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This is the accepted version of a paper published in *Nordisk sygeplejeforskning*. This paper has been peer-reviewed but does not include the final publisher proof-corrections or journal pagination.

Citation for the original published paper (version of record):

Rydmell, L., Ringnér, A., Lagerfors, C., Öster, I. (2013)

Does Gender Matter?: Nurses' communications with children during blood test procedures.

*Nordisk sygeplejeforskning*, 3(4): 300-312

Access to the published version may require subscription.

N.B. When citing this work, cite the original published paper.

Permanent link to this version:

<http://urn.kb.se/resolve?urn=urn:nbn:se:umu:diva-84163>

## Does Gender Matter?

### Nurses' Communications with Children During Blood Test Procedures

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**Conflicts of interests:** The authors report no actual or potential conflicts of interests.  
**Acknowledgment:** No external or intramural funding was received.

## **ABSTRACT**

Equal opportunities for children is in general regarded as crucial; nevertheless, children are still often treated differently due to their sex. This could limit a child's inherent way of expressing him/herself. Nurses need to be aware of how gender constructions influence their interactions with children. The aim of this study was to illuminate interpretative repertoires that a group of nurses use when communicating with children during blood test procedures in two children's hospitals in Sweden. Data was collected by semi-structured observations of nurses conducting blood test procedures on children, and the observations were analyzed using discourse psychology. Two main groups of interpretative repertoires were found. In one group the repertoires were supporting gender stereotyping and in the other group the repertoires were weakening gender stereotyping. In conclusion, nurses' interactions with children during procedures offer the children different socially and culturally constructed interpretative repertoires about gender. Increased consciousness of gender issues is needed among nurses to enable children to be and act freely, without being forced into limited gendered expectations.

## **Keywords**

Interaction, discourse psychology, observations, pediatric nursing.

## **INTRODUCTION**

In the efforts for a more equal society, equal opportunities and treatment of children has been regarded as crucial. Nevertheless, children are still often treated differently due to their sex (Delegationen för jämställdhet i förskolan, 2006; Miller, Lurye, Zosuls, & Ruble, 2009) and the children themselves are also aware of differing

expectations (Francis, 2010; Freeman, 2007; Morrow, 2006). A gender stereotyped approach might therefore limit a child's inherent way of expressing him/herself (Miller, et al., 2009). Within the educational system, there is a long tradition of this awareness (Bayne, 2009), however not as prominent within the health care system (e.g. Karolinska Institute, 2006; Røndahl, 2009; Røndahl, 2011).

## **BACKGROUND**

Within the health care system staff traditionally talk about patients and individuals, often with no awareness about their own assumptions about gender (Meleis, 2007) although "*Nursing care is respectful of and unrestricted by considerations of age, colour, creed, culture, disability or illness, gender, sexual orientation, nationality, politics, race or social status*" (International Council of Nurses, 2006, p. 1). Even when an adult tries to take a gender-neutral standpoint towards children, a binary gender structure is often hidden or repressed, that strengthens cultural gendered norms and behaviors and conceals the diversities among boys and girls (Delegationen för jämställdhet i förskolan, 2006; Granié, 2010). These gender-differentiated expectations limit children's opportunities for various behaviors, such as playing with a doll if you are a boy (Miller, et al., 2009).

Children develop their identity in relation to people around them. They quickly learn about socially acceptable ways of being, gender-related behaviors and what are considered "girls' toys and games" and "boys' toys and games" (Freeman, 2007). Social and cultural binary attribution of gendered characteristics conceals diversity (Brownlie, 2006). In this binary division between the sexes, femininity is constructed as having a lower value than masculinity, which is constructed as the opposite of femininity, and femininity is something that boys should avoid (Freeman, 2007; Miller, et al., 2009). The larger society and adults can often communicate

inconsistent messages to children about expected gendered behavior, which limits cross-gender choices. Both parents and professionals send genderized messages through ordinary routines that they encourage at home and in institutions, e.g. division of labor based on traditional gender roles, and their behavior reflects their values and beliefs (Freeman, 2007).

