Journal of Advanced Nursing

WILEY

SPECIAL ISSUE Gender Equity in Healthcare

JAN Leading Global Nursing Research

EMPIRICAL RESEARCH QUALITATIVE OPEN ACCESS

Nursing at the Intersection of Power and Practice: A Grounded Theory Analysis of the Profession's Social Position

Ariadna Graells-Sans[1,2] | Paola Galbany-Estragués[3,4] | Dolors Rodríguez-Martín[3,5,6] | Àngel Gasch-Gallén[7,8]

[1]Social Determinants and Health Education Research Group (SDHEd), Hospital del Mar Research Institute, Barcelona, Spain | [2]Hospital del Mar Nursing School (ESIHMar), Universitat Pompeu Fabra-affiliated, Barcelona, Spain | [3]Department of Fundamental and Clinical Nursing, Faculty of Nursing, University of Barcelona, Barcelona, Spain | [4]AFIN Research Group and Outreach Centre Autonomous University of Barcelona, Barcelona, Spain | [5]Research Group on Gender, Identity and Diversity (GENI) (2021SGR-0333), University of Barcelona, Barcelona, Spain | [6]UB-City of Cornellà Chair on Gender Perspective and Feminisms, Barcelona, Spain | [7]GIIS094-Research Group Nursing Research in Primary Care in Aragón (GENIAPA), Zaragoza, Spain | [8]GIIS011-Aragonese Research Group in Primary Care Institute of Research of Aragón, Faculty of Health Sciences of the University of Zaragoza, Zaragoza, Spain

Correspondence: Dolors Rodríguez-Martín (dolorsrodriguezmart@ub.edu) | Ariadna Graells-Sans (agraellssans@hmar.cat)

Received: 21 February 2025 | **Revised:** 8 July 2025 | **Accepted:** 25 July 2025

Funding: The authors received no specific funding for this work.

Keywords: gender inequalities | intersectionality framework | nurse's role | power relations | prestige | professional hierarchies

ABSTRACT

Aim: To explore nursing professionals' perceptions of the intersectional positioning of their profession within healthcare and society, examining how axes of oppression shape healthcare responses and resource management.

Design: A qualitative study framed in critical theory paradigm employing constructivist grounded theory, as outlined by Charmaz.

Methods: The study was conducted in Catalonia, Spain, between 2022 and 2023. A total of 26 nursing professionals participated, representing a range of professional roles and settings. Theoretical sampling guided participant recruitment and was saturated after 17 in-depth interviews and 2 thematic focus groups. Interviews and focus groups were transcribed verbatim. Thematic analysis, informed by Charmaz's approach, was applied to identify key dimensions and themes. Intersectionality theory was used as a critical analysis framework.

Results: A predominant theme emerged from data identified as 'intersectional disempowerment of nursing profession'. Four categories shape this positioning: (1) symbolic and historical undervaluation of care, rooted in nursing's feminization and patriarchal norms; (2) patriarchal influence on professional leadership, manifested by men disproportionately occupy leadership roles, reinforcing vertical segregation; (3) intra-professional hierarchies and technocratic influence, forcing prestige disparities within nursing and promoting horizontal segregation; and (4) internalised barriers among nurses regarding professional prestige, authority and recognition which combined undermine nursing's visibility, legitimacy and influence within healthcare.

Conclusions: Nursing cannot be understood as a neutral profession. Its societal positioning is deeply shaped by structural inequities, gendered assumptions and entrenched hierarchies, which collectively undermine its potential for autonomy and recognition.

Impact: This study highlights the need to challenge intersectional hierarchies in nursing, promoting equitable recognition, policy reforms and leadership opportunities to enhance nurses' authority, visibility and professional empowerment within healthcare systems. Addressing these challenges requires systemic policy reforms and a critical re-evaluation of societal perceptions.

What problem did the study address? Nursing's social image is strongly shaped by biomedical, technocratic and social views. The gap between nursing's public image and identity limits professional growth and recognition. Analysing how power relations intersect in nursing's social position is essential. *What were the main findings?* Nursing's role is shaped by the intersection of gender, prestige, socioeconomic status and social recognition. Nurses' empowerment must be tied to transforming unjust institutions and systemic structures. *Where and on whom will the research have an impact?* This study provides a critical analysis of the intersectional positioning of the nursing profession. The findings have implications at multiple levels: micro, by offering nurses a critical perspective on their professional positionality; meso, by providing healthcare managers with insights into the underlying factors contributing to nursing's undervaluation; and macro, by fostering reflection within the broader healthcare community on the power dynamics shaping interprofessional relationships.
Patient or Public Contribution: This study did not include patient or public involvement in its design, conduct, or reporting.
Reporting Method: The manuscript is based on the Consolidated Criteria for Reporting Qualitative Research (COREQ).

1 | Introduction

Understanding the structural positioning of nursing within healthcare systems requires moving beyond single-axis analyses (Aspinall et al. 2022). Previous articles have identified gender as a key determinant of inequality. Gender is a foundational force in shaping both societal and organisational structures, and its influence is particularly evident in the constitution of healthcare systems (Schiebinger 2021). Gender significantly influences the division of labour, access to resources, and decision-making processes within healthcare, impacting not only patients' experiences and health outcomes but also shaping the professional identities of healthcare providers, particularly nurses (Morgan et al. 2016). In this context, it is essential for understanding the distribution of roles, power structures, and the overall organisation of these systems (Theobald et al. 2017).

While gender analysis in health systems research is essential for identifying how gendered power relations contribute to structural inequities in nursing—by shaping the division of labour, the allocation of resources, and the social norms that sustain these disparities—an intersectional perspective offers a more comprehensive lens. This approach allows for a deeper understanding of how nurses experience and respond to overlapping systems of power, beyond gender alone. In this sense, gender is understood as intersecting with other structural dimensions such as professional hierarchy, technocratic values and institutional roles (Otmani del Barrio et al. 2025). Adopting this perspective, the present study explores how nursing professionals interpret and navigate these interconnected forces.

2 | Background

For nursing, the impact of gender extends beyond individual roles to shape the profession's collective image (Takase et al. 2002). Traditionally, nursing has been constructed as a 'caring' profession, historically regarded as an extension of women's 'natural' caregiving roles. Care is an essential human need which has historically taken place by women within the domestic environment (Galbany-Estragués and Comas-d'Argemir 2017). This perception has profoundly influenced the profession's development, positioning nursing as a vocation inherently tied to femininity rather than as a field requiring rigorous scientific expertise (Morris-Thompson et al. 2011) and maintaining a hierarchic structure sustained in a hegemonic masculinity model (Connell 2012). Likewise, this perspective has forced the profession to struggle for its autonomy and recognition of care value (Galbany-Estragués and Comas-d'Argemir 2017). Consequently, nursing has faced ongoing marginalisation within the healthcare system, affecting both male and female nurses.

