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MALE MIDWIVES IN FRANCE: AN EXAMPLE OF MASCULINIZING A “FEMININE” PROFESSION?

ABSTRACT Of 19,208 midwives polled in France in 2010, 349 were men. Based on interviews from a selected group of male midwives and midwifery students, as well as data from a recent study of the midwife profession in France, this study shows that the masculinity brought to this profession by male practitioners can be qualified as “respective masculinity.” This theoretical perspective permits a broader consideration of the existing models that explain male presence in non-traditional professions. These models describe their presence as either a power struggle, a means by which to be promoted, or even as a possible questioning of male identity. Male midwives assert their masculinity by seeking autonomy in their work. They are able to work around the obstacle of showing empathy to female patients, typically considered a gendered predisposition. The case of male midwives shows the dynamics of masculinization when taking into account socio-professional contexts.

KEYWORDS GENDER STUDIES, MALE MIDWIVES, MASCULINIZATION, SOCIOLOGY OF PROFESSIONS, FRANCE

This article describes the observation of a rather unexpected evolution for a Western country such as France, namely the presence of men in the midwife profession. From a statistical point of view, this phenomenon remains very marginal, with our recent poll only counting 345 men (1.8%) of approximately 19,208 midwives (Sicard, 2010). All the same, for reasons primarily based on an evolution in midwife recruitment, it is a likely possibility that their numbers are increasing. The arrival of men in this profession could be interpreted as a developing form of masculinization in one of the most characteristically feminine professions. If this is the case, in what ways is this masculinization apparent? Building on research of male presence in nontraditional occupations, male midwives offer a contemporary example of masculinization taking place in a pro-

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02 fession strongly associated with the feminine gender. This is a phenomenon,
03 studied below, that is beginning to develop in Europe (Charrier, 2004, 2007;
04 Molinier, 1999; Philippe, 2008) if not around the world.

05
06 BACKGROUND: THE SOCIOLOGY OF MASCULINITY

07 One can approach the question of masculinization by considering the social
08 construction of masculinity in a given context. Conceptualization of this field
09 of research is still in process. The sociology of masculinity has shown that so-
10 cial constructions of the male gender are changeable. For Connell (1995), as
11 well as for Collinson and Hearn (1996), masculinity is diverse and complex.
12 Consequently, one must speak of *masculinities*. Other forms of masculinity exist
13 alongside “hegemonic masculinity” (Connell, 2000), the culturally exalted form
14 of masculinity guaranteeing the dominant position of men. Recent research has
15 studied the complexity of masculinity and the ambiguity—even fluidity—of
16 this notion in a “post-structural” perspective (Connell, 2000).

17 This element of fluidity is what French commentators have highlighted.
18 Going beyond the structural position that underlines masculine dominance
19 (Bourdieu, 1998), Welzer-Lang traces contemporary modifications, sketching a
20 complexly changing masculinity (2004). Similarly, Castelain-Meunier observes
21 a “masculine poly-culture” and the emergence of a “modern man” looking to
22 distance itself from “defensive masculinity” which “is unsatisfied in its aspi-
23 rations for equality, does not respond to their efforts to separate from the stran-
24 glehold of their fathers, to their perception of women, their idea of relations
25 with women and children, nor to the numerous practices they seek to innov-
26 ate” (2005, p. 41). These works echo numerous other statements, such as the
27 conclusions at which Galbraith arrives, based on his research of elementary
28 teachers (1992). He observes men who have a “transformed identity,” a mas-
29 culine identity that authorizes the rejection of some masculine character traits
30 while maintaining others. This is also what Holyoake observes in his study of
31 psychiatric nurses who are themselves examples of “soft masculinity” (2002).
32 In short, there exist fringe masculinities developed by men favoring careers or
33 professions typically seen as feminine.

34 The male midwives participating in this study may be part of this movement.
35 The condition of masculinity in flux lead certain men to consider career choices
36 categorized as feminine. In such cases, questions arise concerning men’s gen-
37 der identity, because it is potentially challenged. Men must adjust their gender
38 identity to their professional situation. Connell (1995) emphasizes that men
39 might consider this situation as a type of downgrade. Given that female-coded
40 professions and careers often have in common the fact that they have low qual-
41 ifications, a subordinate rank in the symbolic hierarchy of activities, and are
42 seen as closely tied to domestic tasks in terms of actualized capacities, men
43 scrutinize strong male investment in such careers for fear of being considered
44 too feminine. It is known that women’s entering into traditionally masculine ca-
45 reers also lead to men’s rigid and virile behavior (Cockburn, 1991). Research
46 shows that in atypical situations, men choose to develop values and attitudes
47 that are characteristically (traditionally) masculine (Chusmir, 1990; Jome &

01
02 Toker, 1998). The fear of being “downgraded” pushes men to a personal invest-
03 ment of values and attitudes that are clearly classified as masculine, even
04 as typical of heightened virility.