A British study demonstrated that 10- to 15-year-old youth were highly aware of the dominant societal expectations of girls and boys. Boys were attributed with independence, stoicism, strength, and control. Girls, however, but not boys, thought that stoic and independent behavior was to be expected from people around them. Girls were assumed to be more emotional than boys, and being emotional was emphasized as a positive aspect of femininity (MacLean, Sweeting, & Hunt, 2010).

Nurses working in health care encounter children and youth of various ages. Professional treatment needs to include an awareness of social and cultural gender constructions. Nurses also need to reflect on how these constructions and norms influence their interactions with families (cf. Yagil, Luria, Admi, Moshe-Eilon, & Linn, 2010). Children and youth are aware of adults' expectations of how to behave in socially acceptable ways as boys and girls and they feel pressure to act the "right way" (Morrow, 2006). Children can, for example, feel an unspoken expectation that it is not appropriate to complain about pain. During potentially painful procedures, children state that the nurse's ability to create a comforting and secure situation, and the child's own influence on the distraction methods used are crucial to the total experience of the situation (Nilsson, Hallqvist, Sidenvall, & Enskär, 2011). This is important for nurses to consider when they communicate with families in health care, where children and youth are likely to feel vulnerable, afraid, and insecure (Coyne, 2006).

At a first encounter with a person, people tend to attribute the person gender stereotypes more often as compared to when the person is more well-known (Blair & Banaji, 1996; Ridgeway & Correll, 2004). Therefore, in order to capture the taken-for-granted gender stereotypes that may exist within pediatric nursing, focusing on nurses meeting unacquainted children such as during blood test procedures. However, no studies of the effects of gender perspective on nurses' interaction with children within health care were found in a review of the literature. The aim of this study is to illuminate interpretative repertoires that a group of nurses use when communicating with children during blood test procedures in two childrens' hospitals in Sweden.

## **METHODS**

A non-participating, observational study was used, because we wanted to gain an extended understanding of the behaviors that emerged from the observations, while maintaining our focus on certain predetermined areas of interest.

Observation as a data collection method is particularly useful in gathering information on behavior, such as verbal statements and relations between people, in social situations (Polit & Beck, 2006). In an observational study, the researcher can directly observe how a person behaves, which may differ from self-reported behavior collected in an interview study (Carnevale, MacDonald, Bluebond-Langner, & McKeever, 2008; Yagil, et al., 2010).

### **Sample**

On 22 occasions nurses working in pediatric care were observed while conducting blood test procedures on children aged three to 17 years. That age interval was used because we wanted the children to be able to talk to the nurses and the nurses to be able to explain the procedure. A total of 17 nurses participated in the

study, of whom 14 were women and three were men. Five nurses participated in two observations. All were registered nurses with at least three years of university education. In order to protect the participants' integrity, we have consequently called the nurses she.

### **Context**

The observations took place at two emergency departments at different children's hospitals in Stockholm and at one of the hospitals' children's day care service and out-patients' clinic, during three weeks in 2010.

By coincidence the number of girls and boys were exactly the same, 11 girls and 11 boys went through the blood sample procedures that were observed. The girls were between three and 16.5 years with a mean age of 10 years. The boys were between three and a half and 17 years, with a mean age of seven years. Of these, two girls and two boys were teenagers. One teenage girl participated on two occasions.

It was more common for mothers to come with the children who participated in the study than for fathers to come. On 11 occasions the mothers accompanied the child, on seven occasions the fathers accompanied, and on four occasions the child came with both parents.

### **Procedures**

Permission for the study was received from the head of department at both children's hospitals. The head nurses were responsible for disseminating information about the study, both verbally and in writing. The information letter emphasized that participation was voluntary and that participants could withdraw from the study at any time. In addition, it outlined the study's general aim, namely the analysis of nurses' communication with children at a blood sampling procedure.

At the children's day care service and outpatients' clinic the premise was that prior to the visit the child would not have made contact with the nurse who would perform the procedure. The reason for this was to make observations similar to those made in the emergency departments. The observations were carried out at varying times Monday to Sunday, between 8:00 AM and 11:15 PM. A total of 22 observations were carried out.

All observations were carried out jointly by two of the authors (Rydmeil & Lagerfors) in order to enhance credibility (Bell & Nilsson, 2006). These were made from a discreet location in the room, usually sitting on the floor by the door. We were also careful to be dressed discretely, as not to attract any attention. Usually the same author informed the child (if possible) and parent/s about the purpose of the study and asked if they had questions or if they would prefer us not to be present during the procedure. The information about the study was generally given before the nurse came into the room.