The professional image of nursing is also shaped by a clear biomedical and technocratic influence. Although nursing organisations generally operate within a care-based model, in practice, nursing care often adopts a biomedical orientation, despite its theoretical foundation in a biopsychosocial framework. Certain nursing activities are frequently excluded from nursing records due to the low value assigned to them by nurses, institutions, other healthcare professionals and society. This undervaluation is historically linked to these tasks being classified as 'feminine', non-measurable, and lacking social or economic recognition. Conversely, technical aspects and measurable physical skills are prioritised by professionals and receive greater societal recognition (Norredam and Album 2007). Over the past 45 years, bureaucracy and technological advancements in nursing have increased, reducing the time available for direct patient interaction. This technological emphasis has privileged medical diagnosis and treatment over care and health promotion, undermining nursing autonomy and professional development, despite progress in the profession (Galbany-Estragués and Comas-d'Argemir 2017). In Spain, the emphasis on biomedical aspects may be influenced by the historical origins of the nursing profession, which emerged from the fusion of two distinct fields: 'Practicante' (1857), with a technical focus, and 'Matrona' (1857) and 'Enfermera' (1915), centred on caregiving. These two areas—one biomedical and the other care-focused—remain deeply divided in their understanding of nursing and autonomy, shaping the current development of the profession (del Pino Casado and Martínez Riera 2007).

Despite efforts to overcome gender-based stereotypes and technocratic tendencies, the social image of nursing remains undervalued, often reflecting an external perception that diminishes the professional identity and essential contributions of nurses (Montañés Muro et al. 2023). The dissonance between the

Summary

- What does this paper contribute to the wider global clinical community?
  - This study provides a critical intersectional analysis of nursing's social positioning, highlighting how gender, professional hierarchies and systemic inequities shape nurses' authority, recognition and career advancement.
  - The findings emphasise the need for healthcare policies that challenge gendered hierarchies, promote equitable leadership opportunities, and enhance nursing's visibility and professional legitimacy.
  - By identifying structural barriers to nursing empowerment, this research informs strategies for fostering interdisciplinary collaboration, improving resource distribution, and strengthening nurses' role in healthcare decision-making.

profession's public image and its actual identity poses limitations on both the professional growth of nurses and the broader understanding of the profession's scope (Morris-Thompson et al. 2011). This image is shaped by external perceptions—society's mental construct of nursing often reflects outdated views tied to visual representations and language that compare nursing to other, more traditionally valued professions (López-Verdugo et al. 2021). These biases, in turn, impact the formation of professional identity within nursing, as the social devaluation of caregiving roles leads to a reduced sense of professional autonomy and authority (Carlsson 2020). For instance, studies show that the social image of nursing as a 'supportive' rather than 'lead' profession negatively affects the self-perception and agency of those within the profession, limiting their ability to assert leadership roles within the healthcare hierarchy (Aspinall et al. 2021, 2022).

Intersectionality provides a robust analytical model for examining the complex layers of this phenomenon (Crenshaw 1989). By focusing on how gender intersects with other axes of social stratification, such as race, class and educational level, intersectional analysis deepens our understanding of the unique challenges that nurses face within healthcare systems (Hankivsky et al. 2014). Intersectionality acknowledges that identities are not defined by a single characteristic but are the product of multiple, interlocking social factors (Hancock 2007). Through this lens, it becomes possible to assess how gendered expectations and professional stereotypes within nursing interact dynamically with other social determinants, generating varied experiences of privilege and marginalisation among nurses (Morris-Thompson et al. 2011; Van Herk et al. 2011).

3 | The Study

3.1 | Aim and Study Questions

The aim of this study is to examine the perceptions of nursing professionals from diverse backgrounds and areas of expertise regarding the intersectional positioning of the profession within the healthcare system and in broader societal contexts. It pursues to understand both barriers and opportunities derived from how axes of oppression operate regarding populations' health responses and health resources management.

Thus, research questions guiding this study were: (1) How do nursing professionals perceive their own position within the nursing profession and the broader healthcare professionals and society, regarding their intersectional identities? (2) How do intersecting axes such as gender and professional hierarchies influence their perception of authority, recognition and opportunities for leadership? (3) What differences emerge in these perceptions according to participants' roles, gender, or career trajectories?

4 | Methods

4.1 | Design/Theoretical Framework

This study forms part of a broader qualitative research project that examined the possibilities and challenges of integrating intersectionality theory into nursing practice and higher education.

The overall project, and the specific objective addressed in this article, draws on Charmaz's constructivist grounded theory (CGT) as its methodological approach, which prioritises co-construction of meaning between researcher and participants (Charmaz 2008; Glaser and Strauss 1967). While rooted in CGT, the analytical lens incorporates elements from critical theory—particularly intersectionality—as a sensitising concept to explore structural inequities. This dual approach allows the study to remain grounded in participants' narratives while situating their experiences within broader systems of power.

4.2 | Study Setting and Recruitment

Participants were selected through theoretical sampling following the principles of grounded theory (Charmaz 2006b). Key professional areas within nursing—clinical practice, teaching, management, research and policy—were identified, and participants were chosen accordingly.

To ensure comprehensive representation and depth, two sampling rounds were conducted. In the first, theoretical sampling criteria included selecting individuals working in areas closely related to the study topic, specifically nurses with theoretical or practical knowledge regarding health equity advocacy. Initial contact was made by email, explaining the study's purposes and requesting informed consent for participation. All respondents agreed to participate, with only one person not responding. The initial interviews refined the study topic and assessed the need for further exploration of emerging categories. In the second round, sampling targeted individuals or groups who could provide contrasting perspectives on themes identified in the first round, ensuring diverse views on the study phenomenon. Sampling concluded with two thematic focus groups, one with clinical professionals and another with

teacher-researchers, held in a neutral setting to facilitate discussion and idea exchange.

4.3 | Inclusion and Exclusion Criteria

Inclusion criteria required a university-level qualification in nursing (bachelor's, diploma or degree) and a minimum of 2 years of field experience. Most participants were part of the Catalan health or university system; however, additional testimonies were included from individuals with notable professional trajectories who could provide a counterpoint to the general discourse.

4.4 | Data Collection

Data were collected by the principal investigator, who conducted all interviews and focus groups. As Kvale (2011) argues, conversational methods are fundamental to human interaction and knowledge construction. An interview guide, developed collaboratively with the research team, included core topics aimed at exploring how nurses conceptualise their professional practice through an intersectional lens. It was structured into three distinct sections: the first aimed at exploring professionals' perceptions of the nursing role and core competencies, and how intersectionality is incorporated into practice; the second focused on the training of future nurses, particularly the competencies to be developed in response to emerging social and healthcare needs; and the third invited participants to reflect on the structural transformations required to achieve the ideal of nursing they had described. While the guide provided a consistent thematic framework, it remained open to the incorporation of additional questions and areas of interest introduced by participants themselves, thus supporting a flexible, situated and participant-driven narrative process (Zigon 2012).

Although the broader research project focused on analysing the implications of intersectionality within nursing practice, the interviews revealed an underlying and recurrent theme: how intersectionality affects the profession of nursing itself. In line with the methodological principles of constructivist grounded theory, which embraces the emergence of new themes not initially sought (Charmaz 2006a, 2008), the research team decided to incorporate this emergent dimension into the analysis. A specific analytical objective was subsequently defined to explore how intersectional power structures shape the profession's positioning within healthcare systems and society at large.

Interviews were conducted in person or online—depending on participant preference—between February 2022 and May 2023, lasting between 70 and 120 min. All interviews were recorded for verbatim transcription and supplemented with observational notes regarding conversational dynamics. The focus groups, conducted in May 2023, included six participants from the academic domain and four from clinical practice, each lasting between 100 and 120 min. Theoretical saturation was reached after 17 in-depth interviews and two focus groups.

