Gender inequality in health care;

Elements that impact nursing in patient centred care

Kaisa Vehmasto

Degree Thesis

Bachelor's Degree in Health Science, Nursing

2020

DEGREE THESIS	
Arcada University of Applied Sciences	
Degree Programme:	Nursing
Identification number:	7611
Author:	Kaisa Vehmasto
Title:	Gender inequality in health care: Elements that influence nursing in patient-centred care
Supervisor (Arcada):	Gun-Brit Lejonqvist
Commissioned by:	

Abstract:

The aim of this research is to investigate what elements impact nursing on gender inequality in patient-centred care, which was guided by the following questions: Which elements concerning gender equality influence nursing care? And which impact has gender equality on nurse's decision-making in nursing? This study is conducted as a literature review where 11 articles have been selected using an inductive methodological approach. The findings show elements that have been identified through content analysis an will create comprehension on the complexity of this phenomenon in health care. The complexity lies in the interactive character of the elements making it difficult for nurses to provide patient-centred care that is not influenced by gender as health systems reflect the sociocultural norms and values of the society it is in.

Keywords:	Nursing, Ethics, patient-centred care
Number of pages:	36
Language:	English
Date of acceptance:	

CONTENTS

1 INTRODUCTION

In Western health care one of the central concepts is equality. It aims to promote and secure elements in health to enable individuals to participate in society (Kangasniemi 2010). Equality in health is an important feature, as described in the Declaration of Alma Ata (1978), which was reinforced by WHO (1979), and in the code of professional ethics (ICN) (Kangasniemi 2010). Gender equality is a phenomenon that is difficult to comprehend. Especially in health care because there are many different aspects in care that can be taken into consideration. In this thesis the focus lies on researching what elements influence nursing care, nurse-patient relationship and the importance of this.

The reason why it is remains an important phenomenon as when feminism started in 1900 is because according to the UN human development report (2020) there is a stagnation happening in gender equality globally. This has an impact on health care since gender influences individual's health seeking behaviour (WHO). As it is a human right to receive health care regardless of gender, age, socio-economic or ethnic background (Universal declaration of human rights 1948) it is one of the nurses' responsibilities to assure this is provided.

A nurse has many roles and one of them is the role as an advocate for patients' needs and right. According to ICN nursing "... Includes the promotion of health, prevention of illness, and the care of ill, disabled and dying people. Advocacy, promotion of a safe environment, research, participation in shaping health policy and in patient and health systems management, and education are also key nursing roles" (ICN, 2002). The motivation behind this research has been to gain comprehension on the gender inequality of patients by nurses globally.

Women have been excluded from certain areas in health care because of the nature of a patriarchal society. For example, in cardio-vascular disease and medication. Not until the 1970's women were considered able to be part of trials (Davis 2002). This is important information because it reflects the patriarchal view on gender (Hay et al 2019). The importance of knowing and understanding this for a nurse means that it can in collaboration with other health care professionals ensure that the care given is patient-centred, and not influenced by their gender (Wittman-Price 2005, Kangasniemi 2010). It is

important to be able to distinguish equality and individual nursing. As equal opportunities are the ideal in nursing, in practical nursing critical thinking is required as the needs of the patient are different (Kangasniemi 2010). Equality being the goal in nursing care, to be able to provide this through individual nursing is the aim.

Looking at history there are nurses that roared and made a big influence on the care we give to patients today. In that memory, when knowing the importance of nurses as a role model in life, every single nurse should be able to distinguish individual care by working ethical competent and ethical competencies are learned through role models and experience (Kulju et al 2016).

2 BACKGROUND

In this chapter the concept of gender equality will be explained to understand the impact it has on health. When the connection of gender equality and health is made, comprehension on the role of the nurse will be investigated and how ethics are involved. In this thesis it will be researched which competencies a nurse can use in order to understand the importance of implicit gender bias and how or if this unconsciously influences the care a nurse provides for the patient. Sex should be considered in care; however, gender as a separate concept and the importance of this distinction will be discussed later in this chapter. As a direct consequence of conducting gender equal care, empowerment is involved – what empowerment means for the patient and the role a nurse has in creating possibilities for patients to make empowered choices.

Currently gender inequality is setting the norm and is directly influencing the work of nurses and their relationship with the patients. According to the World Health Organization (WHO) gender has implications on a person's health because cultural and social norms influence a decision a person makes regarding their health. Women and men face different challenges when it comes to health. For women, these challenges take form in restrictions such as economic dependence, patriarchal structures, a bigger responsibility within the household while having limited resources. Whereas men face challenges regarding their health because of social and cultural norms of their masculinity (WHO 2020). Consequently, norms dictate and influence the expectations people have within cultures on masculine and feminine behaviour.

As gender has an impact on decision-making in seeking health care, it is an important feature to take into consideration.

In order to understand the concept of gender equality it should be defined first. According to Merriam-Webster online dictionary (2020) there is a distinguished difference between sex and gender. When talking about sex, one is only referring to the biological forms, while with gender the behavioural, cultural, or psychological traits typically associated with sex are referred.

Equality is more difficult to define. Merriam-Webster dictionary (2020) describes the noun 'equality' as: "The quality or state of being equal". The adjective 'equal' is described in three different ways. Firstly, of the same measure, quantity, amount, or number as another. Secondly, like in quality, nature, or status. Lastly, like for each member of a group, class, or society.

Kangasniemi (2010) states that the basis of equality, in all its complexity in the context of nursing, is simply is the equality of being. According to Kangasniemi (2010) this is the fundamental value in nursing. Gender equality ideally refers to gender where cultural and social norms do not influence the choice one makes regarding personal health or the nurse in what kind of choices it gives to a patient regarding the care they can receive.

Common outcomes are not yet defined since the evidence shows that most research for care and nursing, especially concerning medication treatment, is based on men. The male body is mostly considered the "neutral body" in education, from which it can be concluded that the female body is being excluded from potential benefits. This is in conflict with the human rights (Verdonk 2009). In addition to this, historically women have been excluded from clinical trials and, therefore, from potential health benefits. Hence, while men suffer from restrictions in gender social and cultural norms, women in addition, suffer from decades of health care research exclusion (Davis 2002).

Different researches (Kulju et al 2016, Kangasniemi 2010, Hay et al 2019, Sugimoto et al 2019) show the importance of receiving equal care and importance of ethical competency in nursing; however, it does not show to what extend nurses are providing gender equal in patient-centred care.

When researching to what extend implicit gender bias affects nursing care and whether it results in gender inequal care, there was no evidence that such a research has been performed. In the articles nurse-patient relationships and the importance of it regarding the recovery of the patient (Kulju et al. 2016, Kuokkanen & Leino-Kilpi 2000, Vyonides et al. 2015, Kangasniemi 2002) are addressed. However, it does not specify the patient's gender, which is understandable because ideally nurses create a therapeutic nurse-patient relationship regardless of the gender.

Addressing gender inequality in health through a nursing perspective is important because it is to provoke awareness in the concept. While it can be assumed nurses provide individual care, it cannot be excluded that a nurse is influenced by personal implicit gender bias. This comes from how one is raised, the example parents gave, social and cultural norms they live in (UN Human development report 2020).

Awareness of bias in gender that results in gender inequality is needed for nurses to take a leading role in gender equality. As it is a complex topic and addresses many aspects in life, not just health, nurses hold a role model function in society important role in advancing or halting gender equality. Historically nurses have played big roles in major historical shifts regarding equality. For example, Catherine Pine established a nursing home for suffragettes, where they recovered from the torture they endured while prisoned. It is "An example of how nurses may capitalize on their power to bring about social change" (Attenborough et al. 2019).