An observation chart was constructed and tested in two pilot observations (cf. Björk, Nordström, & Hallström, 2006), which are not included in the analysis. The observation chart recorded the date, time, age, and sex of the child, who was with the child during the procedure (mother, father, or both parents), nurses' sex, the procedure time, type of procedure, color and type of patch or bandages, as well as any reward. After the pilot observations, we decided to write down everything that was said along with actions that took out during the observations in order not to miss any information that may have later been found to be valuable or to contribute to our discernment of communication patterns. Detailed field notes were taken during the observations (Mulhall, 2003). As soon as possible after each observation, the field notes from both observers were merged into one document, resulting in a total of 29 data pages. This was important to ensure that no details were forgotten and that the

notes represented a cohesive whole. When no new data appeared in the observations, data collection was continued for another few observations and then finished.

The observations lasted an average of eight minutes. Girls' procedures averaged 10 minutes (range four-29 min; median eight min) and boys' averaged six and a half minutes (range four-15 min; median six min).

### **Data Analysis**

The analysis was inspired by discourse psychology with a focus on the analytical concept of interpretative repertoires. The theoretical basis is social constructivism where reality is seen as socially constructed and ever changing. Interpretative repertoires can be described as culturally available resources within discourses that people use in the interaction and negotiations with others to create different understandings and identities (Edley, 2001). At different historical times, different discourses are culturally dominant with some interpretative repertoires more available and taken for granted. The purpose of the analysis of interpretative repertoires is to identify the different discourses, not the separate individuals. Individuals' ways of talking are analyzed as social practices. Material used in discourse psychology should be "naturally occurring," such as transcripts of everyday conversations (Edley, 2001; Winther Jørgensen & Phillips, 2002).

The field notes were read through in their entirety several times, focusing on variations in data and searching for patterns of repertoires that the nurses used when communicating with the children. In an iterative process, the identified repertoires were then systematized and further elaborated and their consequences were described. All authors participated in the analysis until consensus was reached.

## **Ethical considerations**

This study was accomplished according to the ethical guidelines described in the Helsinki Declaration (World medical association, 2008). Access to the field was granted by the head of department at both children's hospitals. The information letter to the participating nurses emphasized that participation was voluntary and that participants could withdraw from the study at any time. All participants were aware of being observed and they accepted our presence and our non-participation in the health care procedure studied. Assent was obtained from all children when deemed age-appropriate, otherwise, we asked the parents. No health information was collected from the participants. We were prepared to discontinue observations, should we notice any signs of discomfort due to the partaking in the study from the participants. However, no such signs were noted. The Swedish Act concerning the Ethical Review of Research Involving Humans (SFS, 2003:460) was not applicable in this case, as the study focused on the nurses' acting and they were not judged to be in a vulnerable situation (cf. Andersson & Edberg, 2010; Jangland, Larsson, & Gunningberg, 2011). To protect the participants' integrity, a unique code was assigned to each nurse.

## **RESULTS**

The discourse analysis displayed patterns of interpretative repertoires used by the nurses and we brought these together into two main groups. In one group the repertoires were characterized by supporting gender stereotyping and in the other group the repertoires were characterized by weakening gender stereotyping.

The sub-groups "reinforcing stereotypical genders" and "taking heteronormativity for granted," together create "repertoires that support gender stereotyping." Similarly, "weakening of stereotypical genders," "using a non-gender-

coded approach” and “actively violating stereotypical gender performances” form the second major group “repertoires that weaken gender stereotyping.”

### **Repertoires that support gender stereotyping**

**Reinforcing stereotypical genders** . Nurses conveyed an expectation of boys to be tough, and suggested that they should have no trouble dealing with the blood sample procedure. When a nurse put a tourniquet on a boy she said,

“Here comes the bracelet, we will check your muscles.”

Another nurse called for participation from a boys’ side at this moment and said,

“You can tighten the band until you think it feels ok.”

When meeting a boy, one nurse was quite clear about why she put on an apron,

“Sometimes you get surprised and get very bloody clothing.”