4.5 | Data Analysis

Data analysis followed the constructionist grounded theory strategy based on initial and focused coding phases proposed by Charmaz (2006a). The initial phase involved an open analysis, closely examining the data for significant elements within narratives. The focused phase established relationships between emerging ideas and theoretical constructs (Coffey and Atkinson 1996). Intersectionality was used as an analytical framework, following the critical theory paradigm.

For example, the category 'Patriarchal Influence on Professional Leadership' emerged through an iterative process that began with initial coding of participants' narratives. Early codes such as 'men in decision-making roles', 'difficulty of women accessing power' and 'nurses' reluctance to engage in the public sphere' were identified across multiple interviews. Through focused coding, these elements were clustered under a broader conceptual category reflecting power vertical segregation within nursing. In line with Charmaz's emphasis on variation and meaning-making, we examined internal diversity within this category by comparing how different participants—particularly across gender lines—narrated their experiences. Male nurses often described accelerated access to leadership or technical roles, while female nurses highlighted structural and cultural barriers, as well as internalised limitations. These contrasting experiences within a shared category enriched our theoretical insights into the social processes shaping leadership in nursing.

Theoretical integration was achieved through constant comparison between categories and recursive engagement with the data. Memo-writing, diagramming and team reflection enabled us to identify 'intersectional disempowerment' as the core category that linked all dimensions of the data. This concept captures how interlocking systems—particularly gender and professional hierarchy—construct unequal access to power, prestige and recognition. Intersectionality, as an analytical framework, provided a critical lens to interrogate how these axes of oppression interact and reproduce marginalisation within the profession. This analytic integration reflects Charmaz's (2006a) constructivist grounded theory approach, aiming to theorise social processes rather than merely describe thematic content.

The principal investigator led the analysis, cross-validating findings and themes with the research team, using Atlas.ti software (2022 version).

4.6 | Ethical Considerations

The study was approved by the Fundació de Recerca Sant Joan de Déu ethics committee (approval code PIC-114-20) and follows the bioethical principles stablished in both Belmont report and Declaration of Helsinki (The National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research 1979; World Medical Association 2013). All participants were informed about the study's objectives and the background of the principal investigator and provided verbal or written informed consent before participating. Transcripts were

shared with participants for validation, and each participant selected a pseudonym for use in transcripts and verbatim citations within this article.

4.7 | Rigour and Reflexivity

This study integrates reflexivity as a core methodological component to ensure methodological coherence with the constructivist grounded theory approach (Charmaz 2008). The research team aligns with a constructivist epistemology, viewing phenomena as socially constructed and shaped by individual and collective experience. In this perspective, no source of knowledge holds inherent epistemic privilege; rather, meaning is co-constructed through intersubjective dialogue between researchers and participants (Lincoln and Guba 2005; Weinberg 2008).

The relationship between the principal investigator and participants was characterised by partial familiarity: some of the interviewees were previously known to the researcher through shared academic or professional contexts. To mitigate potential bias and maintain ethical boundaries, each interview began with a researcher positioning statement. In this statement, the investigator explicitly acknowledged her dual role, clarified the purpose of the research, and requested that the interaction be understood as independent from any prior relationship. It was also stated that no information disclosed would be used for professional or personal purposes beyond the scope of the study.

The research team itself is composed of individuals with academic and professional backgrounds in nursing, sociology, feminism and health anthropology. This diversity enriched the analytical process and supported a critical reading of the data. Reflexive memos were written throughout the study to document evolving interpretations, positionalities and possible biases. These memos were shared and discussed collectively to enhance transparency and challenge potential assumptions.

To ensure credibility and confirmability, the study employed several quality strategies consistent with Charmaz's recommendations. Interviews were transcribed verbatim and returned to participants for validation, allowing them to correct, clarify, or remove content as needed. The coding process followed the principles of constant comparison to ensure consistency across data sources and analytical categories. Theoretical coding was developed collaboratively through team discussions, which served as a form of triangulation and enhanced the auditability of the findings.

5 | Findings

5.1 | Characteristics of Respondents

Following the described methodology, a total of 26 participants completed the final sample. Characteristics of the sample regarding gender, age and professional background can be seen in Table 1. The study sample includes a highly diverse professional scope, where most of the participants referred to having hybrid professional backgrounds. Table 1 indicates the latest professional area where participants main activity was developed at the time of the data collection. Despite this diversity, the study sample has a notorious presence of professionals with academic backgrounds, which may indicate a higher tendency to address the topic of this study within this environment.

TABLE 1 | Characteristics of respondents.

	n	%
Total participants	**26**	
Gender		
Woman	23	88.46
Man	3	11.54
Non binary	0	0.00
Age		
20–29	2	7.69
30–39	4	15.38
40–49	10	38.46
50–59	6	23.08
> 60	4	15.38
Professional area[a]		
Clinic	7	26.92
Academic	14	53.85
Community agent	3	11.54
Politics	2	7.69
Maximum academic degree		
Bachelor's degree	1	3.85
Master's degree	8	30.77
PhD	15	57.69
No information available	2	7.69
Qualitative approach		
Interview	16	61.54
Focus group	9	34.62
Both	1	3.85

[a]Area in which the latest main professional activity was developed in the time of the interview/focus group. Note that most participants had hybrid dedications.

5.2 | Perceptions of Nurses' Positions in Healthcare and Society

Following the aim stated in the previous line, this study reveals a comprehensive insight into how nursing professionals perceive their intersectional position within the healthcare structure and the broader social context. Through the iterative analysis of interview and focus group data, four key thematic dimensions emerged, highlighting the nuanced and layered challenges that

the nursing profession faces in gaining recognition and overcoming systemic barriers.

Table 2 presents the analytical process underpinning these findings, outlining the progression from initial coding to focused coding and theoretical integration. Anchored in a constructivist grounded theory approach, this process culminated in the development of the core category 'intersectional disempowerment of nursing', which synthesises how interlocking systems of oppression—particularly gender and professional hierarchy—undermine the profession's status. The following sections present each of the four analytical dimensions in detail.

5.2.1 | Historical and Symbolical Undervaluation of Care

Nursing professionals recognise that gender plays a significant role in shaping societal perceptions of the profession. The predominantly female composition of the nursing workforce is considered tied to historical and social conceptions that have traditionally linked caregiving roles to femininity.

> This has been a profession that has traditionally been feminine, or better said, considered feminine, as part of those aspects innate in women that add to the fact of care, procreation.
>
> (Neka)

Participants highlight the social undervaluation of caregiving itself as a barrier to the profession's development. This feminization is perceived as contributor to a perception of nursing as subordinate within healthcare hierarchies, influenced by patriarchal stereotypes that see caregiving as an extension of women's 'innate' skills rather than as a rigorous, scientific profession. This perspective, the respondents suggested, is linked to broader societal values that undervalue caregiving as a domain associated with women and private life.