This brings upon the complex concept of power and empowerment. In order to understand empowerment a comprehension of power is needed. Merriam-Webster provides several different definitions for the concept of power. Firstly, as the ability to act or produce an effect. Secondly, as a capacity for being acted upon or undergoing an effect. Thirdly, legal or official authority, capacity, or right and lastly, possession of control, authority, or influence over others. Kuokkanen & Leino-Kilpi (2000) describe in their article that within nursing, power is negatively connected with the hierarchical organization and authoritative leadership. This is a consequence of the history in nursing, where nurses were trained by the institutions in order to meet their needs (Mooney & Nolan 2005). However, it does not mean that authoritative leadership in hierarchical organiza-

tion means those higher up have more power, because even leaders can lack this ability (Kuokkanen & Leino-Kilpi 2000). According to Kuokkanen & Leino-Kilpi (2000) as cited by Fouchalt (1978) states that power is complex and polymorphic because it originates from everywhere, meaning that it is difficult for an individual to have power when it is connected through all human interaction through knowledge. Where there is knowledge, there is power, and one enhances the other. Power is not only authoritative because of the human interactive nature of the concept as described by Fouchalt (1978). It also comes with a responsibility because of the interactive connection with knowledge (Kuokkanen & Leino-Kilpi 2000). So, when understanding that power brings knowledge and knowledge brings power, it makes sense when nurses understand the importance of developing ethical competency to provide gender equal care and share this knowledge with their patient. A therapeutic nurse-patient relationship is also an interaction of power, where the nurse and patient are experts on different areas (Kuokkanen & Leino-Kilpi 2000). This way the nurse and patients are able to empower, which is the essence of the critical social theory in nursing as they are both considered to be part of the oppressive group and the importance of equality in a nurse-patient relationship (Wittman-Price 2004). This will be elaborated in the findings chapter.

According to Merriam-Webster online dictionary (2020) empower is defined as to give official authority or legal power to. Empowerment is defined as the act or action of empowering someone or something or the granting of the power, right, or authority to perform various acts or duties. The empowerment of the patient can only be achieved through a therapeutic nurse-patient relationship which will be referred to by using Townsend (2014) definition in this thesis: “An interaction between two people (usually a caregiver and a care receiver) in which input from both participants contributes to a climate of healing, growth promotion, and/or illness prevention”.

3 THEORETICAL FRAMEWORK

In this chapter the critical social theory will be explained by presenting where it originates from and the use of the theory through a nursing perspective.

3.1 Critical social theory

The critical social theory originated in the University of Frankfurt with the Institute for Social Research in 1923. It is also known as the Frankfurt school, where it was founded to contradict and improve through change within social and cultural norms that are within and maintained by society (Kuokkanen & Leino-Kilpi 2000). It is heavily influenced by Marxism and aims to disclose domination at the expense of groups of people that are often underprivileged, hereby referred to the oppressed groups (Kuokkanen & Leino-Kilpi 2000). For example, historically society has been patriarchal globally, where men were the center of society. Within the critical social theory, power is coerced and dominated. The aim of the theory is to analyze current social situations and encourage progression. It is often related to improving conditions of oppressed groups. Within the patriarchal society, social institutions maintain oppression in order to control people, where the critical social theory's purpose is "To expose oppression that may place constraints on individual or social freedom" (Wittmann-Price 2004). According to Wittman-Price (2004) as cited by Habermas's (1969) contemporary social theory, the way to become aware of oppressive practices is through self-reflection and interpersonal development, which will lead to ethical competency (Kulju et al 2016). Thus, the critical social theory allows us to be critical about social phenomena and detect to what extend groups or individuals play a role in maintaining it.

3.1 Critical social theory, nursing context

Within the nursing context the critical social theory is useful for several reasons. Firstly, it offers the researcher an opportunity to look critically at a social phenomenon in the context of history and present social practices. Historically women have been part of the oppressed group where men have been the center of society. There is an abundance of literature regarding marginalization and oppression towards the female sex (Ferrant et al 2014, Sugimoto et al 2019, Witteman-Price 2004, Witteman, Hendricks & Straus et al 2019, Verdonk, Bischop & de Haes et al 2009, O'Donnell et al 2004, Davis 2002). Secondly, at the base of the theory is the assumption that people are capable of self-reflection and develop this interpersonal skill because of a need to be individualistic (Kuokkanen & Leino-Kilpi 2000). This angle will be used to take a closer look at the competencies and skills a nurse has or needs (constant) development.

When using the critical social theory, the main purpose is to alleviate domination in oppressed groups (Wittman-Price 2004). However, how to do so if the oppressed group is not aware of the oppression itself? Empowerment in different social situations is the fundamental aspect in alleviation according to the theory. This can be facilitated in a nurse-patient relationship or among nurses themselves (Kuokkanen & Leino-Kilpi 2000).
The oppressed groups in this thesis will refer to patients, women and nurses (majority of nurses are women). Female nurses emphasize the embodiment of traditional gender role of caregivers. Men will also be looked at because of the need of comparison and inclusion in order to create comprehension of the complexity of gender equality

4 AIM AND RESEARCH QUESTIONS

Currently gender inequality is prevalent in health (UN Human development report 2020). As stated by the WHO, gender impacts an individual's choice in when and if they can, if they will access health care and how they are treated. Because of space and time limitations the LGTBQ+ gender community will not be elaborated in this thesis.

Based on the background the aim of this research is to investigate what elements impact nursing on gender inequality in patient-centred care. In order to meet the aim the following questions were addressed:

• Which elements concerning gender equality influence nursing care

• Which impact has gender equality on nurse's decision-making in nursing

5 METHODOLOGY

This study was conducted as a literature review and the analysis was done by inductive content analysis of original research articles. A literature review is to be critical and summarize research on a certain topic where the goal is to identify gaps and to recommend new research where needed (Granheheim & Lundman 2003).

Articles were collected through electronic search engines and in addition the "snowballing" effect was applied.

5.1 Data collection

The following search engines were used in order to conduct data collection: CINAHL, EBSCO, Pubmed and Science Direct. In addition to collecting data through online search engines the "snowballing" strategy was applied which is considered to be an effective data collection method for literature reviews (Wohlin 2014).

Articles were selected by search words to comprehend the general gender inequality topic in health care and the effect of it in nurses' decision-making in nursing.

5.1.1 Search limits

The criteria used to include articles for this study are influences by the research question and are comprehensive enough to meet the criteria (Randolph 2009). The flowchart provides the results of the search can be viewed in figure 1.

The articles were reviewed for relevance to the research aim and questions with the following keywords were used:

- Nurse-patient relationship
- Gender
- Ethics
- Nursing

List of chosen articles based on the limitations and keywords:

1. Attenborough, J., Reynolds, L., & Nolan, P. (2019). Reflecting on our history: The nurses that roared: Nurses from history who found their voices and challenged the status quo. *Creative Nursing*, 25(1), 67–73. https://doi.org/10.1891/1078-4535.25.1.67
2. Ayala, R. A., Holmqvist, M. T., Messing, H. B., & Browne, R. F. (2014). Blessed art thou among women: Male nursing students and gender inequalities in Chile. *Nurse Education Today*, 34(12), 1480–1484. https://doi.org/10.1016/j.nedt.2014.04.022

3. Bhana, V. M. (2014). Interpersonal skills development in Generation Y student nurses: A literature review. *Nurse Education Today*, 34(12), 1430–1434. https://doi.org/10.1016/j.nedt.2014.05.002
4. Gunn, V., Muntaner, C., Villeneuve, M., Chung, H., & Gea-Sanchez, M. (2019). Nursing professionalization and welfare state policies: A critical review of structural factors influencing the development of nursing and the nursing workforce. *Nursing Inquiry*, 26(1), 1–12. https://doi.org/10.1111/nin.12263
5. Hay, K., McDougal, L., Percival, V., Henry, S., Klugman, J., Wurie, H., … Rao Gupta, G. (2019). Disrupting gender norms in health systems: making the case for change. *The Lancet*, 393(10190), 2535–2549. https://doi.org/10.1016/S0140-6736(19)30648-8
6. Kangasniemi, M. (2010). Equality as a central concept of nursing ethics: A systematic literature review. *Scandinavian Journal of Caring Sciences*, 24(4), 824–832. https://doi.org/10.1111/j.1471-6712.2010.00781.x
7. Kulju, K., Stolt, M., Suhonen, R., & Leino-Kilpi, H. (2016). Ethical competence: A concept analysis. *Nursing Ethics*, 23(4), 401–412. https://doi.org/10.1177/0969733014567025
8. Kuokkanen, L., & Leino-Kilpi, H. (2000). Power and empowerment in nursing: Three theoretical approaches. *Journal of Advanced Nursing*, 31(1), 235–241. https://doi.org/10.1046/j.1365-2648.2000.01241.x
9. Thórarinsdóttir, K., & Kristjánsson, K. (2014). Patients' perspectives on person-centered participation in healthcare: A framework analysis. *Nursing Ethics*, 21(2), 129–147. https://doi.org/10.1177/0969733013490593
10. Vryonides, S., Papastavrou, E., Charalambous, A., Andreou, P., & Merkouris, A. (2015). The ethical dimension of nursing care rationing: A thematic synthesis of qualitative studies. *Nursing Ethics*, 22(8m), 881–900. https://doi.org/10.1177/0969733014551377
11. Wittmann-Price R. A. (2004). Emancipation in decision-making in women's health care. Journal of advanced nursing, 47(4), 437–445. https://doi.org/10.1111/j.1365-2648.2004.03121.x

5.2 Content analysis

The inductive content analysis method was conducted to research the topic of this thesis. When conducting inductive content analysis the goal by enhanced comprehension, is that it will provide new insights and knowledge (Elo & Kyngäs 2007). It allows the researcher to discover new perspectives upon a subject. This method is suggested when there is not enough former knowledge on a phenomenon or when the information is 'fragmented' (Elo & Kyngäs 2007). The inductive content analysis is divided into three phases: Preparation, organizing and reporting phase. The researcher has analyzed the articles in accordance through these phases and will shortly elaborate, which can be viewed in the figure below. In the preparation phase the researcher familiarized herself with the chosen articles in order to be able to start select units of analysis.

