs Ethics*. 2012;19(3):369-379.
29. Jewkes R, Morrell R, Hearn J, et al. Hegemonic masculinity: combining theory and practice in gender interventions. *Cult Health Sex*. 2015;17(suppl 2):112-127.
30. Paechter C. Rethinking the possibilities for hegemonic femininity: exploring a Gramscian framework. *Women's Stud Int Forum*. 2018;68:121-128.
31. Anderson LB, Morgan M. An examination of nurses' intergenerational communicative experiences in the workplace: do nurses eat their young? *Communication Q*. 2017;65(4):377-401.
32. Roberts SJ. Oppressed group behavior: implications for nursing. *Adv Nurs Sci*. 1983;5(4):21-30.
33. Friend ML. Group empowerment in nursing education. *J Nurs Educ*. 2015;54(12):689-695.
34. Peters AB. Faculty to faculty incivility: experiences of novice nurse faculty in academia. *J Prof Nurs*. 2014;30(3):213-227.
35. Walker K. Whither nursing? Reflections on fate and futurity. *Contemp Nurse*. 2004;16(1/2):3-8.
36. McDonald PJ. Transitioning from clinical practice to nursing faculty: lessons learned. *J Nurs Educ*. 2010;49(3):126-131.
37. Guarino CM, Borden VM. Faculty service loads and gender: are women taking care of the academic family? *Res Higher Educ*. 2017;58(6):672-694.
38. El-Alayli A, Hansen-Brown AA, Ceynar M. Dancing backwards in high heels: female professors experience more work demands and special favor requests, particularly from academically entitled students. *Sex Roles*. 2018;79(3):136-150.
39. Britton DM. Beyond the chilly climate: the salience of gender in women's academic careers. *Gen Soc*. 2016;31(1):5-27.
40. DalPezzo NK, Jett KT. Nursing faculty: a vulnerable population. *J Nurs Educ*. 2010;49(3):132-136.
41. Delgado C, Upton D, Ranse K, Furness T, Foster K. Nurses' resilience and the emotional labour of nursing work: an integrative review of empirical literature. *Int J Nurs Stud*. 2017;70:71-88.
42. Fang D, Bednash GD. Attrition of full-time faculty from schools of nursing with baccalaureate and graduate programs, 2010 to 2011. *Nurs Outlook*. 2014;62(3):164-173.
43. Ferrant G, Pesando LM, Nowacka K. *Unpaid Care Work: The Missing Link in the Analysis of Gender Gaps in Labour Outcomes.* Paris, France: Organization for Economic Co-operation and Development; 2014.
44. Wolf N. *The Beauty Myth: How Images of Beauty Are Used Against Women.* New York, NY: Morrow; 1991.
45. Phillips JM, Malone B. Increasing racial/ethnic diversity in nursing to reduce health disparities and achieve health equity. *Public Health Rep*. 2014;129(1, suppl 2):45-50.

46. Van Herk KA, Smith D, Andrew C. Examining our privileges and oppressions: incorporating an intersectionality paradigm into nursing. *Nurs Inq*. 2011;18(1):29-39.
47. Willis D, Perry DJ, LaCoursiere-Zucchero T, Grace P. Facilitating humanization: liberating the profession of nursing from institutional confinement on behalf of social justice. In: Kagan PN, Smith MC, Chinn PL, eds. *Philosophies and Practices of Emacipatory Nursing: Socal Justice as Praxis*. New York, NY: Routledge; 2014:251-265.
48. Varcoe C, Browne AJ, Cender LM. Promoting social justice and equity by practicing nursing to address structural inequities and structural violence. In: Kagan PN, Smith MC, Chinn PL, eds. *Philosophies and Practices of Emancipatory Nursing: Social Justice as Praxis*. New York, NY: Routledge; 2014:266-284.
49. Matwick AL, Woodgate RL. Social justice: a concept analysis. *Public Health Nurs*. 2017;34(2):176-184.
50. Walter RR. Emancipatory nursing praxis: a theory of social justice in nursing. *Adv Nurs Sci*. 2017;40(3):225-243.