> It seems that everyone knows how to care, because care is a task that all people have access to. I think that the nurse could achieve the desired social positioning if in the care she could contemplate all the aspects that influence the person's life and measure the impact of their action.
>
> (Lea)

Also, participants have noted and criticised the recurrent vocational discourse behind this narrative, considering it a risk for professionalisation and professional recognition. The deeply ingrained cultural association of caregiving with femininity and altruism overshadows nursing's basis in scientific knowledge and critical thinking. Some argued that this cultural perception diminishes the recognition of nursing as a highly skilled profession and perpetuates the 'heroic' stereotype, whereby nursing work is appreciated in times of crisis (e.g., the COVID-19 pandemic) but quickly dismissed once normalcy resumes.

> The concept of vocation distances us from the profession as professionals and fosters a belief that nurses act from an innate desire to help and not from a professional vision of self-fulfilment.
>
> (Aina)

Male nurses, although a minority, experience distinct stereotypes and biases. They may encounter assumptions linking

TABLE 2 | Coding process and theoretical integration.

Themes (theoretical integration)	Categories (focused coding)	Codes (initial coding)
Intersectional disempowerment of nursing	Symbolic and historical undervaluation of care	• 'Traditionally considered a feminine profession' • 'Social conception of care as a part of innate feminine role' • 'It seems that everyone knows how to care' • 'The concept of vocation distances us for the profession'
	Patriarchal influence on professional leadership (vertical segregation)	• 'Men in decision-making roles' • 'Difficulty of women accessing power' • 'There are few women who want to take the step' • 'Hegemonic leadership environments'
	Intra-professional hierarchies and technocratic influence (horizontal segregation)	• 'Care-related work is undervalued' • 'Technical roles gain more recognition and prestige' • 'Technical specialities move more money' • 'Men dominating technical specialities'
	Internalised barriers among nurses: professional prestige, authority and recognition	• 'Reluctance to engage in the public sphere' • 'In a feminised profession, masculinist and patriarchal views and structures are also reproduced' • 'We continue to reproduce a very patriarchal system' • 'Increasing workloads' • 'Official position that no correspond to academic level' • 'Lack of public authority'

their presence in nursing to motives that challenge hegemonic masculinity, such as being perceived as less 'masculine' or overly interested in physical care—a perception that often drives them toward higher-paying, less traditionally feminised roles within nursing, such as administration or specialised areas.

> In my case, due to my own questioning of personal, individual gender and identity as a member of a sexual minority, it has not been a problem. (...) When I have been seen as belonging to a feminized collective, it has been indifferent to me. (...) But even so, I must recognize that I have reached positions of greater power for being a male nurse.
>
> (ElPoble)

5.2.2 | Patriarchal Influence on Professional Leadership

The pervasive patriarchal framework within society also permeates the healthcare system, influencing both the internal hierarchy within nursing and its external perception. Participants indicated that while nursing remains a feminised profession, the patriarchal values embedded in society and healthcare continue to hinder the profession's autonomy and advancement.

> A profession in which the majority are women, does not mean that the vision is a feminist one. In a feminized profession, masculinist and patriarchal views and structures are also reproduced, reproduced by female nurses themselves, not only by men.
>
> (Neka)

As an example of this phenomena, many participants described how male nurses disproportionately occupy positions in health administration, leadership roles or highly specialised fields, leading to a vertical segregation within the profession.

> Within our profession all leadership positions are occupied by men in brutal disproportion. White men. You already look at the positions of power of the profession and you see the axes of inequality.
>
> (Eli)

Also, other participants note that it's not only about a disproportion between the number of men and women occupying power positions, but also the existence of a higher challenge for women who succeed to achieve those positions.

> Women, when in decision-making positions, are in a hegemonic environment. There are many other men who are governing, and they must know how to work in these environments and have a critical spirit and not be carried away by the decisions of others. They are smaller in number, and they must be very clear about where they want to go, what they are representing and why they have to defend it. And of course, it is not easy.
>
> (Dara)

Some individuals not only support the notion of women holding more challenging roles in positions of power but also highlight that these obstacles have discouraged certain women from even attempting to reach those roles. For a number of participants, nurses—particularly those who are women—have confined themselves to the private realm of their professional practice, resulting in a self-imposed barrier where women fail to value their own voices in the public domain.

> Gender has a lot to do with public exposure. But also, because there are few women who want to take the step. It is difficult—and it must be said that there are many who do—but many who could do it, because they have the potential to do it, do not give the public sphere the importance that it really has. I think we should give it much more importance, but unfortunately often the thought is: I do the job, I do it well, and I limit myself to fixing what is very close to me.
>
> (Olivia)

This concept is strongly echoed by other participants, who also mention the presence of a lack of appreciation for nurses' ideas by the nurses themselves. This internalised perception not only undermines their contributions but also perpetuates a cycle of silence that hinders progress toward gender equity in healthcare leadership.

> We have a leadership problem: believing in the ideas we have and believing that they are possible.
>
> (Elda)

5.2.3 | Intra-Professional Hierarchies and Technocratic Influence

Patriarchy is also considered by respondents as an influential power that segregates professions horizontally. In this case, interviewers present a notorious consensus on perceiving a shift toward technical care within the nursing scope. For them, this perspective shift is associated with the aforementioned ideas regarding what is socially valued as professional and complex. Respondents noted that nursing is valued differently depending on specialisation and technical complexity, favouring contexts requiring advanced technical skills.

> We continue to reproduce a very patriarchal system in which, normally, what is valued within the nursing profession is being in highly complex units, in other words, anything that is technical. And, in many cases, it is men who are most interested in this, because it has more recognition.
>
> (Mar)

That roles within highly specialised or technically intensive fields present a patriarchal segregation, being often held by male nurses and receive higher social and economic prestige. For instance, intensive care or emergency services, with their emphasis on rapid response and technical expertise, are perceived as more prestigious and holds a higher proportion of male-nurses, whereas geriatric or primary care roles, dominated by female nurses, lack the same recognition despite requiring deep expertise in patient interaction and support. This segmentation results in an imbalance in recognition and remuneration and aligns with social stereotypes that equate caregiving roles with less 'prestigious' or 'scientific' occupations, while roles involving advanced technical skills are seen as more 'professional' and have higher social recognition.

> If you look at the specialties, you will see that primary care is the most discredited medical specialty and where most professionals are women. But if you go to the surgical specialties, which are the ones that move more money and have the highest salaries, men dominate here.
>
> (Beth)

Alongside social and professional hierarchies, economic disparity and job insecurity were recurring themes. Many nurses described their frustration with workload ratios, such as high patient-to-nurse ratios, which they see as limiting their capacity to provide quality care.

> What we should be working on is reducing workloads. We have ratios that are not supported in other European contexts. We should aim to have lower workloads to be able to dedicate time to care as needed, to training the next generation of students, to managing different processes, to evolving as a profession and not to solving things on a day-to-day basis. Because that is what we are doing today: solving moments, but without foreseeing the future.
>
> (Jan)

5.2.4 | Internalised Barriers Among Nurses: Professional Prestige, Authority and Recognition

Beyond the presence of both vertical and horizontal segregation within the profession—mediated by gender and professional hierarchy—several participants highlighted a perceived lack of professional prestige, even within the broader context of healthcare professions. This lack of prestige is closely tied to a sense of insufficient recognition. For instance, Mar, one of the participants, referred to a perceived absence of authority, explaining that she believes the professional voice of nurses has been systematically undervalued and, as a result, holds limited influence in decision-making spaces.