The preparation phase starts with selecting the unit of analysis. This can be a word or a theme. Deciding on what to analyse in what detail and sampling considerations are important factors before selecting the unit of analysis. The sample must be representative of the universe from which it is drawn (Elo & Kyngäs 2007). When organizing the collected data open coding and categories were created where comparisons and connections were made through interpretation of the content. As Elo & Kyngäs (2007) describe, the purpose of a category by describing the phenomenon and to enhance comprehension to generate knowledge.

5.3 Research ethics

This research has been carefully conducted in compliance according to TENK responsible conduct of research (2012). In order to prevent research misconduct the thesis has been written according to the Arcada thesis writing guideline using Harvard referencing system. Research misconduct has traditionally three categorize: Fabrication, falsification and plagiarism (FFP categorization). However, in Finland there is an addition of a fourth aspect in order to "Maintain a more comprehensive and analytical categorization" (Finnish Advisory Board on Research Integrity 2012).

The subject of this research has been accepted by Arcada University of Applied Sciences. In addition, the researcher has only used articles that were peer reviewed and were sought through academic search engines and "snowballing" effect.

The researcher acknowledges the possibility of bias based on personal experiences and sex. Therefore, a strive to maintain objectivity has been made by including male and female gender in this research.

The purpose of this research is not to prove historical gender inequality. It is to investigate the possibilities of progression in gender equality in health, without diminishing the historical facts about gender oppression.

6 FINDINGS

6.1 Table of content analysis

Codes	Category	Theme
Sociocultural	Oppression and empowerment in nursing	Ethics
Political		
Restrictive factors, organizational	Nurse care rationing	Nursing
Ethical competency		
Nurses characteristics and skills		
Equality	Patient-centred	Care
Patient participation		
Therapeutic nurse-patient relationship		

6.2 Oppression and empowerment in nursing

6.2.1 Sociocultural aspect

Hay et al (2019) found that the interaction of health care and sociocultural gender restrictive norms influence the efficiency of the health system, because they are mirrored and reinforced within the health systems and therefore compromising patients' health. For example, where patients look to physicians to cure, they look to nurses to care. The care is considered less skilled in comparison with the cure of physicians, which is also in line with the general sociocultural norms of women's traditional gender role as caregivers (Hay et al 2019, Attenborough et al 2019, Ayala 2014, Gunn et al 2018, Wittman-Price 2004, UN Human development report 2020). Because of sociocultural norms/attitudes towards traditional gender roles, nurses' work in society is often undervalued and underappreciated as it is in the same line as the traditional women caring characteristic (Gunn et al 2018). Because of this designated gender characteristic in combination that globally the majority of nurses are women (WHO 2019) there is a global distrust for increased salaries in nursing, since care is part of women's nature and responsibility (Hay et al 2019). In addition to this phenomenon, religion has reinforced this view of nursing and caring in a self-sacrificing way in European and North American nursing. It is affecting sociocultural norms and the professionalization of nursing (Gunn et al 2018). Therefore, work that involves caring often labelled emotional and self-sacrifice as a female quality rather than the reality of men and women fulfilling these requirements for health organizations (Gunn et al 2018). Thus, the sociocultural constructed norms of less skilled care by nurses versus cure by physicians, reflects in hierarchal health system and is still withholding in organizational policies (Gunn et al 2018). According Ayala (2014) male nurses have a more competitive attitude at nursing because it is assumed that they will be working in leading positions based on their gender. It implies the old presumption that women are considered weak and emotional, whereas men are considered the opposite strong and able to control their emotions (Ayala 2014). However, even though there is a growth in male nurses, women still represent over 70% (WHO 2019) as nurses globally. Existing gender bias could prevent men from becoming a nurse and therefor withholding the nursing profession of strengths and benefits (Gunn et al 2018). Ayala (2014) states that if this were not handled properly it potentially

would lead to: “Earlier historical inequalities”. According to the UN Human development report (2020) there is currently a stagnation happening in the progression of gender equality. Therefore, awareness of the possible problems in the nursing profession as stated by Ayala (2014) should be considered important signals for the society regarding gender bias. Gender bias in nursing is often associated with difficulties in social and financial recognition, where eliminating gender bias would benefit men and women but mostly, nursing profession in general (Gunn et al 2019). Health systems have hierarchies that in combination with sociocultural hierarchies are maintaining these forms of power at the cost patients. Because health systems provide care in the same line as sociocultural norms, it results is poor care for women, men and gender minorities (Hay et al 2019). Through their research it has emerged that men are receiving less priority due to sociocultural gender bias as they have higher risks and a low life expectancy in comparison to women, and due to masculine gender norms at high behavioural risks such as delayed health seeking, substance abuse, injury and suicide (Hay et al 2019). In this patriarchal form health systems are reinforcing sociocultural norms and therefor maintaining gender inequalities within health systems and continues to be oppressive (Hay et al 2019). When oppression is maintained by health systems and other social institutions, the phenomena power, empowerment and oppression are considered social and political (Kuokkanen & Leino-Kilpi 2000). Historically oppression is a universal problem that needs to be addressed because it influences racial minorities, gender and health care patients’ personal choices (Kuokkanen & Leino-Kilpi 2000, Wittman-Price 2004).

6.2.2 Political aspect

The concept of empowerment, as Kuokkanen and Leino-Kilpi (2000) have described, is positive and emphasizes on solutions, which is necessary when there is discrimination on a personal, cultural and/or structural level (Kangasniemi 2010). Even now, women are poorly represented at the top of medical hierarchy globally, such as health ministers and physicians, and are mostly represented at the lower part of health system hierarchies as nurses and midwifes (Hay et al 2019). The UN Human development report (2020) confirms sociocultural based gender bias attitude where globally men are considered more capable of leading functions. As it is established that globally the majority of nurses is, and based on the UN Human development report (2020), continues to be mostly women,

developing professionalization of nursing will empower women economically and as leaders in sociocultural aspect (Attenborough et al 2019, Ayala 2014).

Therefore, nurses need emancipation from the hierarchical constraints within health care (Wittman-Price 2004). Gender equality is best promoted through policies in family, education, economic, and political arenas (Gunn et al 2018). Nevertheless, there are improvements in gender equality through empowerment socially, economically, politically and in health. These movements are targeting sociocultural gender roles and improving for example reproductive rights in Ireland and the justice system for rape in India (Hay et al 2019). Through legislation and politics, equality can be ensured in social, economic and political aspects in order to create gender equal health (Kangasniemi 2010). According to Kuokkanen & Leino-Kilpi (2000) power is shared and the exercise of it merges in empowerment, which means it is a dynamic concept. In this context empowerment is to improve living conditions of oppressed groups as racial minorities, gender and patients (Kuokkanen & Leino-Kilpi 2000). However, empowerment is only a component of the emancipation process.

"Emancipation describes a process of reaching a more positive state of being a state of relative freedom in choice by first acknowledging an affective experience of oppression. The experience is cognitively reflected upon, with or without dialogue. The choice is arrived at by using personal knowledge in combination with empowerment from professional knowledge. The decision is made in a flexible environment and precipitates the desired outcome of free choice." Wittman-Price (2004).

Wittman-Price (2004) emphasizes the fact that nurses need to address oppression through emancipation within professionalization in order to create a social impact, which is a condition for "free choice".

"Choice is emancipating when a person is not only free to choose what is right for them but when that decision can be enacted without consequence. If the choice carries negative consequences, it is still bound by oppression". Wittman-Price (2004).

