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Gender influences on caring, dignity and well-being in older person care: A systematic literature review and thematic synthesis

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Abstract

Globally, healthcare has become dominated by women nurses. Gender is also known to impact the way people are cared for in various healthcare systems. Considering gender from the perspective of how lived bodies are positioned through the structural relations of institutions and processes, this systematic review aims to explore the meaning of gender in the caring relationship between the nurse and the older person through a synthesis of available empirical data published from 1993 to 2022. CINAHL, PUBMED, EMBASE and Web of Science were searched from the beginning of each database's temporal range, and PRISMA guidelines were used for the screening, reviewing and selection processes of available records. A thematic synthesis of the available data resulted in three analytical themes: (i) *vulnerability of the gendered body*, (ii) *norms and values related to gender and sexuality* and (iii) *balancing closeness and distance in the nurse-patient relationship*. These themes are intertwined and represent different aspects of gender meaning in the nurse–patient relationship. This research shows that gender, through its influence on the gendered body, its relationship with power dynamics in the caring process, and its intersection with dimensions of identity, has a significant meaning for the experienced vulnerability in the nurse–patient relationship. This has implications for the well-being and sense of dignity of the older person as well as the nurse.

KEYWORDS
gender, nurses, older people, patients, qualitative research methods, relationships

1 | BACKGROUND

According to a World Health Organization (World Health Organization, Global Health Workforce Network and Women in Global Health, 2019) report across 104 nations, women represent around 70% of the health workforce, while in Europe alone, over 84% of working nurses are women. In addition to women making up the majority of the healthcare workforce, gender is also known to demonstrate particular meaning in the way people are cared for in various healthcare systems, and issues of gender are relevant to

understanding the provision of care on a global scale. Recent studies have highlighted that patients prefer to be cared for by nurses of the same gender, and this has links to care-related satisfaction (Åling et al., 2021; Sharifi et al., 2021; Vatandost et al., 2020). Several issues, such as invasion of privacy, embarrassment about expressing certain issues and female patients' sensitivity, have been recorded along with the fact that patients might feel stressed while receiving care from a nurse of the opposite gender (Maskor et al., 2013; Sharifi et al., 2021). Regarding the care of older people, findings on gender aspects of the nurse–patient relationship are scant. However, from the perspective of recruitment in the field, in general, the care of older people is highly dominated by women nurses, with a large number of the workforce—including registered nurses and auxiliary staff—being women (Behtoui et al., 2017; Huang et al., 2012). In general, men who begin a career in nursing are often met with gendered prejudices that discourage them from caring (O'Connor, 2015). Men have been found to not choose career paths in nursing for older people, preferring instead emergency, critical care and operating theatre; they tend to find intimate care of other males embarrassing or even a threat to their masculine identity (Huang et al., 2012). Assumptions regarding the homosexual orientation of male nurses are also closely related to the views of nursing as effeminate due to the widely accepted image of the profession as female and the relation of this perception with homosexuality (O'Connor, 2015). The above information indicates that attention should be given to various aspects of what gender entails for the nurse–patient relationship.

According to Young (1980), 'gender' is the way that lived bodies are positioned through the structural relations of institutions and processes; thus, it constitutes a part of our social and cultural realities rather than being something inherent. Young (2005), in the following examples of her previous existential phenomenological understandings, combines insights from Merleau-Ponty, (1965) theory of the lived body in his *Phenomenology of Perception* and Beauvoir's (1974, as cited in Young, 2005) theory of the situation of women to define the lived body as 'a unified idea of a physical body acting and experiencing in a specific sociocultural context', which applies to every human existence. Gender, in general, is depicted in everyday practices, shapes personal relationships and promotes suitable social roles and identities (Johnson & Repta, 2012). Differences related to gender in our everyday lives are not necessarily questioned and are present in the form of norms and values, as they imbue our relationships based on our unreflective shared understanding that men and women may have different needs and values. Butler (2004) also describes gender from the perspective of 'performativity', according to which gender consists of an 'act' that comes as both an intentional and performative action. As an example, 'doing gender' as a part of our social interactions also widely occurs in professional life, where physicians, based on their gendered views, tend to treat patients differently or provide them with different access to care and, in this way, form a part of what constitutes medical gender bias (Risberg et al., 2009).

1.1 | Gender within the nurse–patient relationship

The particular focus on gender in this systematic literature review was studied through an exploration of what constitutes a caring relationship between a nurse and older patient. Relationships formed within the caring process are closely linked to nursing activities and are crucial for the health and well-being of individuals receiving care. As stated by Morse et al. (1990), the interaction between the nurse and the patients acts both as expressive and defining of caring, since caring takes place as an interpersonal relationship. Relationships in healthcare settings constitute a part of our very reality, and the nurse–patient relationship cannot be different from the gendered relationships that guide our experience. From a caring science perspective, Todres et al.'s (2007) concept of lifeworld-led care explores the 'whats' of human relationships. With a basis in the lifeworld philosophy of more humanised healthcare, the five fundamentals of lifeworld theory: embodiment, spatiality, intersubjectivity, temporality and mood, in simple words, indicate what relationships are (Todres et al., 2007). Merleau-Ponty (1965), extending Husserl's lifeworld view, explained human existence as a 'lived body' that characterises embodiment, which refers to the concrete here of ourselves described by the bodily way we live meaningfully in relation to the world. Spatiality is described in terms of our existence in relation to what is 'over there' regarding spatial distance or closeness, with distance explained in terms of significance to our daily lives. Temporality is described as the continuities and discontinuities of humanly experienced time, and intersubjectivity involves the way we are in a world with others since we cannot make sense as individuals without reference to the social world. Mood lies within the other dimensions of the lifeworld and shapes one's spatial, temporal, intersubjective and embodied horizon. These five dimensions are important for a holistic understanding of the caring relationship that develops within the caring process while maintaining awareness of its gendered aspects.

