CASE STUDY 4.1

The gendered production of data: Two studies of interviewing male nurses

Source: Williams, C.L. and Heikes, E.J. (1993) 'The importance of researcher's gender in the in-depth interview: Evidence from two case studies of male nurses', *Gender and Society*, 7(2): 280–91.

Christine Williams and E. Joel Heikes both carried out studies in which they interviewed male nurses working in the United States. They note that the impact of gender on the data generated is often commented on, but rarely explicitly explored in studies. When a study is carried out by one researcher, it is difficult to identify precisely how social factors such as the gender identities of interviewee and interviewer shape the data generated, but they were able to explore how gender made a difference by comparing transcripts and their analysis from the studies they undertook independently, but which addressed similar questions about their roles in what is a female-dominated profession.

In terms of the content of the nurses' answers, there were many similarities between the responses the two researchers recorded. Male nurses in both studies talked about how they interacted differently with men and women, and about the types of speciality that were 'more appropriate' for female nurses, such as obstetric nursing. However, when they looked in more detail at what the men said in the two sets of interviews, there were differences in the style: the *ways* in which male nurses discussed gender with the male interviewer were different from how they constructed their arguments with the female interviewer. With the male interviewer, nurses were more likely to be direct and make claims to biological determinacy in accounts of why women were more suited to obstetrics (such as claiming 'there's just this mothering instinct'). This difference in how

the male nurses expressed their views was evident in many of the topics related to gender. When they were asked about their views on the effect of the increasing numbers of men in nursing, they reported positive effects to both the male and female interviewer, but in much more direct ways to the male interviewer. Williams and Heikes suggest the more careful way this was expressed to the female interviewer reflects a social desirability bias, in that male nurses may well be reluctant to appear sexist to a woman, so are unlikely to make the very direct claims they did to the male interviewer, such as attributing current poor pay within the profession to the fact that it was dominated by 'divorced women or single women'. Similarly, in talking to a same gender interviewer, the men were less likely to report instances of being badly treated by male physicians. Such stories may lower their status in the eyes of another man, but are possible to discuss with a woman, who could be expected to be empathetic.

A superficial content analysis of the two sets of interviews would not have revealed the subtle differences in not only *what* was discussed, but in *how* these topics were discussed. These differences are an important contribution to the analysis, as they suggest some of the ways that gender roles, as enacted in the interview, also influence gender roles as they relate to the topic of interest, in this case, the implications of being male in a female-dominated profession.

These studies also illustrate some of the advantages of a qualitative approach to interviewing for relatively sensitive topics. The format of the in-depth interview allows the interviewee to frame their responses carefully, articulating their views in ways that maintain a valued identity in the eyes of the interviewer. In a more structured interview, if there is no space to qualify their answer, with fewer opportunities for the interviewee to nuance their replies, they may only give the socially desirable responses.

Interactions are inevitably gendered, although the precise ways in which gender operates to shape data depend on the cultural context of the study. In this example, the researchers had to reflect on their roles relative to that of the interviewee, as well as the status of their interviewees relative to others that they work with (female nurses, male physicians). This kind of reflexivity is part of the analysis of a qualitative study. This is not a matter of addressing 'bias' but of analysing how gender roles shape what can and can't be said, and what this tells us about the topic under investigation.

Reflective questions

It was a matter of coincidence that these two studies were able to be used and compared with each other to show the effect of the interviewers' gender. Can you think of any other settings where you might deliberately set out to investigate this kind of nuanced difference in *how* people speak? How might you think about taking these issues into account in either research that you might plan to conduct OR in accounts reported in other people's research?

Feedback

One example might be exploring the different ways children speak about their oral hygiene practices (tooth-brushing) when interviewed in a peer-group setting or by an adult. Neither will tell you what they actually do but both will give an indication of how they want to represent themselves in each setting. You will need to remember that these are only *accounts* and that the context in which they are produced will affect the content.

CASE STUDY 4.2

Using vignettes: A study of health capital in seafarers

Source: Bloor, M. (2011) 'An essay on "health capital" and the Faustian bargains struck by workers in the globalised shipping industry', *Sociology of Health and Illness*, 33(7): 973–86.