The same nurse asked the boy if he wanted to be warned before the jab,

“Shall we count to three, or should we just ‘honk and drive’?”

With laudatory comments when the process was over the nurses suggested that the boys had behaved well and that they should be proud of themselves,

“Fantastic, what a guy, looks like you have been doing this your whole life,”  
and,

“You did just great. And your mother thought you were afraid of injections.  
Nonsense!”

And maybe the clearest of all,

“Great. Good kid, you handled yourself like a man.”

As one of the authors approached a family to inform them about the study, the boy was said to be stressed about the upcoming blood test procedure. In response to

the author's question of whether he had had anesthetic cream, the boy said he was offered it, but told one of the authors,

"I said I wanted to be a very manly man. I wanted to be dad's Genghis Khan."

Medals were sometimes given as rewards. One nurse explained the significance of the medal was that one had been good and brave to have taken the test. The same nurse, offering another boy his choice of a reward, told him,

"You've been a hero."

Another boy was given as a reward an intravenous catheter without needle and invited to show it to his buddies. On another occasion a nurse stood with a boy and looked at various gifts in a box. When the boy chose something (we did not see), the nurse, pointing to something else, commented,

"That's cooler."

She then took up a white luminous tag that she voluntarily spoke of seconds after,

"This is for girls, right?"

In one case a nurse supposed that a girl was interested in bookmarks and suggested as a first alternative a pink horse, but the girl chose a sticker in the shape of a moose. In another case, a girl was asked if she wanted to

"Look at our cute stickers?"

This girl was also suggested to choose a horse, which she eventually did.

When it came to the band aids that the children were given, it was difficult to draw any conclusions as most were skin-colored. The boys who received colored plasters, however, got blue or green. At one point it was unclear whether there were more colors to choose from, but for the second occasion the authors concluded that the nurse selected from a stack where there were also yellow, white, and orange band

aids. A girl who got a colored band aid was given a yellow one (though it was unclear in this case as well whether there were more to choose from) with the comment,

“You get this nice yellow one”.

Another nurse commented to a girl on a band aid with teddy bears that held the intravenous catheter,

“This is kind of cute. Isn’t it cute?”

Girls were repeatedly expected to be interested in bookmarks and stickers as described above. That pink is the “right” color for girls was also suggested more than once by the nurses, as shown in this brief exchange,

RN: “Do you have a favorite color?” Girl: “Pink.” RN: “Pink, that’s what I thought.”

This girl chose on her own a pink bandage and a pink lizard as gifts.

Activities and interests were discussed during the procedure. A nurse asked a little boy if he were in kindergarten and continued,

“ . . . and what do you do there? Are you naughty?”

Rowdiness came up in another situation when a boy’s finger did not stop bleeding during a blood test procedure. The nurse commented,

“How naughty!”

One boy was asked which animal he thought was the fastest, a kangaroo or a lion. The same nurse, when performing a capillary puncture on the boy, compared it to a sport,

“Shall we see if we can catch the blood. Look what we can catch. Almost like football.”

Another nurse questioned a boy’s lack of sports interest

RN: "Do you have winter holidays now?" Boy: "Yes." RN: "What do you do?"  
 Boy: "Different stuff." RN: "Do you go skiing? Do you go skating?" Boy: "No." RN:  
 "Why not?"

On two occasions different nurses made different comparisons of the intravenous catheter that children would receive. When a girl was to undergo the procedure the intravenous catheter was compared with a butterfly, in contrast with another nurse's presentation of the intravenous catheter to a boy as a mosquito aircraft. She went on explaining where the gas cap was sitting and then flew around with the catheter and made motor sounds.

Nurses could also reinforce children's own comments, which confirm their gender identities. When it came up that a girl had cats the nurse commented,

"That's cozy."

A nurse noted Spiderman on a boy's sweater.

"Who do you have on your shirt? Have you seen? He throws nets!"

The same nurse told her colleague when she needed help with the blood sampling, that the boy had told her/him that he would go home and play with cars later. She continued,

"Do you have underground parking as well? Wow awesome."