Revisiting Young (2005) views on a socially constructed gender that is affected by norms and values, it is of great value to research the particular meaning of gender in the caring relationship between a nurse and an older person to shed light on the less physical and more humanised aspects of caring for older people, which is in line with the lifeworld foundations of what constitutes a caring relationship. Considering the importance of systematically reviewing the meaning of gender in the caring relationship between older patients and nurses, there is a need to highlight the gap that exists in the literature so far regarding gender issues in healthcare in general. More importantly, the significant lack of research needs to be addressed regarding older people and the gendered relationships that evolve between them and professional caregivers within a variety of healthcare settings.

2 | STUDY AIM

The overall purpose of this systematic review is to explore the meaning of gender in caring relationships between nurses and older patients. The review question addressed in this literature review was as follows:

What is the meaning of gender in caring relationships between nurses and older patients?

3 | DESIGN AND METHODS

This systematic review focuses on the investigation of primary qualitative and mixed-methods studies that explore the meaning of gender in caring relationships between nurses and older patients. The PEOT (Population—Exposure—Outcome—Type of studies) frame was used to address our key concepts 'nurses', 'older people', 'patient–nurse relationship' and 'gender' (Bettany-Saltikov & McSherry, 2012). The review question was formulated as follows: What is the meaning of gender (as exposure) in the nurse–patient relationship (as outcome) of older patients and nurses engaging in the care of older people (as population)? The quality of the included papers was assessed using the Critical Appraisal Skills Programme (CASP) checklist for qualitative studies. Data were synthesised thematically according to Braun and Clarke (2006).

3.1 | Search strategy

The search strategy was developed through consultation with a university librarian. Four online databases (CINAHL, PUBMED, EMBASE and Web of Science) were searched for studies published from the beginning of each database's temporal coverage (with the start of each database ranging from 1993 to 1999) to 2021. An extra literature search took place within the same databases to cover the time span from November 2021 to the end of 2022.

On the basis of a free terms search, specific keywords and synonyms were used that applied to each part of the PEOT frame, as presented in Table 1. In addition to ensuring a comprehensive search, we adjusted our searches to Medical Subject Terms (MeSH terms) in PubMed, Emtree terms in EMBASE and CINAHL Subject Headings in CINAHL. Boolean operators 'AND' and 'OR' were used to combine our search terms and truncations to include the most possible variations in terms.

3.2 | Inclusion/exclusion criteria

Before initiating the screening process, specific eligibility criteria were set to guide the selection and evaluation of the identified records.

3.2.1 | Inclusion criteria

All primary qualitative and mixed-methods studies examining gender in relation to the caring relationship between nurses (including registered nurses, licensed practical nurses and auxiliaries) and older patients (aged 65 years and older) were considered for inclusion. The population in each study was older patients and/or nursing staff working in various settings (hospitals, home care, rehabilitation wards, etc.). Having included mixed-methods studies, we chose to assess only the qualitative part of each mixed-methods study to remain close to the qualitative nature of our research question. In addition, the emphasis of the included studies was on gender aspects within the nurse–patient relationship, providing either a gender analysis or reporting outcomes with references to the participants' gender.

3.2.2 | Exclusion criteria

We excluded quantitative studies, studies whose participants were only nursing students or informal caregivers, studies that did not

TABLE 1 Basis of free terms search and keywords.

PEOT	Keywords/search terms
Population/condition	Nurse* *AND* aged OR elderly OR "older person" OR "older people" OR "older patient*" OR "older adult*" *AND*
Exposure	"female staff" OR "female nurse*" OR "male staff" OR "male nurse*" OR "gender bias" OR "gender stereotyp*" OR "gender role*" OR "gender norm*" OR gendered OR "gender impact" OR gender *AND*
Outcomes	"nurse-patient relations" OR relation* OR interaction* OR communication OR "patient satisfaction" OR preference OR attitude *AND*
Type of studies	"qualitative research" OR "qualitative study" OR "feminist research" OR phenomenology OR "phenomenological research" OR "empirical research" OR ethnography OR "ethnographic research" OR "grounded theory" OR "case study research" OR "mixed methods" OR "mixed-methods"

display separate findings when populations were diverse (e.g. studies including both nurses' and physicians' experiences) and those that did not include experiences relevant to older patients.

3.3 | Search outcomes

The database searches retrieved 301 records. Endnote software was used to sort and screen the retrieved documents. Records were reduced to 216 after duplicates were removed. These documents were reviewed by title and abstract, applying inclusion/exclusion criteria. From this review process, 35 records remained for full-text screening. After full readings by the main author and discussions with the authoring team, 28 records were excluded. Reasons included *not meeting population criteria*, *not meeting study design criteria*, or *not including gender-specific analysis or gender-relevant findings*. In total, seven studies were included. Hand searching and reference list screening revealed no further relevant papers. One mixed-method and six qualitative studies were included in this review. The PRISMA flow diagram, as displayed in Figure 1, shows an overview of the screening, reviewing and selection processes of the records from the search process of this systematic literature review.