There is debate about the mechanisms that link working conditions to health, and about how far people's own assessments of their health are reliable indicators for their health status. In contributing to these debates, Mick Bloor explores the concept of 'health capital' – the idea of a store of health that can be depleted, and also exchanged for other kinds of capital, such as financial resources. His particular interest is in the effects of labour intensification (the amount of work produced per hour) on health. Shipping is, argues Bloor, a 'proto-typical' industry in this regard, as it was an early adopter of the

processes of labour intensification as a result of the increasing globalisation of trade. These processes have had dramatic impact on the working lives of seafarers. Keeping the costs of sea freight low in competitive global trade has increased the number of vessels registered in countries with poorer controls over pay. Transnational companies own ships, but they are typically operated by out-sourced, multinational crews on short-term contracts, with little job security and increasingly onerous on-board duties. These and other changes (such as more efficient turn-around times at ports) have vastly reduced the amount of 'down time' seafarers have. As a consequence, work has become harder, more pressured, and less secure.

The case of seafarers is, then, a useful one for exploring how work intensification affects health status. Given Bloor's interest in self-assessments of health status, a qualitative study was appropriate, in order to generate accounts of how workers understood those effects, and whether a model of 'health capital' was useful for thinking about what was going on.

However, a qualitative interview study presented some practical problems arising from the very conditions that Bloor set out to study. An international labour force, although all working in English, might not be able to contribute to an in-depth interview in English, and it would be impossible to have interviewers fluent in all languages used by crew from around the world. Second, interviews were conducted while ships were docked in Cardiff, UK, but with little 'down time', seafarers might well be reluctant to take time away from other tasks that had to be fitted in while in port to take part in an interview. Indeed, around 50% of those invited, declined the invitation to an interview, most of whom gave 'too little time' as the reason. As Bloor notes, rapport had to be established quickly, and the limitations of the setting meant that there 'was a danger that, across barriers of age, country and differing first languages, seafarers would give abbreviated stock answers to standard enquiries about their health' (2011: 978).

Instead of relying on detailed answers to open questions in in-depth interviews, Bloor's main approach in the interviews was therefore to ask interviewees for their responses to three vignettes. Each vignette presented the case of a seafarer, with details of their work role, age, family circumstances, health-related behaviours and their work role. Each had a new work demand. 'Nonoy', for instance, was described as 'a 44-year-old Filipino messman ... a non-smoker and a non-drinker ... he is now the only messman and he has to work long hours ... he feels healthy at the moment although is sometimes tired' (p.986). After each vignette, the participant was asked: 'Do you think he will still be fit enough to go to sea in five years' time?'. Some participants spontaneously related these vignettes to their own situations, others were prompted by follow-up questions on whether they would be able to keep working, and what they could do to keep healthy.

Analysis of the transcribed interviews used analytic induction (see Chapter 8), drawing on detailed consideration of deviant cases and comparisons within the data to explore the value of 'health capital' as a concept for understanding of the relationship between health and work. Generating responses to vignettes, rather than answers to direct questions about their own health status, allowed insight into the tacit assumptions that workers bring to their understanding of health at work. It also allowed Bloor to look at differences in concepts of health capital across his sample of seafarers. Comparing responses to the vignette of 'Nonoy', for instance, only the officers and the younger ratings believed he would be fit for work in five years' time, as he didn't drink or smoke. Older respondents, however, had a concept of work itself 'wearing you out', a state which could not be offset by healthy behaviour. Topics not mentioned in responses to the

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vignettes were also instructive: only one respondent, for instance, mentioned the trade union as a possible source of support for problems at work, and only one mentioned senior officers. These respondents had few external resources on which to draw for help: the damaging effects of work on health were simply what one had to put up with. As one respondent put it, about a vignette: 'What can he do? He has to work'.

Reflective questions

Reflect here on the use of vignettes; what kinds of details were required in order to generate meaningful data? Imagine you are interested in finding out if gendered norms and expectations differently affect the diets of men and women in a shared family home – how might 'vignettes' help generate meaningful data? Would there be advantages over using more traditional one-to-one in-depth interviews?

Feedback

Things that might be understood as directly affecting a person's health and its possible long-term effect on their ability to work, could be things such as smoking and drinking, their age, opportunities for other forms of employment (qualifications, experience etc.), or having a dependent family. This emphasis on 'background' or structural factors also invites participants to comment on what they consider more proximate circumstances that they believe will affect health, such as current working practices. In a study of gender and diets, vignettes might present situations in terms of gender differences (e.g. portion size, responsibility for choosing the food bought) which participants may simply see as 'natural' family arrangements; this would allow people to have negative views of the hypothetical arrangements without appearing disloyal to their own family if they were to be asked directly about their own circumstances.