05 BACKGROUND: MEN IN NON-TRADITIONAL OCCUPATIONS

06
07 Presence of men in non-traditional careers has been conceptualized in very
08 different ways in theories that go beyond perceptions of identity and the social
09 construction of gender. In keeping with the belief that domination is central,
10 Williams (1989) shows substantial benefits of this situation for men, notably
11 with respect to internal hierarchy. She defends the notion of the “glass escalator.”
12 Men guarantee themselves a high profitability in their career advancements,
13 which leads in turn to holding dominant positions in these careers. This
14 dynamic entails side-benefits for men that have traditionally feminine careers.
15 One observes a two-fold advantage: men work in fields of specialization that
16 plays to their strengths, and are also typically better financially compensated.
17 Angeloff and Arborio (2001), discussing the case of cleaning agencies, reveal the
18 strategies used by some men working in this supposedly feminine career as
19 they strive to build an ideal niche for themselves, thus making their career more
20 satisfying. Men succeed in monopolizing more technical tasks, that is to say, the
21 tasks that offer the most assurance of escaping an undervalued or submissive
22 position.

23 In the domain of conjugal and familial advice, Philippe (2008) shows that the
24 few men present obtain numerous benefits regarding career development,
25 recognition of their abilities, and choice of their field of work. Moreover, if these
26 benefits are judged to be too restricted, they can change their professional orien-
27 tation. This tends to support the belief that most men who have dedicated
28 themselves to non-traditionally male careers do so for strategic purposes and
29 in the likelihood of obtaining many advantages.

30 Some authors have tried to classify these strategies by pursuing more nu-
31 anced considerations of the dimension of power. In a study based on several
32 cases of men working in typically feminine careers and examining the identity
33 challenges this poses, Cross and Bagihole (2000) conclude on three scenarios:
34 the maintenance of traditional masculine values and consequently of masculine
35 power; the reconstruction of masculine identity leading to a weakening of said
36 power; and finally, a combination of these two possibilities. The authors state
37 that masculine power and its potential weakening coexist. Simpson (2004),
38 building on the work of Williams and Willemez (1993), also shows that there
39 are three types of actors: “seekers,” men that have voluntarily chosen to inte-
40 grate into a feminine profession; “finders,” men that adopt such a profession
41 without considering it as a career; and “settlers,” professionally unsatisfied
42 men issued from other, generally masculine, professions who permanently set-
43 tle into such a career. If it seems that initial research underscored the impor-
44 tance of strategic and power relations, more recent findings nuance this
structural position regarding the analysis of changing social construction of
masculinities.

45 The situation of men in healthcare professions has been well-researched in
46 France, as in Anglo-Saxon countries. These studies typically report on male

nurses and of male primary school teachers, more seldom on careers like home-maker aides or child minders. These care-based fields are all associated with psychological and social care, as well as with working relationships with patients. Acknowledgement concerning men in such fields is often varied. Vilbrod and Douget (2008) demonstrate a logic of segmentation (Bucher & Strauss, 1992) valid for male private practice nurses in France, given that the latter often feel that they are not doing the same work as their salaried colleagues. Female private practice nurses, on the other hand, do not typically share this sentiment: "being a private practitioner is a synonym for autonomy, liberty, and responsibility" (p. 281). This logic was also identified by Angeloff and Arborio (2001): men, once settled and assigned either by institution or as requested by their female colleagues, or even by their own initiative, take on tasks typically classified as masculine, such as handling of materials. The authors put "at the forefront, evidence of sex-based segmentation in the areas where one would have thought that it was not an option, considering the history of these careers and their lack of social appreciation" (2001, p. 12). In Ireland, Loughrey (2007) notes that if nurses maintain close ties with classical masculine traits, they also show characteristics culturally defined as feminine.