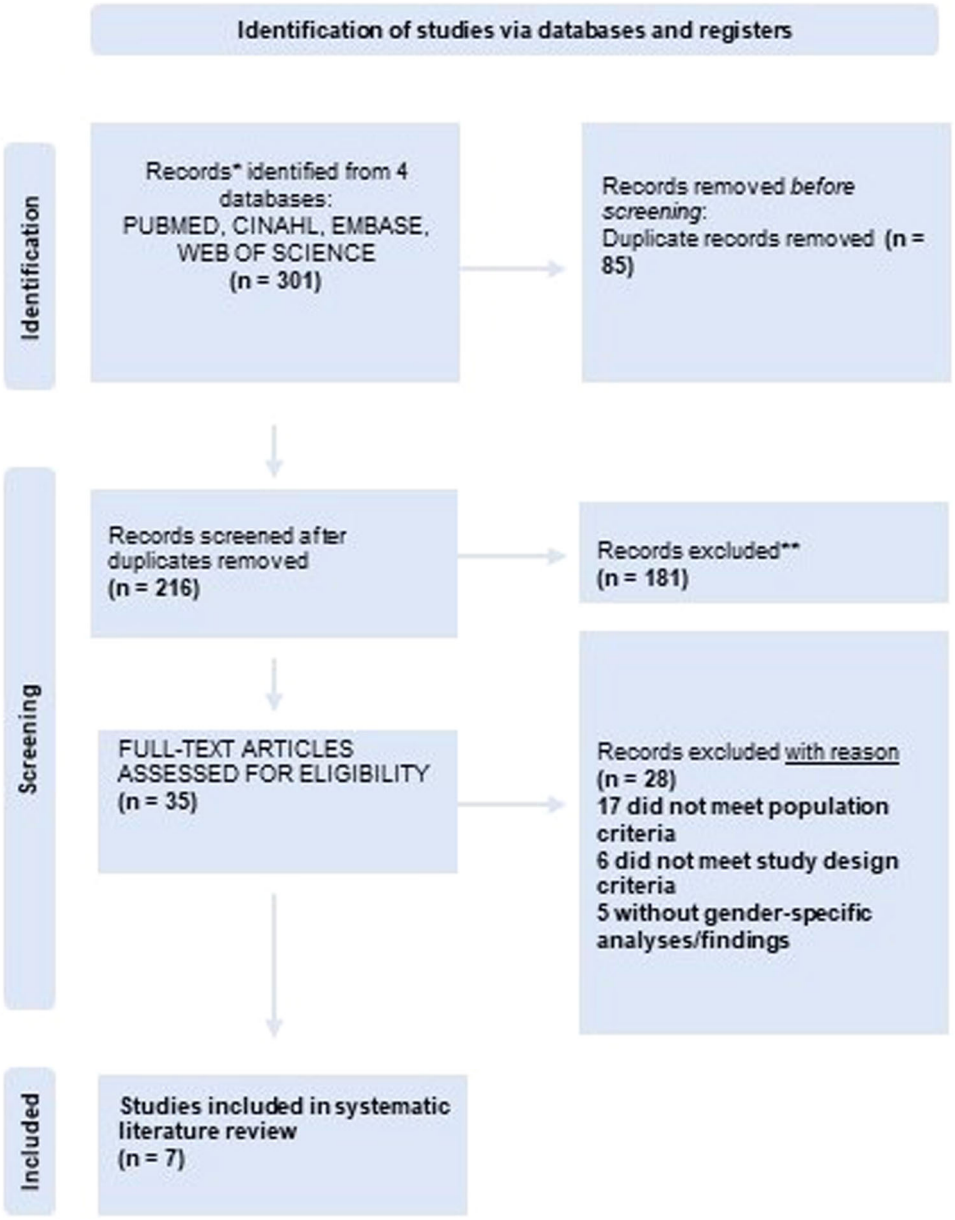

FIGURE 1 PRISMA flow diagram. *Consider, if feasible, reporting the number of records identified from each database or register searched (rather than the total number across all databases/registers); **If automation tools were used, indicate how many records were excluded by a human and how many were excluded by automation tools. *Source*: Page et al. (2021). For more information, visit: http://www.prisma-statement.org/

3.4 | Quality assessment

Studies were assessed for methodological quality using CASP for qualitative research (CASP, 2019). To systematically assess the above issues, the CASP tool makes use of 10 questions/criteria concerning different parts of a research study, which should be answered with a yes, no or cannot tell. The CASP checklist does not suggest a scoring system; therefore, we used this tool to systematically address quality issues with the selected studies (Table 2). The number of criteria met for each study and the quality level (referred to as *high*, *moderate and low*) help the reader understand how we assessed the overall methodological quality of each paper selected in this systematic literature review. One of the selected studies (Afolabi et al., 2020) was based on a mixed-methods design, so we systematically assessed only the qualitative part, which was the part used for the later thematic analysis. Most studies displayed *high* methodological quality based on the assessment using the CASP tool criteria, meeting either 8, 9, or 10 out of 10 items/criteria. The quality assessment was conducted independently by the first author, and the authoring team members reviewed the results to discuss any discrepancies and reach a consensus.