> We don't have the authority. I think this is a concept that is very important. Nurses know and we say many things, but their word has little value, because we have little authority. And we are not recognized in this sense.
>
> (Mar)

In contrast with this vision, other participants have noted that nursing profession is not the most undervalued collective within the healthcare hierarchy. Participants such as Eli considers nursing location as 'ambivalent', due to its position below and over others, simultaneously. As her, other interviewers have problematized this situation, arguing that the aim should be the erasing of hierarchies, rather than positioning professional status in a higher one.

> Too often we fight for the hierarchy of our own profession, when the purpose should be that there is no discrimination due to this condition.
>
> (Jass)

Additionally, nurses expressed concerns over discrepancies between their academic qualifications and the roles assigned to them within the Spanish healthcare system, noting that, unlike other healthcare professionals with similar education levels, nurses are often classified at lower professional tiers, impacting their wages and career development opportunities. Several participants identified this lack of formal recognition as a significant factor in the undervaluation of nursing's role within the healthcare system.

> We have an official position within the structure that does not correspond to our academic level. Despite being graduates, the system still identifies us as diploma graduates.
>
> (Sol)

Finally, prestige emerges as a pivotal factor influencing nurses' intersectional experiences within healthcare, where all the aforementioned variables converge. As participants referred, it is influenced not only by external societal perceptions of the profession but also by internal professional view about their values and priorities. Building on previously discussed concepts, the interview analysis highlights a perception that the shift toward technical specialisation is driven, in part, by the pursuit of prestige and recognition. Some interviewees shared experiences of undertaking actions that, while contrary to their initial professional inclinations, were motivated by the need to align with prevailing standards of prestige within the profession.

> I ended up doing a master's degree in ICU despite not being a technical person, but I did it because the professional stream led you there. But there comes a time when you discover that it's not for you and you say to yourself: "Look, I've gotten to do what has the most prestige, but it's not for me". (...) But I wanted that prestige, surely, the prestige that we all seek, in the end, right? But prestige is not in that. When you have sought it and you get into it, prestige is in your profession, in caring, in serving.
>
> (Dara)

6 | Discussion

The findings of this study highlight the multifaceted and intersectional positioning of nursing professionals within both the nursing profession itself and broader healthcare structures. This positioning is deeply influenced by two primary axes of oppression—gender and professional hierarchy—which are embedded in larger societal structures such as patriarchy and classism. These forces condition how power, professional prestige and authority are distributed and recognised.

Regarding patriarchal influence, findings reveal its significant influence on a predominantly female-dominated profession, wherein longstanding gender norms have shaped nursing's role and value and restrict its growth opportunities. Nursing's historical association with femininity has reinforced social perceptions that caregiving is an inherent quality of women, not a specialised skill set deserving professional recognition, a vision that is still prominent, specifically for women nurses (Pincha Baduge et al. 2024). The perception of caregiving as a vocational, altruistic endeavour emphasises dedication over expertise, reinforcing the societal undervaluation of nursing and marginalising it within scientific and clinical hierarchies. These findings are consistent with previous research on how patriarchal norms persist in feminised professions (Brandford and Brandford-Stevenson 2021; Smith et al. 2020), contributing to burnout and the systemic devaluation of nurses' work (Montañés Muro et al. 2023) and facing limitations in accessing essential resources (López-Verdugo et al. 2021). Additionally, other authors have highlighted how media further amplifies these dynamics by portraying nurses as subordinate, disempowered, and often through highly sexualised imagery (Kress et al. 2018).

Alongside gender, professional hierarchy emerged as a second key axis shaping nurses' perceptions of their status. Participants described a stratified professional landscape in which roles associated with technological complexity and acute care—often male-dominated—carry higher prestige and authority. These findings resonate with literature that identifies the valorisation of technical specialties as linked to their exclusivity and association with advanced knowledge (Norredam and Album 2007).

This intersection of patriarchy and professional hierarchy forms a matrix that helps explain the distribution of power, prestige, and visibility within the nursing profession (see Figure 1). On one side, professional hierarchy privileges highly technical specialties such as surgery or oncology, where male presence and resource allocation are more prevalent. In contrast, areas such as geriatrics or chronic care—fields with a stronger presence of female nurses—are undervalued, despite requiring complex relational and clinical skills (Pelley and Carnes 2020). This pattern contributes to horizontal segregation, whereby certain specialties garner more prestige and resources, reflecting broader societal biases regarding caregiving and technical proficiency. Consequently, this segregation not only reinforces the concentration of men in high-prestige roles but also restricts career mobility for many nurses, thereby exacerbating the gender-based distribution of labour within the profession (Aspinall et al. 2022). Furthermore, other authors have noted that these patterns are evident from the earliest stages of training, where female students tend to show greater interest in developing caregiving competencies, while male students are more inclined towards leadership-oriented trajectories (Carlsson 2020).

Parallel to this, access to decision-making roles and leadership is also shaped by the intersection of gender and hierarchy. Despite being a feminised profession, men continue to be overrepresented in leadership and administrative roles, benefiting from what has been described as the 'glass escalator' effect (Brandford and Brandford-Stevenson 2021; Williams 1992). This phenomenon—contrasting with the 'glass ceiling' effect faced by women in male-dominated fields—allows men to progress more rapidly in professions dominated by women, sustaining patriarchal power structures even within seemingly egalitarian contexts. Male nurses are often treated as symbolic tokens, granted additional authority and visibility (Salamonson et al. 2023; Santos and Amâncio 2019) while the structural barriers women face in attaining leadership remain largely unchallenged (Williams 2013). As articulated by the World Health Organization (2021), the paradox of global health delivery is that it is predominantly managed by women, yet leadership roles are disproportionately occupied by men.

The intersection of gender and professional hierarchy not only structures leadership access but also underpins the broader unequal distribution of recognition and legitimacy across healthcare professions. Nurses continue to be relegated to lower tiers of influence, and their leadership contributions are often undervalued or excluded from formal decision-making (OECD 2021). As highlighted in previous studies, entrenched hierarchies frequently dismiss nursing leadership as 'not real leadership' (Aspinall et al. 2021), further reinforcing marginalisation.

Taken together, these findings led to the identification of a core category in our grounded theory analysis which allows theoretical integration: 'Intersectional disempowerment of nursing'. This conceptual category encapsulates how overlapping systemic forces—gendered access to leadership, professional hierarchies, technocratic dominance, and the persistent undervaluation of care—converge to undermine nurses' authority, visibility and access to power. Figure 1 placed in the section above resumes this analysis process.