**Taking heteronormativity for granted.** At one point it became clear that heteronormativity was transmitted to a little boy. At a previous blood test procedure he had received a bookmark in the shape of a lion, and when it was time for the next blood test procedure the following conversation was developed,

"What have you got? A lion?" The nurse then commented that it looked like a lion mother. "We may find the lion father./ /Do you want us to see if we have one more lion?"

## **Repertoires that weaken gender stereotyping**

**Weakening of stereotypical genders .** A nurse encouraged the toughness of a girl,

“Do you want to remove it [the anesthetic patch] yourself? There you go. What a girl!” And,

“You’re a tough girl, this will be a piece of cake.”

Another nurse praised the strength of a girl when she took off the anesthetic band aid she was wearing.

Many nurses understood that boys could find a blood test procedure scary:

“I’ll tell you so that you do not feel worried.”

“The only tip—I usually do not watch—is not to watch.”

“You’re welcome to look the other way if you feel uncomfortable.”

And the nurses many times asked boys to sit on a parent’s lap or hold a parent’s hand. One boy who was asked if he wanted to hold his mothers’ hand, said no, and looked at us.

When the boys expressed concern about the blood test process, nurses confirmed that it was perfectly allowable to feel that way, for instance in the following examples,

Boy: “Sometimes when I get a shot I cry.” RN: “It’s okay to cry, many children cry.”

**Using a non-gender-coded approach.** The nurses praised the children generously for having gone through the procedure; no difference could be related to sex. There were also examples of nurses who let children choose bandages and presents themselves. One nurse said to a girl,

“Do you want to see if you can find anything in our gift box?”

Nurses also suggested to children that they choose non-typical gender-coded gifts such as luminous tag, key ring, and erasers.

**Actively challenging stereotypical gender performance.** There were examples of occasions when nurses did not take into account gender-coded attributes. One boy was offered a pink medal (although there was no other color available, as the authors checked afterwards), one girl was given a light blue bandage, and a boy who had chosen hockey cards was encouraged to choose a pink lizard instead,

“ . . . or if you want a nice pen, or a luminous tag, or a heart?”

However, he stuck to his hockey cards.

A boy was asked how old his little brother was and another was asked if he and his mother used to bake, to which the boy replied that they liked to bake cakes.

## **DISCUSSION**

The aim of this study was to illuminate interpretative repertoires that a group of nurses use when communicating with children during blood test procedures in two children's hospitals in Sweden. To the best of our knowledge, there are no previous articles published about this subject, which makes this a novel contribution to the increased understanding of how taken for granted social and cultural gender construction influence talk when pediatric nurse's interact with children.

In this study, nurses were shown to use interpretative repertoires that both support and weaken gender stereotyping . Grown-ups seem to treat children as expected for their gender (Miller, et al., 2009). In the repertoires that weakened gender stereotyping, girls were expected to like pink, horses, scrap books, and stickers, whereas boys were expected to be tough and to be able to endure. When activities were discussed one nurse was so surprised that a boy neither went skating

nor skiing that she questioned why he did not. On two occasions nurses made use of metaphors when describing the venous catheters. In the case of a girl, the metaphor was a butterfly, and for the boy, it was an airplane.

Interpretative repertoires that weakened gender stereotyping were also found. In strong contrast to expectations of boys to be tough, many nurses recognized that boys could experience discomfort during blood sampling and tried to help them find strategies for relief such as by holding somebody's hand or not looking at the needle. One nurse explicitly acknowledged that boys were allowed to be worried and cry. There were also examples of girls who were expected to be tough. Some nurses also actively counteracted gender stereotyping, for example by choosing or suggesting gifts that were rather more typical for children of the opposite sex.

Most commonly nurses used more or less a mixture of interpretative repertoires at each observation when they communicated with the children. The age of the children did not seem to be important to the choice of interpretative repertoire, nor did the gender of the nurse.

Children seem to know what is expected from them because of their gender (Francis, 2010; Freeman, 2007; Morrow, 2006). This was visible in our material at several occasions. Two boys looked at the observers and smiled tentatively when the nurses suggested they hold the parents' hand. The most obvious example of this was the boy who refused the anesthetic cream because he wanted his father to be proud of him. However, health care personnel can either emphasize or downplay differences according to gender. In this example, the nurse had an excellent opportunity to help the boy find an alternative gender identity by pointing out that the anesthetic cream is meant for everyone.