3.5 | Data extraction and thematic synthesis

Data from the seven included papers were extracted to a bespoke table that captured the aim, design methodology, sampling method and quality assessment (Table 3). Each study was conducted in a different country (Australia, Greece, Nigeria, Norway, Sweden, Turkey and the United Kingdom) and provided primary data representing a total of 129 participants, including caregivers, such as nurses, staff nurses, practice nurses, physicians, general practitioners, auxiliaries, paid and unpaid carers providing home care, as well as older patients (aged 66–85 years old). Due to a significant lack of relevant results in our systematic search, we chose to assess studies that included a broader range of health professionals as a population. However, we assessed only the experiences of nursing staff and older people within each study (excluding those of physicians or informal caregivers). This gave us the opportunity to conduct an in-depth inspection of each study and an analysis of gender-specific findings, even if each selected study did not always aim for gender analysis itself. In addition, since it was not possible to select populations of nurses working exclusively with older patients due to the lack of relevant research, a thorough search was conducted within each study selected for full-text screening to identify findings particularly relevant to older patients.

Six steps of inductive thematic analysis were used to synthesise findings: *familiarisation with the data*, *generating initial codes*, *searching for themes*, *reviewing themes*, *defining and naming themes*, and *producing the report* (Braun & Clarke, 2006, 2012).

Throughout the analysis, themes were developed following a gradual thematic map in different levels of abstraction, as follows: The initial first-order themes were introduced as text parts from our whole data set that were grouped together to form common descriptive themes. These were grouped together based on a higher-level abstraction of the themes to form second-order themes. Third-order themes consisted of overarching analytical themes that evolved from the continuous abstraction of first- and second-level themes. The whole process was realised by the first author in collaboration with the authoring team. Figure 2 presents a thematic map of the three main themes in relation to the whole data set, as proposed by Braun and Clarke (2006), namely, (1) *Vulnerability of the gendered body*, (2) *Norms and values related to gender and sexuality*, (3) *Balancing closeness and distance in the nurse–patient relationship*.

4 | RESULTS

The meaning of gender in the caring relationship between nurses and older patients was explored through three overarching analytical themes that are interrelated and intertwined. In this study, the meaning of gender was formed through the gendered experiences of the

TABLE 2 Quality appraisal of records based on Critical Appraisal Skills Programme (CASP) qualitative research checklist.

	CASP qualitative research checklist criteria									
Studies included	**Item 1**	**Item 2**	**Item 3**	**Item 4**	**Item 5**	**Item 6**	**Item 7**	**Item 8**	**Item 9**	**Item 10**
Afolabi et al. (2020), Nigeria	Y	Y	Y	Y	Y	N	Y	N	Y	Y
Andersson and Hansebo (2009), Sweden	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Edwards (1998), UK	Y	Y	Y	Y	Y	Y	Y	N	Y	Y
Foss and Sundby (2003), Norway	Y	Y	Y	Y	Y	U	N	Y	Y	Y
Malta et al. (2018), Australia	Y	Y	U	Y	Y	N	Y	Y	Y	Y
Nakopoulou et al. (2009), Greece	Y	Y	Y	Y	Y	Y	U	Y	Y	Y
Özen (2020), Turkey	Y	Y	U	Y	U	N	Y	N	Y	Y

Notes: Y, yes; N, no; U, cannot tell; Item 1, clear statement of aim; Item 2, suitable qualitative methodology; Item 3, appropriate research design; Item 4, proper recruiting strategy; Item 5, adequacy in data collection; Item 6, adequate relationship between researcher and participants; Item 7, ethical considerations; Item 8, rigour in data analysis; Item 9, clear statement of findings; Item 10, overall value of research (usefulness of results locally).

TABLE 3 Characteristics of studies included and Critical Appraisal Skills Programme (CASP) tool assessment.