Following this finding, we assert that a nuanced interpretation of the social positioning of the nursing profession must adopt a critical lens that considers the interplay of various axes of power and domination. This approach moves beyond reductive, single-axis explanations and fosters a more comprehensive understanding of the complex and often contradictory forces that shape nursing as both a profession and a social institution (Hancock 2007). Within this critical framework, a central question emerges: What is the relationship between the nursing profession and the distribution of power? Addressing this question demands a clear understanding of who holds power, who benefits from current structures, and how these dynamics can be transformed. This line of questioning resonates with a wealth of literature advocating for the nursing profession to actively 'empower itself' as a means of fostering liberation and agency (Friend and Sieloff 2018). However, our

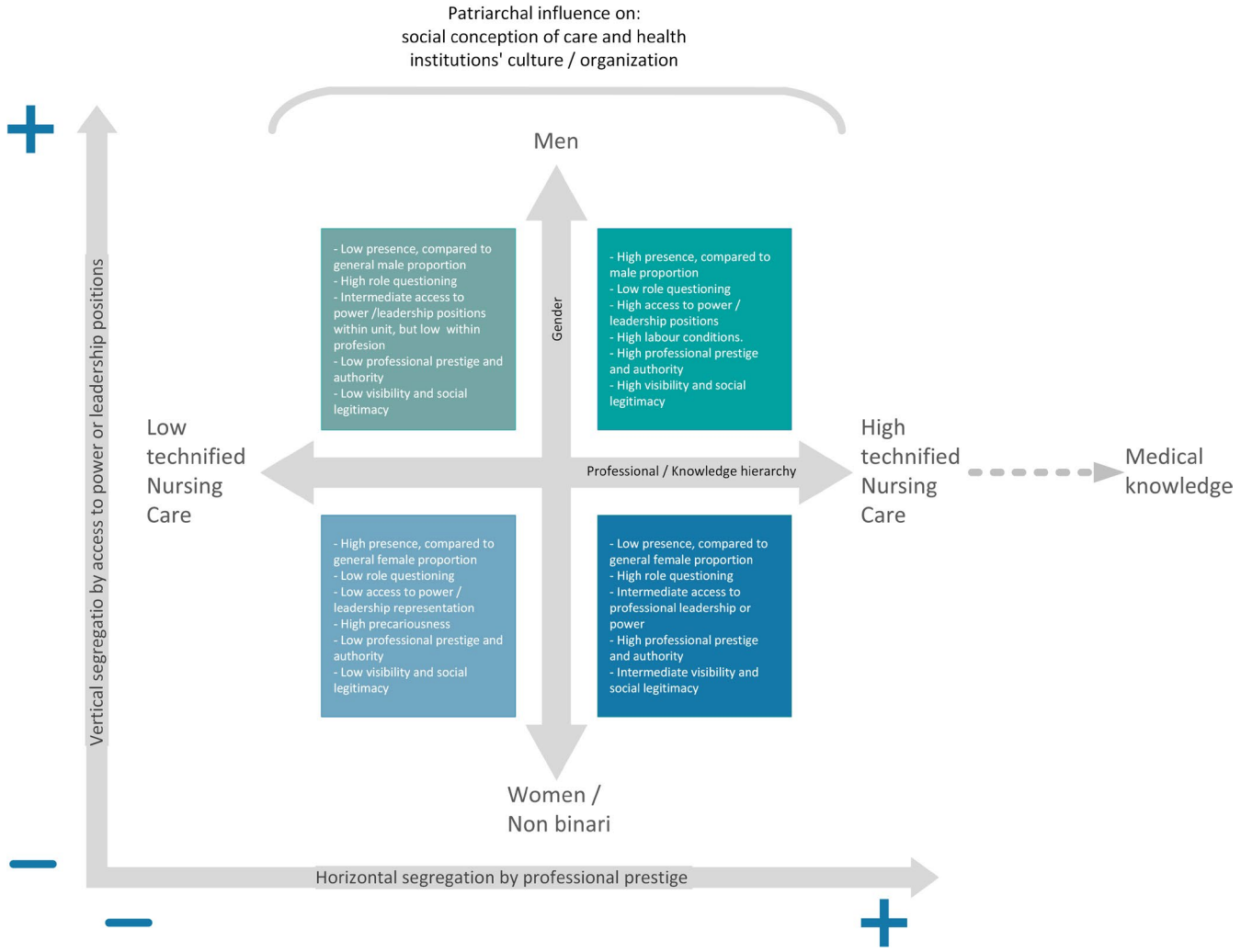

FIGURE 1 | Conceptual framework of GT main theme: Intersectional disempowerment of nursing. [Colour figure can be viewed at wileyonlinelibrary.com]

study's emphasis on the intersectional positioning of nursing suggests a need to reflect critically on the real possibilities and limitations of such empowerment. Echoing earlier research, this study proposes a critical analysis of the concept of empowerment, noting that the literature often overlooks the impact of context, culture, and gender on its attainment. Moreover, as other authors have argued, authentic empowerment cannot be separated from structural transformations (Aspinall et al. 2019; Sepasi et al. 2016). This critique underscores the inadequacy of relying solely on individual agency to achieve professional empowerment, obscuring the deeper forces at play. Instead, true empowerment requires collective action and systemic reform. Additionally, some authors have examined the power dynamics that exist between different healthcare professions, arguing that hegemonic narratives often obscure underlying relations of oppression and hierarchy. Thus, they have warned against the dominant rhetoric suggesting that 'all healthcare professionals are united for the patient's good', cautioning that such narratives may undermine the advocacy efforts of non-hegemonic professional groups and serve as power strategies, deflecting attention from issues critical to marginalised groups within healthcare, which may otherwise challenge existing power structures (Kagan and Chinn 2010).

6.1 | Strengths and Limitations of the Work

A key strength of this study is its use of intersectional theory to analyse how multiple systems of oppression intersect to shape the nursing profession's social positioning. By moving beyond singular, unidimensional analyses, this approach provides a critical perspective on the structural factors that influence nursing's authority, recognition and professional development. The study challenges dominant narratives and offers a nuanced understanding of the complex interplay between gender, professional hierarchies and systemic inequities.

However, certain limitations must be acknowledged. Although the qualitative paradigm employed does not seek to produce generalisable results, potential selection biases in participant recruitment and characteristics may have influenced the findings. Despite efforts to ensure participant diversity, a significant proportion of those interviewed were already sensitised to the study's themes. Additionally, the sample included a notable representation of nurses with doctoral degrees or academic affiliations, likely reflecting the predominance of these discussions in academic settings. This composition may have led to an overrepresentation of perspectives aligned with the study's

theoretical framework, potentially reinforcing participant consensus. Furthermore, the sample was geographically limited to Spain, a factor that must be considered when interpreting the results. The findings are embedded within a specific legal, historical and socio-cultural context, which, while potentially sharing commonalities with other settings, cannot be assumed to be universally generalisable. Contextual specificity is therefore essential to understanding the implications of this study.

6.2 | Recommendations for Future Research

Given the limitations mentioned above, this study should be considered a foundation for further research incorporating more diverse perspectives, including those from other professional groups and individuals with varying levels of familiarity with the subject. Future studies should expand on these findings to deepen understanding, explore alternative viewpoints, and enhance the applicability of intersectional analysis in nursing research and policy development.

Future research should focus on examining the specific mechanisms by which these intersectional influences operate. By exploring strategies for equitable recognition, visibility and advancement, nursing as a profession can be better positioned to assert its authority, fulfil its potential within healthcare hierarchies, and advocate more effectively for both the profession and the populations it serves. Ultimately, this intersectional approach offers a path toward a more autonomous, respected, and empowered nursing profession within the broader healthcare system.

6.3 | Implications for Policy and Practice

This study provides a critical analysis of the intersectional positioning of the nursing profession, highlighting structural barriers that influence its authority, recognition and professional development. The findings offer valuable insights at multiple levels.