Studies of male midwives are all but nonexistent. Only Bagihole and Cross (2000) address the case of the male midwife. The authors, concentrating on obstacles encountered by the gender minority, put the male midwife in a "mixed" category. The male midwife positions himself in competition with his female colleagues, which is proof that he has not totally relinquished their masculine power, all the while keeping a distance from definitive masculine traits. Nevertheless, this might be generalizing the situation.

Despite of undoubted significance, these theoretical patterns are limited when taking into consideration the presence of men and the masculinization of the midwife profession, indeed for two reasons. On the one hand, men entered into the field after professional evolutions that affected all French midwives. Most of the studies referenced here do not take into consideration the professional dimension; their arguments start from the point of view of men issued from professional heterogeneous backgrounds. On the other hand, this masculinization importantly refers to the concept of empathy, as a supposed handicap. Female midwives have always claimed to have a predisposition or specific ability to "put themselves in the place of the women in labor," because they are female. They supposedly know best how to accompany women through the birthing experience. Empathy is a veritable "gender capacity" (Schweyer, 1996), a capacity acquired though feminine socialization and the lived experience of giving birth. This empathy is presumed despite the fact that many midwives, especially the youngest ones, practice without having given birth themselves. The latter essentially occupy the same position as male midwives, except that they are attributed a maternal power (Jacques, 2007). Empathy must also be understood as a widespread social representation, historically tying women to the role of accompaniment (Gélis, 1984, 1988; Knibiehler & Fouquet, 1977). The capacity for empathy, then, remains a criterion in the evaluation of the work of midwives, even where not explicitly discussed.

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METHODODOLOGY

This article is based on research conducted on male midwives in France, and took place in two steps. In 2003, we questioned 100 male midwives via mailed questionnaires; 62 responded at the time. This step had several goals. We needed to better define the characteristics of the social demographic, as well as determine elements specific with regard to professional practice. Afterward, we conducted thirteen detailed, semi-structured interviews from the pool of respondents. During this phase, we were more interested in their professional experience than in their personal experience. We were therefore able to collect data about their socialization, the way they show empathy, the reasons for their professional decisions, and the reactions of those around them regarding their decision. These interviews were supported by an additional ten interviews previously conducted with students of the midwifery school in Grenoble; these interviews were specifically concerned with professional decision motivations. Finally, interventions in several midwifery schools, contacts with the National Order of Midwives (Ordre National des Sages-Femmes), and participation in the Society of the History of Birth's work, allowed us to familiarize ourselves with French midwifery's professional environment.

The presently defended points of view also required access to statistical data. The Order of Midwives has its own professional listing, but this source proved to be inefficient since the available data at times proved out of date. In order to have the most precise information concerning the number of practicing male and female midwives, we used statistical data from the Direction of Research, Studies, Evaluation and Statistics (DREES, Ministry of Health). The present article equally benefited from the results of a study led by the author from 2009 to 2010 based on French midwives. This study established a global view of the profession and compiled the principle issues facing the 811 midwives (4.3% of the midwife population) studied via questionnaire. The results, in sum, reflected a representative sample of the total population of midwives and allowed comparative considerations of the reception of men in the midwife profession.¹

THE MIDWIFE PROFESSION IN FRANCE

The midwife profession is regulated. It has an independent Professional Order since 1995, when there were no longer any gynecologist or obstetrician members. The work of a midwife differs from that of an obstetrician² by the

¹ The results have not yet been published, but a synopsis can be consulted (Charrier, 2011).

² A note concerning language: "male midwives" (*hommes sages-femmes*) is only used in French as concerns men who are practicing midwives, while in English this terminology (including the term "men-midwives") is occasionally used to designate delivery doctors (*médecins*), notably those who in the 18th compete with midwives during delivery. We will call them obstetricians (*obstétriciens*).

01
02 division of work between “eutocic” birth and “pathological” birth. In reality,
03 it is not so rare that midwives would intervene in a pathological delivery, hence
04 today this is not an operating distinction. Medicalized interventions are in-
05 creasing due to the current focus on obstetrical risks, and they determine the
06 professional practices of midwives (Carricaburu, 2005).