Authors year country	Study aim	Study design methodology	Sampling method	CASP assessment criteria not satisfied
Afolabi et al. (2020), Nigeria	To assess nurses' knowledge and attitudes by gender regarding the care of elderly patients with dementia and explore gender differences in attitudes and associated factors.	A sequential explanatory mixed-methods design using semi-structured self-administered questionnaires and in-depth interviews.	In-depth interviews with 10 nurses selected by snowball sampling (and data from 100 nurses selected through a multistage sampling technique).	6. The researchers did not critically examine their role in the study. 8. The qualitative analysis process was not described in depth.
Andersson and Hansebo (2009), Sweden	To explore, from a gender perspective, older peoples' experiences with nursing care after a stroke.	A qualitative study based on interviews.	Five women and five men between 66 and 75 years of age who had received nursing care at a ward for stroke rehabilitation.	Satisfied all criteria.
Edwards (1998), UK	To discover nurses' and patients' perceptions of space and touch during their interactions with each other.	An ethnographic study based on participant observation and semi-structured interviews with staff and patients.	Six patients (four female and two male) between 76 and 85 years of age, and seven staff nurses (five female and two male) between 22 and 54 years of age.	8. The qualitative analysis process was not described in depth.
Foss and Sundby (2003), Norway	To investigate the construction of the gendered patient in hospital.	Interpretative sociology based on unstructured, open-ended interviews.	Twelve informants: female and male physicians, nurses and auxiliaries at one surgical and one medical ward.	6. Cannot tell if the researchers critically examined their own role in the study. 7. No reference to ethical considerations.
Malta et al. (2018), Australia	To explore health practitioners' knowledge of and attitudes towards management of sexual health among older patients.	A qualitative study based on semi-structured interviews.	Fifteen general practitioners and six practice nurses in rural/metropolitan general practices. The youngest participant was aged < 30 years, and the oldest was > 60 years.	3. Cannot tell if the researcher justified the research design. 6. The researchers did not critically examine their role in the study.
Nakopoulou et al. (2009), Greece	To explore perceptions on sexual health issues and how these might inhibit or enhance Greek nurses' abilities to incorporate sexual health assessment into everyday practice.	A qualitative research design using seven focus groups.	Forty-four Greek staff nurses attending a course leading to their professional upgrading (age range: 27–45).	7. Cannot tell if ethical issues were taken into consideration.
Özen (2020), Turkey	To understand later-life care at home from the perspectives of the carers: unpaid family caregivers, paid caregivers and nurses.	Qualitative methods, through in-depth interviews.	Nineteen caregivers providing home care for people aged 65 and over. Eight unpaid family carers, eight paid carers and three professional carers (nurses).	3. Cannot tell if the researcher justified the research design. 5. Cannot tell if the researcher justified the methods chosen. 6. The researcher did not critically examine their role in the study. 8. The qualitative analysis process has not been described in depth.

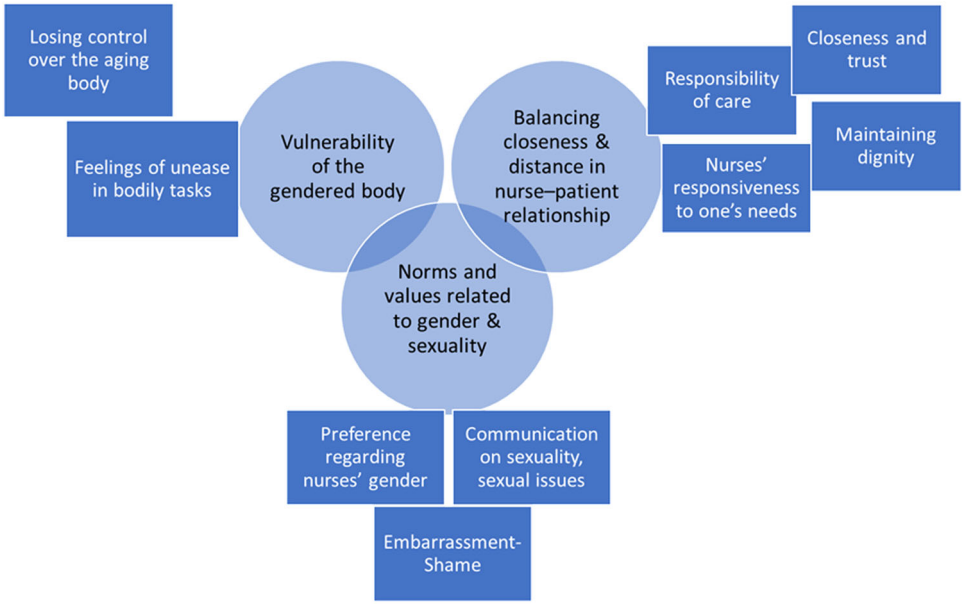

FIGURE 2 Final thematic map, according to Braun and Clarke (2006), presenting three final overarching themes.

participants (who, in the selected articles, were referred to in a binary way, such as 'male/female nurse', 'old man', 'old woman', etc.) and was explored through different aspects of the nurse–patient relationship.

4.1 | Theme 1: Vulnerability of the gendered body

The theme of the vulnerability of the gendered body was demonstrated within the caring relationship between the nurse and the older person and in relation to the gendered aspects of this multidimensional relationship. Caring for an older person and being cared for by a nurse evoke feelings connected to human vulnerability.

The meaning of gender in caring relationships between nurses providing care for older people and older people receiving care also implies a shared vulnerability. The body, particularly the gendered body of the older patient, can be the most prominent depiction of vulnerability, and this can lead to feelings of shyness, shame or embarrassment and is often linked to the performance of intimate tasks of bodily care (Andersson & Hansebo, 2009; Edwards, 1998; Malta et al., 2018; Özen, 2020). In one study, older men showed vulnerability regarding their bodily care, as they preferred to manage by themselves rather than rely on close bodily tasks provided by the nursing staff; they reported embarrassment, particularly when having to be naked in front of the nurses (Andersson & Hansebo, 2009). One participant in the study resigned himself to the situation, saying, 'You have to sort of either accept it…' (being naked in front of the nurses) '…or you beat your head against a wall, isolate yourself or whatever' (Andersson & Hansebo, 2009, p. 2041). However, older men did not mention embarrassment in reference to nurses of a specific gender, although they clearly showed a preference for female nurses when it came to the performance of bodily care. In another study by Edwards (1998), older men also reported that they preferred female nurses when they required help with intimate tasks. For example, an old man indicated that 'it didn't feel right having a man doing such intimate tasks' (Edwards, 1998) and that he did not regard nursing as a male profession. Similarly, caring was regarded as a female occupation in a study by Özen (2020), which included paid, unpaid carers and nurses providing home care as participants; however, this statement regarding caring as a female job was expressed only by paid carers and not by nurses, who were the particular focus of the current systematic review.