At the micro level, they encourage nurses to engage in critical self-reflection regarding their professional positionality, fostering awareness of how gendered and hierarchical structures shape their roles and opportunities within healthcare. By recognising these dynamics, nurses can better advocate for their professional authority and contribute to collective efforts toward greater equity.

At the meso level, the study provides healthcare managers and policymakers with a deeper understanding of the systemic factors that contribute to the profession's undervaluation. Identifying these root causes can inform institutional strategies aimed at improving nurses' working conditions, career advancement opportunities and decision-making power within healthcare organisations. Addressing these disparities through targeted interventions, such as leadership development programmes and policies that promote equitable representation in governance structures, is essential for strengthening the profession's role.

At the macro level, the findings call for a broader reflection within the healthcare sector on the power relations that shape interprofessional hierarchies. By critically examining these dynamics, institutions can work toward dismantling traditional hierarchies that marginalise nursing and instead foster more collaborative and equitable healthcare environments. This shift requires systemic policy reforms that challenge entrenched biases, promote interdisciplinary respect, and acknowledge nursing's contributions to patient care and public health.

Ultimately, this study underscores the urgency of re-evaluating healthcare policies and societal perceptions to ensure that nursing is recognised as an autonomous and valued profession, capable of exerting greater influence within the healthcare system.

7 | Conclusions

The findings of this study underscore that nursing cannot be understood as a neutral profession, as its positioning is deeply shaped by intersecting dynamics of gender and professional hierarchy. These forces significantly influence nursing's societal status, the legitimacy of its professional voice, and its distribution of authority within healthcare. The study brings to light two pivotal concerns for the profession: professional power and empowerment, as well as visibility and recognition. These issues are intrinsically tied to nursing's intersectional positioning, reflecting the constraints and opportunities that arise from its feminised and historically subordinated role within healthcare.

This research emphasises the multifaceted inequities that undermine nursing's potential for autonomy and recognition. Structural disparities, gendered assumptions about caregiving, and entrenched hierarchies collectively constrain the profession's visibility, economic stability, and influence within healthcare systems. Addressing these intersecting challenges calls for a critical re-evaluation of both healthcare policies and societal perceptions of nursing. Such efforts will require not only recognition of nursing's complex skill set but also targeted policy reforms that address gender and power disparities within the profession.

Author Contributions

Ariadna Graells-Sans made substantial contributions to conception and design, or acquisition of data, or analysis and interpretation of data. Ariadna Graells-Sans, Paola Galbany-Estragués, Dolors Rodríguez-Martín and Àngel Gasch-Gallén are involved in drafting the manuscript or revising it critically for important intellectual content; given final approval of the version to be published. Each author have participated sufficiently in the work to take public responsibility for appropriate portions of the content and agreed to be accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved.

Conflicts of Interest

The authors declare no conflicts of interest.

Data Availability Statement

Research data are not shared.

Peer Review

The peer review history for this article is available at https://www.webofscience.com/api/gateway/wos/peer-review/10.1111/jan.70126.

References

Aspinall, C., S. Jacobs, and R. Frey. 2019. "Intersectionality and Critical Realism: A Philosophical Framework for Advancing Nursing Leadership." *Advances in Nursing Science* 42, no. 4: 289–296. https://doi.org/10.1097/ANS.0000000000000275.

Aspinall, C., S. Jacobs, and R. Frey. 2021. "The Impact of Intersectionality on Nursing Leadership, Empowerment and Culture: A Case Study Exploring Nurses and Managers' Perceptions in an Acute Care Hospital in Aotearoa, New Zealand." *Journal of Clinical Nursing* 30, no. 13–14: 1927–1941. https://doi.org/10.1111/jocn.15745.

Aspinall, C., S. Jacobs, and R. Frey. 2022. "Intersectionality and Nursing Leadership: An Integrative Review." *Journal of Clinical Nursing* 32: 2466–2480. https://doi.org/10.1111/jocn.16347.

Brandford, A., and A. Brandford-Stevenson. 2021. "Going Up! Exploring the Phenomenon of the Glass Escalator in Nursing." *Nursing Administration Quarterly* 45, no. 4: 295–301. https://doi.org/10.1097/NAQ.0000000000000489.

Carlsson, M. 2020. "Self-Reported Competence in Female and Male Nursing Students in the Light of Theories of Hegemonic Masculinity and Femininity." *Journal of Advanced Nursing* 76, no. 1: 191–198. https://doi.org/10.1111/jan.14220.

Charmaz, K. 2006a. "Coding in Grounded Theory Practice." In *Constructing Grounded Theory. A Practical Guide Through Qualitative Analysis*, 42–71. SAGE Publications.

Charmaz, K. 2006b. "Theoretical Sampling, Saturation and Sorting." In *Constructing Grounded Theory. A Practical Guide Through Qualitative Analysis*, 96–122. SAGE Publications.

Charmaz, K. 2008. "Constructionism and the Grounded Theory Method." In *Handbook of Constructionist Research*, edited by J. A. Holstein and J. F. Gubrium, 397–412. Guilford Press.

Coffey, A., and P. Atkinson. 1996. "Concepts and Coding." In *Making Sense of Qualitative Data. Complementary Research Strategies*. SAGE Publications.

Connell, R. 2012. "Gender, Health and Theory: Conceptualizing the Issue, in Local and World Perspective." *Social Science & Medicine* 74, no. 11: 1675–1683. https://doi.org/10.1016/j.socscimed.2011.06.006.

Crenshaw, K. 1989. "Demarginalizing the Intersection of Race and Sex: A Black Feminist Critique of Antidiscrimination Doctrine, Feminist Theory and Antiracist Politics." *University of Chicago Legal Forum* 140: 139–167.

del Pino Casado, R., and J. R. Martínez Riera. 2007. "Estrategias para mejorar la visibilidad y accesibilidad de los cuidados enfermeros en Atención Primaria de salud." *Revista de Administración Sanitaria Siglo XXI* 5, no. 2: 311–337.

Friend, M. L., and C. L. Sieloff. 2018. "Empowerment in Nursing Literature: An Update and Look to the Future." *Nursing Science Quarterly* 31, no. 4: 355–361. https://doi.org/10.1177/0894318418792887.

Galbany-Estragués, P., and D. Comas-d'Argemir. 2017. "Care, Autonomy, and Gender in Nursing Practice: A Historical Study of Nurses' Experiences." *Journal of Nursing Research* 25, no. 5: 361–367. https://doi.org/10.1097/JNR.0000000000000184.

Glaser, B. G., and A. L. Strauss. 1967. *The Discovery of Grounded Theory: Strategies for Qualitative Research*. Aldine Transaction.

Hancock, A.-M. 2007. "When Multiplication Doesn't Equal Quick Addition: Examining Intersectionality as a Research Paradigm." *Perspectives on Politics* 5: 63–79. https://doi.org/10.1017/S1537592707070065.

Hankivsky, O., D. Grace, G. Hunting, et al. 2014. "An Intersectionality-Based Policy Analysis Framework: Critical Reflections on a Methodology for Advancing Equity." *International Journal for Equity in Health* 13, no. 119: 133–166. https://doi.org/10.1007/978-3-319-98473-5_6.

Kagan, P. N., and P. L. Chinn. 2010. "We're All Here for the Good of the Patient: A Dialogue on Power." *Nursing Science Quarterly* 23, no. 1: 41–46. https://doi.org/10.1177/0894318409353808.