A concept close to power, oppression, is discriminating on a personal, cultural or even structural level (Kangasniemi 2010). The concept of oppression is presently less obvious

than in the past, which makes it difficult to recognize or to interpret it correctly (Wittman-Price 2004). However, through objectivity nurses can recognize oppression, which is the condition in creating emancipated health care and an equal environment (Wittman-Price 2004). Empowerment and oppression are connected to power that is to control, creating possibilities and impacting others (Kangasniemi 2010). It is considered an imbalance, which is also seen in nursing through relations as teachers and student, researchers and subject, nursing staff and patient (Kangasniemi 2010). However, there are different types of imbalance as Kangasniemi (2010) describes. Temporary power that is considered part of development, for example towards recovery as in a nurse-patient relationship. In these cases the imbalance does not imply inequality as the aim of it is to develop towards equals or peers.

6.3 Nurse care rationing

6.3.1 Rationing

There are multiple elements that effect nursing and nurse-patient relationships. These form difficult circumstances that limit nurses in their decision-making and creating a gap in ideal ethical decision making and nursing practice (Vryonides et al 2015)

The practice of nursing is influenced by nurses' decision making (micro level), factors at organizational (meso) level and lastly on political (macro) level (Vryonides et al 2015). Vryonides et al (2015) explains that decision-making in nursing is globally effected by political decisions, organizational and socioeconomic circumstances of which lead to scarce of resources. These changes require professional competency in ethical decision making and handling moral problems, which this scarcity can cause (Kulju et al 2016).

Nurses' decision-making process is prioritizing aspects of nursing care because of insufficient time and resources to provide the care nurses perceive their patients' need, hereby referred to as nursing care rationing. This phenomenon has been given several definitions such as: "The withholding of, or failure to carry out necessary nursing tasks, nursing care that has been omitted (either partially or totally) or delayed, care needs not being met, care not performed, priority setting, or care prioritization that are due to inadequate nursing resources" (Vryonides et al 2015).

This missed nursing care is affecting nurses' internal processes that guides them in the prioritizing decision-making process of nursing care in what can be missed, what is necessary or what can be performed later (Vryonides et al 2015). These decisions are not solely influenced on macro and meso levels, but also by team norms and their decision –making habits as well as personal values, attitudes and beliefs about the nurses' perception of care (Vryonides et al 2015). Most nursing care rationing are fundamental elements of care that are prioritized as low on a regular basis such as communication, patient support, patient hygiene among others (Vryonides et al 2015). The ideal of distributing equal care means equal availability of health services, equal treatment and equal access to health services regardless of individual difference (Kangasniemi 2010).

Vryonides et al (2015) explain that one factor that is influencing nurse care rationing is what nurses perceive as working "by the clock", instead of what patient need. They explain to feel forced into prioritizing between equally important needs of their patient, which results in higher prioritization to essential medical and physiological needs and lower prioritization to communication, social, psychological and relational needs (Vryonides et al 2015).

Consequently, nurses feel being forced by impacts from a macro and meso level in performing unfair, prejudiced and unethical nursing care practice while putting patients' health at risk (Vryonides et al 2015). Wittman-Price (2004) explains that oppression and unequal power are restricting choices and therefore an individuals self-esteem and sense of autonomy. Naturally it follows that an empowered nurse can develop nursing care that will increase self-confidence and allows for more freedom of action (Kuokkanen & Leino-Kilpi 2000). Empowerment in nursing means independence, responsibility and autonomy in decision-making (Kuokkanen & Leino-Kilpi 2000).

One way of creating an empowered work floor is through a flexible environment. Wittman-Price (2004) explains the concept as following: "It can be described as one that is responsive to change leading to personal benefits for individuals and therefor society. It increases choice and thereby enhances self-esteem and understanding".

When a nurse is unable or unwilling to adjust to the nursing care rationing it can make the nurse uninterested. When unable or unwilling to accept a role where nurses are to ration

nursing care, it will enviably lead to unfair and unethical distribution of care, nursing resources or unacceptable practices (Vryonides et al 2015).

This will affect a nurses' perception of professional and ethical decision-making and personal development (Vryonides et al 2015). To maintain a professional attitude nurses should be true to the ideals and expectations in order to provide equal nursing care (Vryonides et al 2015). To remain an ethical approach in nursing care will have positive patient outcomes and professional fulfilment for nurses (Vryonides et al 2015).

However, even though providing equal nursing care nurses feel that it is not realistic (Vryonides et al 2015). Therefore, nurses have developed nursing care standards that are influenced by a biomedical ethos, biomedical needs, and visible clinical tasks, while they neglect basic human needs and essential elements of care such as empathetic listening and communication (Vryonides et al 2015) and maintaining the hierarchical health system (Gunn et al 2018, Hay et al 2019). Because of the inability to provide the care that is perceived as needed it is threatening nurses care (Vryonides et al 2015). This stands in direct conflict with the definition of nursing.

6.3.2 Ethical competency

Ethics are considered as the foundational competency in health care (Kulju et al 2016). It is part of professionalism and best learned through role models and experience that consist of virtues, principles and critical reflection (Kulju et al 2016, Kangasniemi 2010). Ethics refers to the study of morals, principles and decision-making skills (Kulju et al 2016). In the previous subchapter described interpersonal skills are considered part of ethical competency. It is a generic competence that is guiding the others (Kulju et al 2016). Nurses are required to make decisions that affect other people, which can be challenging. For this reason, nurses need in addition of technical competence, to comprehend the ethical dimensions in situations. This is learned through education and developed through work experience (Kulju et al 2016).

One of the aims of achieving ethical competency is to provide moral basic right to equal treatment for nurses and patients (Kangasniemi 2010). Meaning in nursing that care should be human-oriented, to recognize a patient's need, to take into consideration social

and cultural background in order to ensure dignity and respect in providing equal nursing care (Kulju et al 2016).

However, this is a challenging aim because equality does not collaborate theoretically and functionally as the following example is given by Kangasniemi (2010):

"It is impossible to achieve simultaneously, equality of being and equal opportunities: if all patients are to be offered similar treatment regardless of their age or ethnic background (equal opportunities), individual differences are not taken into consideration (equality of being)"

Controversially, it is through these differences culturally, values and beliefs that provide the best treatment from patients' perspective (Kangasniemi 2010). Even though impartiality and objectivity are required to theoretically ensure equal care, it is not possible in practical nursing (Kangasniemi 2010).

As the basics of ethical competence are learned through education, it is further developed from professional experience and is enhanced throughout the career (Kulju et al 2016). Certain virtues have been identified to enhance the ethical competency that motivates and allows the nurse to act and/or choose actions in a situation, such as empathy and practical wisdom (Kulju et al 2016). Ethical competency requires good communication, by which it means "The ability to express oneself clearly, to participate, influence and be listened to" (Kulju et al 2016, Bhana 2014).

The concept analysis by Kulju et al (2016) divided ethical competence in the following terms: a) Character strength b) Ethical awareness c) Moral judgement skills and d) Willingness to do good:

"Character strength. At the core of ethical competence – guiding the person to desire and do good – is character strength. Ethical competence is a function of individual characteristics, which, at the organisational level, includes the ability and strength to support ethical processes. Without character strength, an individual does not have the desire to do what is right, the temperance, humanity or courage to implement the right action".

"Ethical awareness. Ethical awareness, meaning ethical perception, attentiveness or sensitivity to identify an ethical problem, is an important attribute to ethical competence when dealing with a situation in which it is difficult to recognise what constitutes good

or bad. A professional also needs to have the awareness to recognise the individual needs and social and cultural background of a patient".

"Moral judgement skills. An ethically competent person is able to think and act openly, without moral fixations or automatic ways of action; having the ability to consider critically and logically all values, principles, needs and beliefs; and making moral judgements consistently, from the alternatives involved in an ethically demanding situation. This attribute includes also that the professional is autonomous in his or her thinking".

"Willingness to do good. Ethical competence is willingness to implement the decisions made and act for the benefit of other people. A professional person needs to have motivation and a desire to do the good thing, so willingness to do good was named to be an essential part of ethical competence".

Ethical competent working has several benefits. Firstly, it can provide the best possible solutions for the patient. Secondly, it will reduce moral distress at work and encourage development in society (Kulju et al 2016). Ethical competent working fundamentally means moral equality in care and safety (Kulju et al 2016). By being able to work ethical competent it will reduce moral distress, ethical tensions in care and because of this it will lead to less stress at work (Kulju et al 2016). In short, to be ethical competent will lead to wellbeing. Ethical competency includes the following characteristics such as: Ethical awareness, courage, willingness and skills in decision-making and ethical action (Kulju et al 2016, Bhana 2014, Wittman-Price 2004).