The findings elaborated on several aspects regarding older women receiving care. According to Andersson and Hansebo (2009), in situations when older women described the type of help that they needed, no feelings of embarrassment were evident when close bodily care took place (Andersson & Hansebo, 2009). However, this was in contrast with relevant experiences reported by Edwards (1998) when female patients showed a preference for female nurses regarding intimate tasks, such as bathing and toileting purposes. However, older women would eventually accept male nurses, as it was their job, but the women stated that it would have been increasingly difficult had they (the female patients) been younger. In the same study, a female patient reported that she was 'ashamed of her body now she is old' (Edwards, 1998, p. 813), expressing shame linked to the process of ageing that she was experiencing. Along with feelings of shame, feelings of helplessness were present, and it did not matter who dealt with them anymore (Edwards, 1998).

4.2 | Theme 2: Norms and values related to gender and sexuality

Contextualised norms and values related to sexuality and sexual issues are inextricably linked with bodily care and the intimacy that is

an inseparable part of these tasks (Edwards, 1998; Malta et al., 2018; Nakopoulou et al., 2009). Male and female nurses felt uneasy when caring for older people of the opposite gender and of a similar age. This was particularly acute for female nurses who felt embarrassment when caring for male patients who were close to them in age. Male nurses did not report shame or embarrassment but highlighted the need for a chaperone when performing intimate tasks to avoid possible sexual allegations against them (Edwards, 1998).

Nurse participants also reported that older patients had significant difficulty communicating sexuality issues to them (Malta et al., 2018; Nakopoulou et al., 2009). This is evident in the initiation of conversations on sexual matters, according to Nakopoulou et al. (2009). At first, a risk of misunderstanding the nurse's position arises in this kind of issue; the patient may think that the nurses are harassing them. Sex-related discussions are also considered a taboo subject between nurses and older patients, and links to the opposite gender and a larger age gap between them are prominent (Nakopoulou et al., 2009). As one participant stated, 'An old male patient will not discuss it with a young female nurse' (Nakopoulou et al., 2009, p. 2128). This is obviously an uncomfortable matter among patients, so they are not at ease discussing it with the nursing staff. This issue was also present in a study by Malta et al. (2018), which highlighted the barriers to sexual health discussions among female nurses and older men. One female practice nurse stated, 'A lot of male patients aren't comfortable talking to me' (Malta et al., 2018, p. 810). Male patients felt more comfortable turning to male general practitioners to discuss their sexual issues; however, older female patients chose to discuss their sexual health with female practice nurses, as they were considered approachable: 'The practice tends to know me, know that I am here. So, the women tell each other. It's nice' (practice nurse; Malta et al., 2018, p. 810).

4.3 | Theme 3: Balancing closeness and distance in the nurse–patient relationship

This analytical theme depicts another aspect of the study's aim of understanding the meaning of gender in the caring relationship between nurses and their older patients. Closeness and responsibility towards the patient highlight important elements of the caring relationship between the nurse and older person, and gender has a key meaning in the way this evolves (Afolabi et al., 2020; Andersson & Hansebo, 2009; Foss & Sundby, 2003; Özen, 2020).

When it comes to how nurses view their relationships with patients, differences have been reported regarding the way male and female patients communicate their needs (Foss & Sundby, 2003). Nursing staff expressed values and beliefs, such as the lack of clarity in female patients' communication: 'Men are more direct. They send clear signals. But you really have to ask women and try to talk to them a bit… Women, at any rate those who are a bit older, don't dare to be definite in their questions. And you know, the physician does not easily grasp these hidden things' (female nurses' aid; Foss & Sundby, 2003, p. 48). This also highlights the closeness in caring relationships between nurses and older patients and the importance of gender in those relationships, which is not necessarily understood by the physicians who provide care, as the nurses indicated. The same study highlighted how older men show gratitude and appreciation to the nurses, adopting an informality in their caring relationships with (particularly women) nurses, and how this appears different with women patients, who seem to maintain a more distant approach: 'You can joke a bit with the elderly men. I think there is a difference there… that we are sweet and good-natured, right? … and they, they have lots of girls running in and doing things for them… I do really think they are grateful and appreciate you. And then, when you go into the next room, to the women, you feel you are just doing your job. That is an important difference' (female nurse; Foss & Sundby, 2003, p. 49). This kind of appreciation in the nurse's caring relationships with older men was also reported in a study by Afolabi et al. (2020, p. 216), where a female nurse highlighted that men with dementia 'appreciate you more' even if caring for them turns more demanding. A contradictory caring relationship was also stressed regarding older women with dementia, who were mentioned as 'too petty and fragile' or 'wanting unnecessary attention' (Afolabi et al., 2020, p. 217).

Nurses' responsiveness to older patients' needs has been related to positive experiences of caring for them, as stated in Andersson and Hansebo (2009), and this is evident for patients of both genders. Men described that they experienced nursing care in a positive way when they 'received help when they needed it, nurses came when they called, they were treated well' (Andersson & Hansebo, 2009, p. 2041). Women patients also considered their caring experiences to be positive when nurses listened to them, at the same time being considerate and helpful. In the same study, men and women stated the importance of knowing nurses by name as a basis for a trusting relationship in their care. A closer caring relationship with one individual nurse was also described as especially important. According to these findings, a more personalised approach from nurses was highly valued, and this was important for all patients, regardless of their gender.