Kress, D., C. A. Godack, T. L. Berwanger, and P. M. Davidson. 2018. "The New Script of Nursing: Using Social Media and Advances in Communication – To Create a Contemporary Image of Nursing." *Contemporary Nurse* 54, no. 4–5: 388–394. https://doi.org/10.1080/10376178.2018.1537720.

Kvale, S. 2011. *Las entrevistas en Investigación Cualitativa*. Fecha de publicación.

Lincoln, Y. S., and E. G. Guba. 2005. "Paradigmatic Controversies, Contradictions, and Emerging Confluences." In *The SAGE Handbook of Qualitative Research*, edited by N. K. Denzin and Y. S. Lincoln, 3rd ed., 193–215. SAGE Publications Inc.

López-Verdugo, M., J. A. Ponce-Blandón, F. J. López-Narbona, R. Romero-Castillo, and M. D. Guerra-Martín. 2021. "Social Image of Nursing. An Integrative Review About a Yet Unknown Profession." *Nursing Reports* 11, no. 2: 460–474. https://doi.org/10.3390/nursrep11020043.

Montañés Muro, M. P., J. C. Ayala Calvo, and G. Manzano García. 2023. "Burnout in Nursing: A Vision of Gender and 'Invisible' Unrecorded Care." *Journal of Advanced Nursing* 79, no. 6: 2148–2154. https://doi.org/10.1111/jan.15523.

Morgan, R., A. George, S. Ssali, K. Hawkins, S. Molyneux, and S. Theobald. 2016. "How to Do (or Not to Do) ... Gender Analysis in Health Systems Research." *Health Policy and Planning* 31, no. 8: 1069–1078. https://doi.org/10.1093/HEAPOL/CZW037.

Morris-Thompson, T., J. Shepherd, R. Plata, and D. Marks-Maran. 2011. "Diversity, Fulfilment and Privilege: The Image of Nursing." *Journal of Nursing Management* 19, no. 5: 683–692. https://doi.org/10.1111/J.1365-2834.2011.01268.X.

Norredam, M., and D. Album. 2007. "Review Article: Prestige and Its Significance for Medical Specialties and Diseases." *Scandinavian Journal of Public Health* 35, no. 6: 655–661. https://doi.org/10.1080/14034940701362137.

OECD. 2021. *Health at a Glance 2021: OECD Indicators (Health at a Glance)*. OECD. https://doi.org/10.1787/ae3016b9-en.

Otmani del Barrio, M., M. del Pilar-Labarda, P. Awor, et al. 2025. "Why Does an Intersectional Gender Approach Matter for Social Innovations in Health?" *BMJ Innovations* 11, no. 1: 1–4. https://doi.org/10.1136/bmjinnov-2025-001374.

Pelley, E., and M. Carnes. 2020. "When a Specialty Becomes 'Women's Work': Trends in and Implications of Specialty Gender Segregation in Medicine." *Academic Medicine* 95, no. 10: 1499–1506. https://doi.org/10.1097/ACM.0000000000003555.

Pincha Baduge, M. S. D. S., B. Garth, L. Boyd, et al. 2024. "Barriers to Advancing Women Nurses in Healthcare Leadership: A Systematic Review and Meta-Synthesis." *EClinicalMedicine* 67: 102354. https://doi.org/10.1016/j.eclinm.2023.102354.

Salamonson, Y., D. Maneze, B. W. Smith, et al. 2023. "Are Men Treated Differently in Clinical Placements During Nursing Studies? A Cross-Sectional Study." *Journal of Clinical Nursing* 32, no. 17–18: 6354–6365. https://doi.org/10.1111/jocn.16760.

Santos, M. H., and L. Amâncio. 2019. "Gender and Nursing in Portugal: The Focus on Men's Double Status of Dominant and Dominated 1."

International Journal of Iberian Studies 32, no. 3: 159–172. https://doi.org/10.1386/IJIS_00003_1.

Schiebinger, L. 2021. *Gendered Innovations: Integrating Sex, Gender, and Intersectional Analysis Into Science, Health & Medicine, Engineering, and Environment*. Latin American Science, Technology and Society. https://doi.org/10.1080/25729861.2020.1867420.

Sepasi, R. R., A. Abbaszadeh, F. Borhani, and H. Rafiei. 2016. "Nurses' Perceptions of the Concept of Power in Nursing: A Qualitative Research." *Journal of Clinical and Diagnostic Research* 10, no. 12: 10–15. https://doi.org/10.7860/JCDR/2016/22526.8971.

Smith, C. M., S. H. Lane, D. E. Brackney, and C. E. Horne. 2020. "Role Expectations and Workplace Relations Experienced by Men in Nursing: A Qualitative Study Through an Interpretive Description Lens." *Journal of Advanced Nursing* 76, no. 5: 1211–1220. https://doi.org/10.1111/jan.14330.

Takase, M., E. Kershaw, and L. Burt. 2002. "Does Public Image of Nurses Matter?" *Journal of Professional Nursing* 18, no. 4: 196–205. https://doi.org/10.1053/jpnu.2002.127014.

The National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research. 1979. "The Belmont Report: Ethical Principles and Guidelines for the Protection of Human Subjects of Research." https://www.hhs.gov/ohrp/sites/default/files/the-belmont-report-508c_FINAL.pdf.

Theobald, S., R. Morgan, K. Hawkins, S. Ssali, A. George, and S. Molyneux. 2017. "The Importance of Gender Analysis in Research for Health Systems Strengthening." *Health Policy and Planning* 32, no. Suppl_5: v1–v3. https://doi.org/10.1093/HEAPOL/CZX163.

Van Herk, K. A., D. Smith, and C. Andrew. 2011. "Examining Our Privileges and Oppressions: Incorporating an Intersectionality Paradigm Into Nursing." *Nursing Inquiry* 18, no. 1: 29–39. https://doi.org/10.1111/j.1440-1800.2011.00539.x.

Weinberg, D. 2008. "The Philosophical Foundations of Constructionist Research." In *Handbook of Constructionist Research*, edited by J. A. Holstein and J. F. Gubrium, 13–39. Guilford Press.

Williams, C. L. 1992. "The Glass Escalator: Hidden Advantages for Men in the 'Female' Professions." *Social Problems* 39, no. 3: 253–267. https://doi.org/10.2307/3096961.

Williams, C. L. 2013. "The Glass Escalator, Revisited: Gender Inequality in Neoliberal Times, SWS Feminist Lecturer." *Gender and Society* 27, no. 5: 609–629. https://doi.org/10.1177/0891243213490232.

World Health Organization. 2021. "Closing the Leadership Gap: Gender Equity and Leadership in the Global Health and Care Workforce." Policy Action Paper.

World Medical Association. 2013. "World Medical Association Declaration of HelsinkiEthical Principles for Medical Research Involving Human Subjects." *JAMA* 310, no. 20: 2191. https://doi.org/10.1001/jama.2013.281053.

Zigon, J. 2012. "Narratives." In *A Companion to Moral Anthropology*, edited by D. Fassin, 204–220. Wiley-Blackwell. https://doi.org/10.1002/9781118290620.

Supporting Information

Additional supporting information can be found online in the Supporting Information section. **Data S1:** jan70126-sup-0001-DataS1.docx.