However, to be able to work ethical competent it requires support from the organisational (meso) level which needs political and economic (macro) support (Kulju et al 2016, Vryonides et al 2015).

6.3.3 Nurses characteristics and skills

The concept of empowerment forms an umbrella in professional development in nursing (Kuokkanen & Leino-Kilpi 2000). As discussed in previous subchapters, empowerment can be perceived as a consequence from an unequal power situation. An example of this is a nurse-patient relationship where the inequality is created through knowledge, skills and by sociocultural appointed authority (Kangasniemi 2010). Equality in health

care aims to promote and secure the health aspects that will enable equal functioning in society for all citizens (Kangasniemi 2010). As described in the background, knowledge increases power therefore it is necessary to look closely at the impact of knowledge, empowerment and equality in nursing. Kangasniemi (2010) describes this phenomenon as: "From the viewpoint of equality, knowledge is a crucial element of empowerment: if nurses do not give their patients enough information, they are preventing empowerment and creating inequality".

The emancipatory role on nurses in patient care leads to improved decision-making skills or an increase in patient autonomy (Wittman-Price 2004). This improvement is achieved by developing a therapeutic nurse-patient relationship, which is through good communication. A nurse creates a therapeutic nurse-patient relationship through developing interpersonal skills. These are described as skills that are required for communication and interaction with others (Bhana 2014, Kulju et al 2016).

Caring forms the central of nursing care and is the base nurse-patient relationship because it takes place between at least two persons (Kangasniemi 2010, Bhana 2014). Care is an interactive phenomenon as the care is based on the relationship between a nurse-patient relationship and it is through this interaction that the level of equality becomes visible. It is by trust and responsibility (Kangasniemi 2010). In order to develop this interpersonal skill self-reflection is considered a condition (Kuokkanen & Leino-Kilpi 2000, Kulju et al 2016). Interpersonal skills are identified as: Self-disclosure, trust, communication, expression of feelings and helpful listening and responding, as some of the interpersonal skills (Bhana 2014). A nurse is to develop interpersonal skills through self-reflection in order to manifest a therapeutic nurse-patient relationship to ensure the patient is able to make emancipated decisions. By doing this the nurse is empowering the patient. However, the definition of empowerment is easily mistaken for the concept of nursing care, which can undermine the value concept of empowerment. Therefore, it is important to distinguish the difference (Kuokkanen & Leino-Kilpi 2000).

6.4 Patient participation

In contemporary health care patient participation is considered one of the most important ideals (Thorarinsdottir & Kristjansson 2014). Patient participation means the active involvement and participation in patients' own health care in cooperation with health care professionals, such as doctors, nurses, midwifes, pharmacists and dentists (ILO 2008, WHO 2010) who share their knowledge. This is a shift from the former paternalistic form of health care where health care professionals provide care for patients who have minimal and passive roles in their own health. This new form of shared decision-making process between nurse and patient (Wittman-Price 2004, Thorarinsdottir & Kristjansson 2014).

For the purpose of this thesis this subchapter will continue from a nursing perspective.

In order for patients to be able to choose freely what kind of health care would be most fitting, a non-judgemental environment is needed. Because if chosen differently than what is suggested with consequences in the form of sanctions of any sorts, is just another form of oppression (Wittman-Price 2004). With the collaboration between nurse and patient concerning the patients' own health care, they still have tasks and roles and different types of knowledge, meaning there is still the concept of power (Kangasniemi 2010). Whereas it used to be the nurse who was considered the expert, the patient is considered the experts on their own health. Creating an exchange of knowledge and power and equal circumstances for each other. A shared responsibility and authority can lead to empowerment, this goes both ways in a nurse-patient relationship. As this quote nicely summarized: "An empowered person does not pretend to have acquired more power but feels empowered" Kuokkanen & Leino-Kilpi 2000.

Thorarinsdottir & Kristjansson (2014) research shows that being regarded as a person and unique individual is considered important. Equality aims to provide moral basic rights to equal care for nurses and patients (Kangasniemi 2010). However, according to Thorarinsdottir & Kristjansson (2014) study patient can experience their participation as a difficult power struggle where the nurse is providing and sometimes forcing care from what is in the nursing perspective best, but perceived as unwanted by patients. This is described in their study as 'constrained patient participation'. (Thorarinsdottir & Kristjansson 2014). Whereas the opposite is described as an *ideal* patient participation, which is person-centred. In order to create such an nurse-patient relationship with ideal patient

participation it is important to involve respecting or addressing patients as unique individuals from a holistic perspective and entering their worlds by understanding their concerns, experiences, needs and preferences (Thorarinsdottir & Kristjansson 2014). Thus, in person-centred care the person is addressed instead of only the reason why the person is seeking healthcare (Thorarinsdottir & Kristjansson 2014). Meaning that a nurse is to ensure a therapeutic nurse-patient relationship in order to share power and knowledge that manifest through ideal patient participation and is perceived by patients as 'partnership' through interpersonal interaction (Bhana 2014, Thorarinsdottir & Kristjansson 2014). A therapeutic nurse-patient relationship is based upon mutual respect, trust and equality of worth. Patients must be active and equal participants in their own empowerment. In short, it is perceived better by patients to facilitate empowerment, rather than empowerment on itself (Kuokkanen & Leino-Kilpi 2000). The nature of a therapeutic nurse-patient relationship is that it enables the patient to participate in their own care and in order to do that they must understand the condition they have.

Bhana (2014) describes this as "insight through consideration" and the knowledge of the patient enhanced by "The nurse's communication of relevant information to the patient in a safe environment". Nurses share power through language, and it is suggested that through a therapeutic nurse-patient relationship open and meaningful communication is enabled that facilitates empowerment between nurses and patients (Kuokkanen & Leino-Kilpi 2000, Thorarinsdottir & Kristjansson 2014).

According to the analysis based on patients' experiences, values, preferences and needs that is performed by Thorarinsdottir & Kristjansson (2014) they were able to identify three phases of ideal patient participation: The human-connection phase, the phase of information processing and the action phase, each of which is further divided into sub-attributes (Figure 2). In the first phase, a human connection between patients and nurses is developed, in which patients perceive respect and recognition as persons and equal individuals. In the second phase, seeking and receiving appropriate information, where nurses are providing relevant information and providing explanation.

Thorarinsdottir & Kristjansson (2014) found that the ongoing dialogue and involvement was considered of more importance than the actual decision. In this process patient increased their knowledge by exploring choices, suggestions and alternatives. However, the

most valued aspect was the continues connection between nurse and patient. Lastly, in the action phase where the patient would accept or delegate responsibility regarding their own health (Thorarinsdottir & Kristjansson 2014).

The outstanding finding in the analysis is the importance of equality between nurses and patients with mutual respect that ensures person-centred care. It is the power sharing that was considered the highly appreciative among patients (Thorarinsdottir & Kristjansson 2014). Thus, the facilitating of empowerment through a therapeutic nurse-patient relationship. For nurses it gives to challenge to develop ethical competency and to be critical to become aware when they are acting with implicit paternalistic assumption to act in the patients' best interest.

7 DISCUSSION

This research has shown the complexity of gender inequality in health care. To comprehend the complexity of this phenomenon and the affects it has on nursing, different elements have been identified through the research. In identifying the categories, the researcher was guided by the aim and the research question.

The critical social theory allowed the researcher to analyse current social situations through the chosen literature in order to be able to encourage progression in gender equality. Awareness is important because it allows individuals to be critical in situations to develop and encourage progression.