A mutual understanding regarding the body's vulnerability and the ageing process that it undergoes was expressed by the nursing staff, according to Afolabi et al. (2020). One female nurse stated that nurses have 'the responsibility to fully understand and be cooperative' with older people because of 'the degenerative process of aging' to which they are subjected (Afolabi et al., 2020, p. 215). Findings from the same study elaborate on the willingness of nurses to care for both genders, which is imbued by feelings of responsibility towards the older patient with dementia. As one female nurse remarked, 'the core of nursing is caring… without any discrimination irrespective of gender' (Afolabi et al., 2020, p. 216). A male nurse highlighted the responsibility of a well-educated nurse to be ready to care universally for people with dementia: 'I am called to care and not segregate' (Afolabi et al., 2020, p. 216).

5 | DISCUSSION

This systematic literature review explored aspects of the meaning of gender in caring relationships between nurses and older patients through a thematic synthesis of qualitative studies. The analysis

resulted in three main analytical themes: (i) *vulnerability of the gendered body*, (ii) *norms and values related to gender and sexuality* and (iii) *balancing closeness and distance in the nurse-patient relationship*. These themes highlight interrelated aspects of the meaning of gender in caring relationships between nurses who provide care and the older recipients of care.

From the perspective of lifeworld-led care, a need exists for understanding patients' vulnerabilities and freedoms in the search for possible deeper potentials and existential horizons (Dahlberg et al., 2009). When it comes to older patients, vulnerability is strongly intertwined with the fragility of old age and the recognition of the otherness of both parties in a caring relationship. The study's results particularly highlight the vulnerability of the gendered aspects in the nurse–patient relationship. The study's findings elaborate that nurses' and older people's strong attachments to certain social norms and values within their contexts shape their views of what is acceptable in the caring process, regardless of who gives and who receives care. These are norms and values regarding sexuality that are intertwined with and led by gender. Butler (1999), in her original work *Gender Trouble*, contends that we become closely attached to the identity categories that regulate us, as gender is performative and not biologically based and, thus, constitutes an identity based on how we psychologically incorporate social norms. Therefore, it is important that the studies that were selected for this systematic review provide a worldwide view of different cultural contexts; this is crucial for the meaning of gender and its relationship to norms of sexuality and how these are met across different cultures. These might highly differ across, for example, European or African contexts, and this should provide awareness of the diversity that might exist across different cultural backgrounds when existing literature is evaluated or further gender research is conducted.

The results related to norms on gender and sexuality show that male nurses often express awareness of social boundaries and taboos in the care of female patients and that trespassing these boundaries might have consequences, such as sexual allegations. A study by Grey (2010) highlights the importance of gender stereotypes as a factor leading male nurses to feel uncomfortable in close physical and emotional contact with patients. Similar findings emerging from older patients' experiences from the selected studies suggest that it is not acceptable for men to care for other men (Edwards, 1998). Other experiences confirm that there is a distance kept in the caring relationship of nurses towards older people and vice-versa resulting from gender barriers that prevent them from talking to the nurses about specific aspects of their health, such as sexual problems and sexuality (Malta et al., 2018; Nakopoulou et al., 2009).

These findings imply the vulnerable position of the older patient compared to nursing staff of a different gender, as well as the vulnerability of the professional who is afraid of allegations, since norms and values on sexuality may lead patients to think that their caregivers view them sexually (Nakopoulou et al., 2009). All the above are also related to the vulnerable position of an older patient who needs help with bodily tasks that require intimacy and who also has to deal with the degenerative process of ageing and the general loss of control over their self-dependency. This vulnerability might be enhanced by a lack of personal space. Young (2004), in her essay *A Room of One's Own: Old Age, Extended Care and Privacy*, references the lack of privacy that comes with old age and places special focus on the loss of personal space that comes with the need for nursing care for older people who cannot live independently. In addition to that loss, our findings show that their dependency in performing bodily tasks leads to feelings of shame in older patients and is imbued by the gendered meaning that they ascribe to caring relationships with their caregivers (Andersson & Hansebo, 2009; Edwards, 1998; Malta et al., 2018; Özen, 2020). According to Young (2005), the lived body acts in certain sociocultural contexts and, at the same time, defies the distinction between sex and gender, following the rejection of the distinction between nature and culture. A 'body-in-situation', as described by Young (2005), or the constant move between the 'embodied' reality and the dimension of 'spatiality' (Todres et al., 2007), may describe how gender unfolds within the caring relationships that constitute a central part of the patient's reality.

In addition to the above, our results show that there are different levels of closeness in the relationship between nurses and older patients that are relevant to how nurses view their patients of different genders. Norms regarding how men or women should behave play an important role in how female nurses experience caring for older people of different genders. This might explain the different approaches and how 'distant' and 'professional' or 'informal' nurses treat older men and women. Although the relationship with older women seems more indifferent and sometimes negatively imbued, female nurses' relationships with older men were described as more playful or 'flirtatious', which again brings norms and values regarding sexuality to the fore (Afolabi et al., 2020; Foss & Sundby, 2003). Studies have shown that nursing staff (especially females) might also feel physically and sexually at risk (e.g., in male-dominated clinical settings, such as mental health) because of the aggressive or harassing behaviour of certain patients (Grey, 2010). This implies a vulnerability on the nurses' part and is also supported by our findings, as previously discussed. All the above highlight that norms on gender and sexuality go hand in hand with levels of closeness and vulnerability that occur in the nurse–patient relationship, revealing tensions that should be elaborated on in gender research. This is evident for older patients, where research on caring relationships and gender matters is still new. However, professional responsibility and the universality of caring might act beyond gender barriers that may exist, adding new dimensions in this area that require further investigation.