07 French midwives work primarily in hospitals (76%), most practice in the pub-
08 lic sector (75%), while the remaining 25% work in private institutions. The level
09 of medical care provided at time of birth varies (anesthesia, epidural, cesarean,
10 forceps-facilitated, episiotomy, etc.) but the practice of non-medicalized deliv-
11 ery is limited to home deliveries, which is a marginal practice.³ A minority of
12 midwives (17%) works in private practices, either individually or with a group.
13 This type of practice has been on the rise for the past ten years. The vast ma-
14 jority of these midwives do not actually do deliveries, since they rarely have ac-
15 cess to a maternity ward. As such, the majority of private practice midwives
16 undertake pre- and post-natal care. Other midwives are spread out among in-
17 structors in midwifery schools, in Mother and Child Protection services (Pro-
18 tection Maternelle et Infantile), as salaried employees administering State and
19 other public services. The latter offers services to women in social and/or fi-
20 nancial difficulty.

21 Medical schools include midwife training, but midwife schools are becoming
22 increasingly independent. Midwife instructors supervise the training of a class
23 of students and intervene on the same level as professors specialized in ob-
24 stetrics, gynecology, anatomy, law, sanitation, and social sciences. Training is
25 alternated with clinical training, mostly in public hospital. The duration of
26 training increased from 3 to 4 years in 1984. It currently takes 5 years to com-
27 plete, after obtaining a high school diploma, because it is now obligatory to
28 take a qualifying exam in the first year of medical studies. The average age of
29 students to complete their formation has increased to 24.3 years (Schreiber,
30 2004), and the age of midwives is also becoming more homogenous, that is, the
31 gap between older and younger (at graduation) is reduced.⁴ The profession has
32 little unemployment; the birth rate has been increasing steadily in France since
33 2000.⁵

34 Although the profession is traditionally seen as feminine, it can no longer be
35 said that this is what attracts candidates. In fact, current motivations to enter
36 into the practice have little to do with the feminine dimension. In a study con-
37 ducted in 2009-2010 based on a representative sample of French midwives, we

38 ³ According to Jacques (2007, p. 163), 1,300 home deliveries took place in France, ac-
39 counting for roughly 0.16% of births. We exclude home deliveries due to constraints,
40 such as when the women were unable to go to a medical establishment for reasons such
41 as lack of time or lack of means.

42 ⁴ We were able to obtain the average age at time of graduation from a non-published
43 study of midwives (c.f. methodology section). Forty-seven percent of midwives born
44 after 1976 are 24 years old ($SD = 1.8$). For those born before 1976, there are more 23-
45 year-olds, but they only account for 31% of the population ($SD = 2.6$).

⁵ 828,000 births in 2010. The fertility rate per woman is 2.01 children.

Table 1
Distribution of Reasons for Professional Choice

	%
By vocation	20.3
By chance	10.2
Because it's in the medical field	22.4
Due to interest in birth and/or infants	30.1
By default, not having been accepted into medical/pharmacy/other school	6.9
To work in a hospital setting	5.8
To have private practice	1.9
Because it's a feminine profession	2.4
Total	100

were able to determine the reasons for entering professional practice. Despite the popularly held view, midwives who choose midwifery by vocation are the minority, accounting for about 20% in all age groups interviewed. The reasons for this professional choice are divided (Table 1).

The main attraction is interest in birth and/or infants. The medical aspect of the profession is also attractive, especially to the younger generation of midwives. Motivations of male midwives are comparable to those of female midwives. It should be remembered that since academic standards for entering into this field of work are higher than for other professions, personal interest is not always sufficient. Moreover, in France, midwifery is considered to be a medical profession.⁶

Factors Enabling Men to Enter the Profession

The entry of men into midwifery in France is the result of the convergence of several factors. On the one hand, there is the legal dimension: the profession has only become open to men recently. It is not that the practice of midwifery was forbidden, but men were not allowed to follow the training course. That changed when a European directive was passed concerning non-discrimination on grounds of gender in all sectors of professional activity, aimed at guaranteeing women access to all levels of employment.⁷ As a result, the first male midwife got his diploma in 1985.⁸

On the other hand, things were changing in the minds of professional midwives. They wanted more recognition and professional independence in relation to the other childbirth-related professions (gynecology, obstetrics,

⁶ Midwifery is a medical profession recognized by the Public Health Code.

⁷ A European directive at the beginning of the 80s explained the need for non-discrimination on gender grounds in professional life in all EEC member states. French law had to conform to this directive and notably allow men to gain access to the training course in midwifery, because the ban was at that level (May 12, 1982).

⁸ The length of the study used to be three years; currently it is four.