According to this research, nurses are maintaining gender inequality in health care for several reasons. Firstly, because they are working in health systems that are influenced by sociocultural norms that maintains patriarchal and hierarchical health systems. Secondly, nurses form a minority that is based on sociocultural gender restrictive norms (Kuokkanen & Leino-Kilpi 2000, Attenborough et al 2018, Kangasniemi 2010, Wittman-Price 2004). The analysing of the articles through the lens of the critical social theory, resulted in the following conclusion from a nurses perspective: As nurses' professional position in society and therefore also health systems, are not appreciative and based on sociocultural restrictions that are associated with the profession and are in line with female gender characteristics. Therefore, nurses need emancipation from the hierarchical constraints within health care (Wittman-Price 2004). Because this has been historically

influenced by religion and by oppression of the patriarchal society that still has impact today globally as the UN human development report (2020) shows (Thorarinsdottir &Kristjansson 2014, Gunn et al 2018, Hay et al 2019). However, it is difficult to recognize oppression presently since it is not as obvious as in the past. For example, even though society is still patriarchal, globally women have achieved a right to vote and form an interactive part of society. But when looking at politics in general alone where 20,7% of government ministers were women in Social affairs, Family/Children/Youth/Elderly/Disabled, Environment, Employments and Trade/Industry (UN Women 2019). Which are in line with sociocultural female gender norms. Because gender oppression is less obvious than in the past, it makes it difficult to recognize or to interpret it correctly (Wittman-Price 2004). However, through objectivity, self-reflection and interpersonal development nurses can recognize oppression, which is the condition in creating emancipated health care and an equal environment (Wittman-Price 2004, Kulju et al 2016). The base of critical social theory is that even though when oppressed or oppressive, people capable of self-reflection and develop this interpersonal skill because of a need to be individualistic (Kuokkanen & Leino-Kilpi 2000). Empowerment can take place in different social situations in a nurse-patient relationship or between nurses themselves. (Kuokkanen & Leino-Kilpi 2000).

Research shows that oppression leads to a decrease in individuals' self-esteem and autonomy, but that shared responsibility and authority can lead to empowerment. With this finding in mind it shows how important it is to provide person-centred care. This is in line with contemporary nursing ideals where through patient participation, patients are actively involved in their own health care in cooperation with health care professionals who share their knowledge (Wittman-Price 2004, Thorarinsdottir & Kristjansson 2014).

This form of person-centred care through patient participation emphasizes that nurses need to address oppression through emancipation within professionalization in order to create a social impact, which is a condition for "free choice". Choice in itself is an emancipated concept and arguably it is a nurses' role to facilitate this for patients. This is done by developing interpersonal skills to become ethical competent in order to ration nursing care and to be able to provide person-centred care. When providing person-centred care, patients are able to make a considered free choice that is right for them is without consequences. Otherwise it is still bound by oppression (Wittman-Price 2004). This process of

empowerment in nursing means independence, responsibility and autonomy in decision-making (Kuokkanen & Leino-Kilpi 2000). "An empowered person does not pretend to have acquired more power but feels empowered" Kuokkanen & Leino-Kilpi (2000). Empowerment is a positive phenomenon, which focuses on solutions instead of problems.

Where individuals globally express a longing to be regarded as a person who is unique, this is to be the starting point of any nurse-patient relationship. Where equality aims to provide moral basic rights to equal care, in addition with the knowledge people's wish to be respected and valued for their uniqueness, shows the importance of gender equal care (Kangasniemi 2010, Wittman-Price 2004, Thorarinsdottir & Kristjansson 2014, Hay et al 2019). A nurse-patient relationship cannot always be equal. However, because it is a temporary imbalance with the aim of restoring it, this imbalance does not imply inequality (Kangasniemi 2010).

Different impacts force nurses to ration their care: political, economical and sociocultural elements. Through legislation and politics equality can be ensured in so-cial, economical and political aspects in order to create gender equal health (Kangas-niemi 2010). To judiciously ration nursing care ethical competency in nursing will allow the nurse to be able to provide the best possible care and solutions for the patient, which includes moral equality in care and safety (Kulju et al 2016). By being able to work ethical competent it will reduce moral distress, ethical tensions in care and therefore, reduce stress at work (Kulju et al 2016).

8 CONCLUSION

This review has shown that there are different elements that impact nursing care rationing, which can be reviewed in figure 3. The aim of this study is by using the critical social theory to analyse current social situations and encourage progression. The identification of these elements was a complex process as they also influence each other. Because of the complex and interactive character of the elements, there is not one element to single out in order to create progression gender equality in health care. Therefore, it is recommended to investigate if there is a connective factor in the elements that can be identified in order to create progression on all elements.

Sociocultural norms have the biggest impact on society and therefore also on health systems. Although nursing cannot change the social and cultural norms alone, they share a responsibility in progression in health care. Nurses have an opportunity to create progression in gender equal care as there is a temporary power shift in a nurse-patient relationship. As nurses are rationing their care they are in temporary power, meaning they can facilitate empowerment to patients for them to be able to make emancipated free choices. This is achieved by developing interpersonal skills to become ethically competent in order to create a therapeutic nurse-patient relationship which is inviting for patient participation and enables nurses to ration person-centred nursing care. This process is influenced by sociocultural norms, political and economic elements. For nurses to remain objective and critical they are part of enabling progression in providing gender equal care in an oppressive health system. This is an important phenomenon because the nurse-patient interaction reflects the sociocultural norms in gender equality. It is important to note that nurses are not responsible for the medicine or recovery of the patient. However, because nurses form a connective factor between different occupations (doctors, physiotherapists) in health care and the patient it is the believe of the researcher that nurses carry a responsibility in patient care to ensure patients are able to make their own free choice concerning their health and not enforced by society. This is in accordance with the definition of a nurse and the wish of the patient to have somebody speak for them. To inform the patient in collaboration with doctors and other health care professionals to ensure the patient can make a considered, free decision concerning their health. Nurses and other health care professionals have a duty in ensuring this a free choice and not forcing care from which they believe is best for the patient. Contemporary health care is developing from patriarchal and hierarchal systems towards emancipated health systems where patient participation is considered the norm. To conclude, nurses are maintaining gender unequal care because health systems mirror patriarchal society. When looking back historically, nurses have influenced society on many occasions as for example Catherine Pine with the suffragette movement. To become ethical competent nurses, on aspect is through examples. Therefore, to create gender equal health care for patients there is a need for nurses to act like role models and examples for each other, patients and society.

8.1 Strength and limitations of the study

The difficulty of this study lies in recognizing gender inequality in its current form in society. Through all its layers it is hard to comprehend in what way it is affecting patients, nurses and individuals based on gender. The strength of this study lays the on-going gender inequality and the impact of it on both genders, this current phenomenon in the context gap of what a nurse's role and responsibility in this is. The subjects of empowerment and emancipation are providing steps towards a gender equal society, which will be mirrored in health systems. As gender inequality is a global problem it was addressed, as thus, which is a limitation alone. Only English articles were used and therefore excluding studies in other languages with other results (Vryonides et al 2015). Gender inequality has a long history due to the nature of a patriarchal society; therefore articles were taken into consideration from 2000-2020 to understand the timeline and comprehension on the current form of gender inequality.

Because of the complexity of gender inequality and the different aspects in life it affects on a daily base on many levels, it was a very broad subject to study and risks of excluding perspectives and perceptions due to time and space limitations. Where only 11 articles were used for this study in order to allow the researcher to focus on one small aspect that influences nurses on practical daily level. By identifying elements that impact nursing care rationing in creates understanding and strengthens nurses in their ethical competency. However, due to the complexity of gender inequality in health care not all elements could be discovered and it is the recommended to expand this study in order to find these.