6 | LIMITATIONS

This systematic review resulted in a limited number of selected studies due to the significant lack of literature in this area. Gender aspects in the nurse–patient relationship, especially regarding older patients, are under-researched, and a gap in the existing literature is prominent as discovered after the thorough and long process of

searching for available records in this study. In addition, studies that were eventually included were not always specifically relevant to gender or our selected populations in their aim and particular focus, which shows the difficulty in tracing results relevant to our study aim. To fill this gap, we chose to conduct a thorough search within each study, opting for findings specific to our aim. The selected studies were mainly qualitative; further research elaborating on quantitative aspects might be beneficial in future reviews, as well as research directed to the experiences of older patients.

7 | PHILOSOPHICAL IMPACT

In this systematic literature review, vulnerability is key when related to aspects of gender that pervade the caring relationship between nurses and older persons. Gender itself has a particular meaning when caring occurs in a shared space in which power relations may be unequal, and the patient's autonomy is at risk of being threatened. The gendered body, shaped by societal norms and expectations, can significantly influence the experience of vulnerability as part of the caring relationship.

Through a phenomenological lens, the vulnerability of the body illuminates the intertwining of subjective experience, social dynamics and ethical considerations of the caring process. One key aspect concerns the recognition of the embodied nature of experience which has been covered by Iris Marion Young's embodied phenomenology and the early works of Husserl and Merleau-Ponty: The body is not an object but a fundamental mode of our existence, it is "lived" and our perception of the world is shaped of our body's capacity to move, touch and interact with the environment (Husserl, 1970; Merleau-Ponty, 1962/2002; Young, 1980). However, when it comes to nursing the body, it is typical that the disease is treated while the embodied human being is neglected in this way not promoting healing (Keller, 2020).

Older patients' experiences of dignity in the caring process have been associated with losses or threats concerning the bodily self. The exposure of the aging body, coupled with a loss of control over bodily functions, can give rise to feelings of embarrassment that directly impact an individual's sense of dignity. In this context, the role of nurses becomes paramount in safeguarding patients' dignity while addressing these sensitive concerns (Høy et al., 2016). Closeness and reciprocity in the nurse-patient relationship come as essential elements to address the unique needs of older persons.

However, the gendered aspect of the body comes as a challenging agent that complicates levels of closeness in the caring process. An aging gendered body intertwines with norms regarding sexuality and heteronormative relationships. In the intersection of gender and ageism, this can mean either a problematic inability to "perform" for older men (Calasanti & Slevin, 2001) or an experience of the feminine body as lacking power, resulting in shame which is antithetical to the value of human dignity (Calasanti & Slevin, 2006).

The experience of vulnerability within the nurse-patient relationship is shaped by a range of influential factors, including broader social, cultural and institutional contexts. These factors interact with the naturalisation of social inequalities, such as the perceived inherent nurturing qualities of women or the presumed innate aggressiveness of men (Calasanti, 2019). As a result, power dynamics within the nurse-patient relationship are established, influencing how vulnerability is perceived, experienced and addressed by both parties involved. The intersections of gender with other aspects of identity, such as age and sexuality may further complicate experienced vulnerability, as individuals may face unique challenges based on their intersecting dimensions of identity.

The diverse manifestations of embodied vulnerability in individuals play a pivotal role in shaping caring and exerting a profound impact on well-being. Philosophical perspectives offer valuable insights into the ethical dimensions of vulnerability, underscoring its significance in fostering compassionate and personalised care practices. First, they illuminate the intrinsic interconnectedness of human existence and the role of the lived body, emphasising how vulnerability is a fundamental aspect of the human condition. Second, these perspectives illuminate how cultural expectations related to gender influence the way both parties involved in the caring relationship experience embodiment and vulnerability. Moreover, philosophical inquiry highlights the ethical obligation to ensure that individuals receive personalised care tailored to their unique needs, circumstances and values. These insights enable compassionate care by promoting a deeper understanding of vulnerability as an inherent aspect of being human and involved in a caring relationship. When healthcare providers and caregivers recognise vulnerability as a shared experience, they are more likely to approach patients with empathy and sensitivity, thereby enhancing the quality of care. Additionally, by emphasising the importance of personalised care practices, philosophical perspectives encourage healthcare professionals to tailor their interventions to each patient, ensuring that their individual needs and preferences are met, further promoting compassionate and patient-centred care.

By acknowledging the multifaceted nature of caring relationships and the diverse experiences of the individuals involved in the caregiving process, opportunities arise for transformative caring relationships that promote comprehensive well-being and uphold the principles of dignity in caring.

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CONFLICT OF INTEREST STATEMENT

The authors declare no conflict of interest.

DATA AVAILABILITY STATEMENT

Data sharing is not applicable to this article as no datasets were generated or analysed during the current study.

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