01
02 medicine, anesthesiology, and nursing). From the end of the nineties onwards,
03 there was a concerted push toward professionalism (Freidson, 1970). The
04 2001 strike, which was the profession's first big clash with the government, was
05 enthusiastically supported. It explicitly demanded social recognition of the pro-
06 fession. Midwives from all over the country made a point to differentiate their
07 skills from those of the other natal professionals. Generally, they were looking
08 to increase the range of their responsibilities, for example by being able to pre-
09 scribe a wider range of medicines. Finally, midwives managed to renegotiate
10 the medical status of their profession thanks to a new system of recruitment.
11 Future midwives have to pass a competitive qualifying exam for the first year
12 of medicine, and no longer just a competitive exam for the College of Mid-
13 wifery. The field now uses the PCEM1 (Premier Cycle des Etudes Médicales
14 1ère Année, or First Year Pre-Medical Studies) entrance exam. This is the same
15 exam used by students wishing to enter into medical, midwifery, dental, or
16 chiropractic studies. Thus, there is no longer an entrance exam specific for mid-
17 wifery.

17 It is during this period when midwives expressed a desire to "reconquer" the
18 medical field⁹ that men chose to enter into midwifery training. By opening up
19 the recruitment system to students aiming for medical careers, midwives had
20 opened their recruitment base to students who had not previously considered
21 the profession, particularly men. In fact, in every medical school, the students
22 are graded at the end of the qualifying exam. Each of the medical professions
23 is restricted by a *numerus clausus*, a limited number of places. As a result, those
24 students who tested highest have the widest range of choices. Generally,
25 prospective students make their decisions following this hierarchy: doctor, den-
26 tistry, massage and physiotherapy, and midwifery. Many students with a sim-
27 ilar high school diploma or school profile (Baccalauréat S: in Science and
28 Mathematics) are attracted to a medical career, and will often retake the exam
29 if they fail the first time.¹⁰ Under these conditions, the student aiming for a car-
30 eer in medicine may not score high enough to become a doctor, but high
31 enough for another medical profession such as a midwifery.¹¹ This procedure,
32 which opened the way to get into the profession upside down, immediately
33 gave young men the possibility of becoming midwives.

33 This selection process became operational in medical schools in France in Oc-
34 tober 2003. Until this time, male presence was essentially unapparent. After the
35 profession was opened to men, a significant number of those trained in 2003 en-
36 tered the profession, thanks to information spread via specialized journals. Ini-
37 tially an experimental move, the school of midwifery in Grenoble has opted
38 for coed recruitment since 1992. In hindsight, looking back over more than

39 ⁹ Midwives have had to accept the entry of anesthesiologists and pediatricians into the
40 maternity field over the course of the past two decades.

41 ¹⁰ Repetition of the year is permitted under exceptional circumstances.

42 ¹¹ A student at the top of the list is not restricted by rank. The student has the greatest
43 choice of routes. We met female midwife students who, at the end of the competitive
44 exam could have gone on to study medicine, but who preferred midwifery.

01
02 twenty years of students, the school has the unique capability to show that the
03 proportion of men has remained stable; between 1 and 4 per graduation class
04 of 20 students. We can even say that there is not a role reversal in the propor-
05 tions of men to women in the profession, but rather a continuous yet minor
06 presence of men (Table 2).

07 *Professional Organization of Natal Care in France*

08
09 Midwifery became an actual profession during the 17th and 18th centuries in
10 Europe (Shorter, 1984). However, since the 18th century, midwives have found
11 themselves in a subordinate position in relation to (male) doctors, who at-
12 tempted to establish a rational knowledge of delivery and obstetrics (Gelis,
13 1984). At the same time, midwifery was becoming a livelihood rather than just
14 a function filled by women for the good of, and compensated by, the commu-
15 nity. In its modern incarnation, midwifery is concurrent with the appearance
16 of a new player in the field: the obstetrician, ancestor of obstetrician-gynecol-
17 ogists. Men wishing to enter into this field of work progressively transformed
18 their knowledge into an autonomous medical discipline known as obstetrics.
19 Although obstetrics already existed, the field evolved into a renowned scien-
20 tific discipline that uses a scientific, standardized approach (Schlumbohm,
21 2002). These new male players in the field eventually took a significant place
22 in most European countries (Donninson, 1977), notably in midwife training. In
23 fact, although the first attempts to professionally train midwives occurred
24 thanks to the work of Mme de Coudray, who was herself a midwife, male ob-
25 stetricians quickly assumed leadership roles in these schools (Gelis, 1988).