Heteronormativity was also intimated to a child when a nurse suggested looking for a picture of a lion daddy that would match the lion mummy the child

already had. This can create problems since people breaking the norm may feel excluded. A fraction of Swedish nursing staff members have also reported avoiding taking care of gay or lesbian patients, and lesbian and gay patients also sometimes perceive that avoidance (Röndahl, 2005). This is just as problematic in a pediatric setting—both for the children that begin to discover their non-heterosexuality as well as for children who have parents of the same sex.

One could interpret these results as a duality in the nurses that we studied. Nurses may be aware of the gender stereotyping and even actively strive to diminish them, still, in many situations they continue to conserve them. This corresponds to Freeman's (2007) results, where children stated that their parents preferred them to play with gender-stereotypical toys although many parents claimed that they did not object to the children playing with toys typical for the opposite sex. Gender awareness in Swedish nursing education may also be ambiguous. All university education in Sweden is supposed to include a gender perspective (SFS, 1992:1434), and most nursing curricula also emphasize it, so it is not unreasonable to assume that nurses should be attentive to gender issues. On the other hand, students both self-report and seem to have shortcomings in gender awareness in their education (Karolinska Institute, 2006; Röndahl, 2009; Röndahl, 2011).

However, could it be that the world of pediatric nursing is an overly heteronormative and gender-conservative world? Since most children are brought up in a heterosexual context, the heteronormative, nuclear family is taken for granted, thus other family formations are uncommon in a pediatric context. Furthermore, as compared to an adult ward, a pediatric ward has several toys, many of them gender coded. Common gender stereotyping are also conserved, e.g. the mother being the one who usually stays with the children at the ward.

## **Methodological considerations**

The settings chosen—emergency departments and out-patient clinics—were a conscious choice. At this kind of setting, encounters are short and the nurse does not know the child from before. Nurses should therefore be more prone to attribute gender stereotypes to the children they meet, so we believe that we were more able to elicit the gender stereotypes than if the child and nurse knew each other since before.

A possible weakness with all observational studies is that the people observed may adapt their behavior during observations, still, research shows that that problem may not be severe (Schnelle, Ouslander, & Simmons, 2006). Performing blood sampling requires the nurse to concentrate on her task, and it is our experience that they were indeed focused on the procedure rather than on our presence. Selecting field notes as our data collection strategy probably was experienced as less intrusive by the nurses as opposed to rigging up a video camera.

We did not inform the nurses about the gender aspect of this study, which minimizes the risk that they consciously tried to act “politically correct.” We regard a gender perspective analysis as equivalent to any other analytic tradition, such as grounded theory or phenomenology. In this case, just as in other cases, it is not a custom to inform the participant about the planned method of analysis.

The observations resulted in a relatively small sample size – 22 observations – which might limit the transferability of these results to other contexts.

As with all other interpretations, this one can be subject to criticism. To reach reliability in the means that different researchers interpret a text in similar ways is not possible when doing discourse analysis. Therefore, all authors reflected over and discussed the results continuously during the analysis, so we argue we have reached the most likely interpretation. The authors have different experiences from general nursing, pediatric nursing, gender studies, and research methodologies, all

contributing with different perspectives that also strengthen the analysis. Regarding validity, Winther & Jørgensen (2000) point out that the analytical claims ought to give the discourse a trustworthy sense of context. Further the analytical frame should generate new understandings and the results must contain representative examples from the empirical material. We have carefully followed these guidelines.

## **CONCLUSION**

In this paper, we demonstrate how nurses' interactions with children during procedures offer the children different socially and culturally constructed interpretative repertoires about gender. Some of these repertoires can act as an obstacle to the children in finding their own way of living, whereas others may open up alternative ways to construct identities. Therefore, we argue that it is important to present different interpretative repertoires to children in order for them to select the most suitable in each situation. The cultural values inherent in pediatric nursing should be an interesting field of research.

Increased gender awareness in nurses is crucial if children are to have opportunities to be and behave freely, without being forced into possibly restricting gender-stereotypical expectations. If the children are treated in an open and allowing way, their interaction with the health care system can increase their self-esteem. It is also desirable that the nursing profession participate in the work for equality of opportunity by not strengthening traditional gender roles.

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