FIGURES

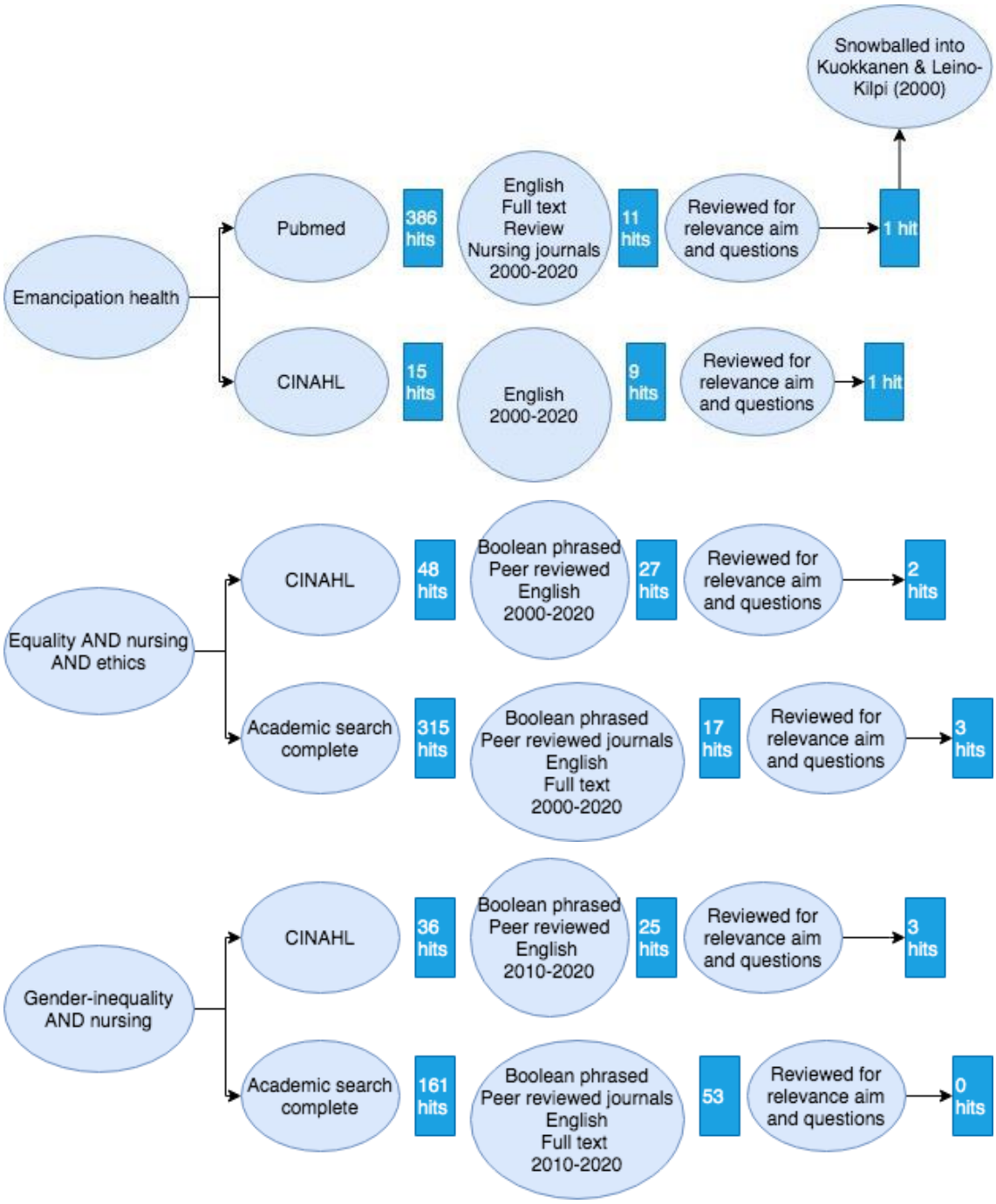

Figure 1. Flowchart data collection and search limits

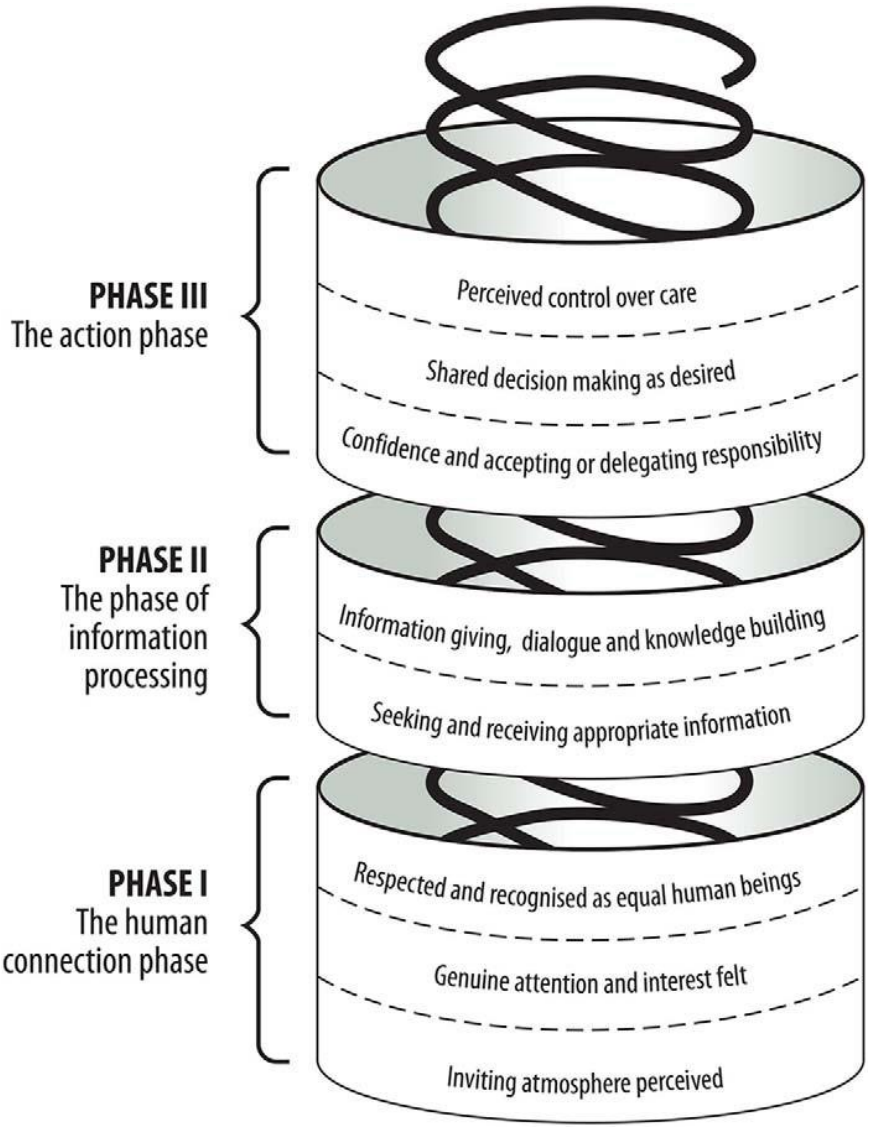

Figure 2 . Thorarinsdottir & Kristjansson (2014) Conceptual framework of person-centred participation in healthcare

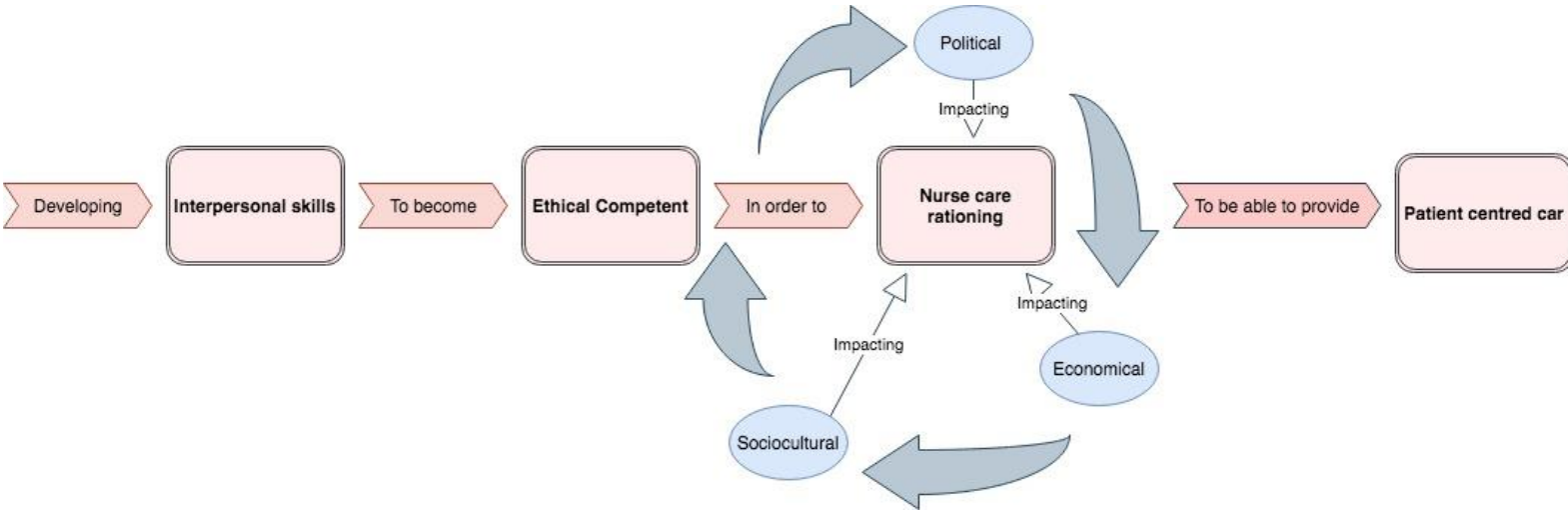

Figure 3. Conclusion of this study in a flowchart

REFERENCES

1) Attenborough, J., Reynolds, L., & Nolan, P. (2019). Reflecting on our history: The nurses that roared: Nurses from history who found their voices and challenged the status quo. *Creative Nursing*, *25*(1), 67–73. https://doi.org/10.1891/1078-4535.25.1.67
2) Ayala, R. A., Holmqvist, M. T., Messing, H. B., & Browne, R. F. (2014). Blessed art thou among women: Male nursing students and gender inequalities in Chile. *Nurse Education Today*, *34*(12), 1480–1484. https://doi.org/10.1016/j.nedt.2014.04.022
3) Boniol, M., McIsaac, M., Xu, L., Wuliji, T., Diallo, K., Campbell, J. (2019) Gender equity in the health workforce: Analysis of 104 countries. Working paper 1. *World Health Organization*, Geneva: WHO/HIS/HWF/Gender/WP1/2019.1 Licence: CC BY-NC-SA 3.0 IGO.
4) Davis, A. (2002) The study population: women, minorities, and children, *Institutional review board second edition*, Burlington: James & Bartlett Learning, page 129-133
5) Elo, S., & Kyngäs, H. (2008). The qualitative content analysis process. *Journal of Advanced Nursing*, *62*(1), 107–115. https://doi.org/10.1111/j.1365-2648.2007.04569.x
6) Declaration of Alma-Ata (1978) [online] available at: https://www.who.int/publications/almaata_declaration_en.pdf?ua=1 [accessed 28th February 2020]

7) Ferrant, G., Pesando, L. M., & Nowacka, K. (2014). Unpaid Care Work: The missing link in the analysis of gender gaps in labour outcomes. *OECD Development Centre*, 12.
8) Finnish advisory board on research integrity (2012) *Responsible conduct of research and procedures for handling allegations of misconduct in Finland.* [online] available at: https://www.tenk.fi/sites/tenk.fi/files/HTK_ohje_2012.pdf [accessed 7th April 2020]
9) Gunn, V., Muntaner, C., Villeneuve, M., Chung, H., & Gea-Sanchez, M. (2019). Nursing professionalization and welfare state policies: A critical review of structural factors influencing the development of nursing and the nursing workforce. *Nursing Inquiry*, *26*(1), 1 12. https://doi.org/10.1111/nin.12263
10) Graneheim, U.H. & Lundman, B., 2004, Qualitative content analysis in nursing research: concepts, procedures and measures to achieve trustworthiness. *Nursing education today*, 24, pp.105–112.
11) Hall, J., Hsu, Y., Jahic, A., Kovacevic, M., Mukhopadhyay, T., Ortubia, A., & Rivera, C. (2020). Human Development Perspectives tackling social norms: a game changer for gender inequalities [online] available from: http://hdr.undp.org/en/GSNI [accessed 1st February 2020]
12) Hay, K., McDougal, L., Percival, V., Henry, S., Klugman, J., Wurie, H., Rao Gupta, G. (2019). Disrupting gender norms in health systems: making the case for change. *The Lancet*, *393*(10190), 2535–2549. https://doi.org/10.1016/S0140-6736(19)30648-8
13) International council of nurses, ICN. (2012). The ICN Code of Ethics for Nurses. *International Council of Nurses*, 8 [online] available from: https://www.icn.ch/sites/default/files/inline-files/2012_ICN_Codeofethicsfornurses_ eng.pdf [accessed 7th april 2020]15.
14) Kuokkanen, L., & Leino-Kilpi, H. (2000). Power and empowerment in nursing: Three theoretical approaches. *Journal of Advanced Nursing*, *31*(1), 235–241. https://doi.org/10.1046/j.1365-2648.2000.01241.x

15) Kangasniemi, M. (2010). Equality as a central concept of nursing ethics: A systematic literature review. *Scandinavian Journal of Caring Sciences*, *24*(4), 824–832. https://doi.org/10.1111/j.1471-6712.2010.00781.x

16) Kulju, K., Stolt, M., Suhonen, R., & Leino-Kilpi, H. (2016). Ethical competence: A concept analysis. *Nursing Ethics*, *23*(4), 401–412. https://doi.org/10.1177/0969733014567025

17) Merriam-Webster Online Dictionary. http://www.merriam-webster.com/dictionary (2013) [accessed 8th April 2020]

18) Mooney, M., & Nolan, L. (2006). A critique of Freire's perspective on critical social theory in nursing education. *Nurse Education Today*, *26*(3), 240–244. https://doi.org/10.1016/j.nedt.2005.10.004

19) O'Donnell, S., Condell, S., & Begley, C. M. (2004). "Add women & stir" - The biomedical approach to cardiac research! *European Journal of Cardiovascular Nursing*, *3*(2), 119–127. https://doi.org/10.1016/j.ejcnurse.2004.01.003

20) Randolph, J.J. (2009). A guide to writing the dissertation literature review. *Practical Assessment, Research & Evaluation*, 14(13), 1–13

21) Sugimoto, C. R., Ahn, Y., Smith, E., Macaluso, B., & Larivière, V. (2019). Factors affecting sex-related reporting in medical research : a cross-disciplinary bibliometric analysis. *The Lancet*, *393*(10171), 550–559. https://doi.org/10.1016/S0140-6736(18)32995-7

22) Thórarinsdóttir, K., & Kristjánsson, K. (2014). Patients' perspectives on person-centred participation in healthcare: A framework analysis. *Nursing Ethics*, *21*(2), 129–147. https://doi.org/10.1177/0969733013490593

23) Townsend, M. (2014). Psychiatric mental health nursing: Concepts of care in evidence-based practice. Retrieved from http://ebookcentral.proquest.com Created from arcada-ebooks on 2019-09-03

24) Universal declaration of human rights (1948) [online] available at: https://www.un.org/en/universal-declaration-human-rights/ [accessed 15th March 2020]

25) Verdonk, P., Benschop, Y., De Haes, H., & Lagro-Janssen, T. (2009). From gender bias to gender awareness in medical education. *Advances in Health Sciences Education*, *14*(1), 135–152. https://doi.org/10.1007/s10459-008-9100-z

26) Verdonk, P., Benschop, Y., de Haes, H., Mans, L., & Lagro-Janssen, T. (2009). "Should you turn this into a complete gender matter?" Gender mainstreaming in medical education. *Gender and Education*, *21*(6), 703–719. https://doi.org/10.1080/09540250902785905

27) Vryonides, S., Papastavrou, E., Charalambous, A., Andreou, P., & Merkouris, A. (2015). The ethical dimension of nursing care rationing: A thematic synthesis of qualitative studies. *Nursing Ethics*, *22*(8), 881–900. https://doi.org/10.1177/0969733014551377

28) Wittmann-Price R. A. (2004). Emancipation in decision-making in women's health care. Journal of advanced nursing, 47(4), 437–445. https://doi.org/10.1111/j.13652648.2004.03121.x (accessed 17th January 2020)

29) Wohlin (2014), Guidelines for Snowballing in Systematic Literature Studies and a Replication in Software Engineering In Proceedings of the 18th International Conference on Evaluation and Assessment in Software Engineering (EASE '14). *Association for Computing Machinery*, New York, NY, USA, Article 38, 1–10

30) World Health Organization (WHO) *Gender*. [online] available at: https://www.who.int/health-topics/gender [accessed 25th February 2020]

31) World Health Organization (WHO) (2017), *Human rights and health, key facts.* Available at: https://www.who.int/news-room/fact-sheets/detail/human-rights-and-health [accessed 15th March 2020)

32) Witteman, H., Hendricks M., Straus, S., Tannebaum, C. (2019) Are gender gaps due to evaluations of the applicant or the science? A natural experiment at a national funding agency. *The lancet*, 393 (1017), 531-540

33) The work of World Health Organization (1979) Biennial Report of the Director-General to the World Health Assemble and to the United Nations [online] available at:https://apps.who.int/iris/bitstream/handle/10665/204174/9241560630_eng.pdf?sequence=1&isAllowed=y [accessed 15th March 2020]

34) Transforming and Scaling Up Health Professionals' Education and Training: World Health Organization Guidelines 2013. Geneva: World Health Organization; 2013. Annex 1, Definition and list of health professionals [online] Available from: https://www.ncbi.nlm.nih.gov/books/NBK298950/ [accessed 7th April 2020]