26 Table 2

27 *Numbers and Proportions of Male Midwives 1990-2008*

28 Year	29 N° Female midwives	30 N° Male midwives	31 % Male midwives
32 1990	10,705	45	0.42
33 1995	12,218 ^a	65 ^b	0.53
34 1996	12,662 ^a	76 ^b	0.60
35 2001	14,725	95	0.65
36 2002	15,122	110	0.73
37 2003	15,684	137	0.87
38 2004	16,134	156	0.96
39 2005	16,550	160	0.97
40 2006	16,995	174	1.02
41 2007	17,483	200	1.14
42 2008	17,998	240	1.33

43 Statistics: DREES

44 ^a Source: French National Council of Gynaecologists-obstetrician: http://www.cngof.asso.fr/d_cohen/coA_03.htm (accessed November 26, 2008) ^b Source: Order of Midwives

01 This provides a background to the contemporary delegating, or “bundling
 02 of tasks” (Hughes 1981), between obstetricians and midwives. Over the years,
 03 this arrangement became a tradition: men were responsible for mastering medical
 04 and scientific skills including operations, particularly caesareans and forceps
 05 use, while women were responsible for accompanying the patients, using
 06 so-called “female skills” such as empathy. As a result, once the current profession
 07 of midwifery was established, this professional organization of natal care
 08 was imposed on midwives. Moreover, women had no official representatives.
 09 A professional organization of midwives in France was not founded until the
 10 end of World War II. However, male obstetricians ran the Order of Midwives.
 11 It was only in 1995 that women took over the leadership role of that Order.

12 This state of affairs led to numerous feminist-based critiques. Oakley (1980)
 13 showed that in the United States, the medicalization of natal care and the increased
 14 number of obstetricians since the 18th century has not been accompanied by an
 15 increase in guaranteed safety during delivery for either the mother or the infant.
 16 The same author shows elsewhere that modern obstetrics is not a guarantee for
 17 the health of women in labor (Oakley, 1984). Other studies, adopting Foucault’s
 18 point of view (2000[1963]), insist on the association between male constructions
 19 of female inferiority and the social construction of birth and delivery pathology.
 20 These studies have suggested that, in the name of safety for women, the medicalization
 21 of the natal process and the distinction between pathology and physiology have
 22 been imposed upon them (Cahill, 2000). In France, midwives can only use
 23 prescriptions reserved for normal deliveries (i.e., without predicted complications).
 24 The public health code divides deliveries into two categories: “normal” deliveries
 25 and those requiring an operation. Even if this division of work appears to be
 26 a function of and adapted to the hierarchical organization of work in French
 27 hospitals, it is also a way of keeping obstetrical power in the hands of men and
 28 doctors (Dagnaud & Mehl, 1988).

29 FINDINGS

30 *Who Are Male Midwives?*

31 Are we in the presence of men who have had a unique socialization that
 32 might explain their non-traditional professional choice? Or are they simply
 33 “failed doctors” who managed to enter into the medical profession in a round-
 34 about way and are accepting concessions to their original ambition?
 35

36 In the course of male socialization, women, particularly mothers, play an
 37 important role. However it is difficult to conclude on a “matrilineal” professional
 38 affiliation even though two male midwives did have a midwife mother.
 39

40 I have a unique story. I am a fifth generation midwife. So there is a certain
 41 weight of family tradition. And my sister didn’t take over, it’s—it’s more
 42 a joke than anything else—it.... No, that’s the legend My mother was
 43 a midwife, my grandmother was a midwife, my great-grandmother was a
 44 midwife and my great-great-grandmother was a midwife. In fact she was

01 a nun, what we call a defrocked nun. (Franck, 32 years old, hospital mid-
02 wife)
03

04 Mothers are more present than fathers in the men's life narratives. Mothers
05 seem to be the most sensitive to their sons' career choices, often in a positive
06 way.
07

08 My parents are very open. With my mother, there was no problem. She
09 knew a little bit about the field. She's a doctor. She's very focused on re-
10 flection, on listening, finally on opening up. For her, there was no problem.
11 (Simon, 25 years old, student)

12 Fathers are not absent, but they seem to have had little influence over their
13 sons' career choices. They are particularly attentive to the fact that their son's
14 chosen profession permits a rapid, guaranteed integration into the work force.
15 As such, the position of male midwives implies an "open socialization" (Char-
16 rier, 2009) in that they achieve equilibrium between masculine and feminine
17 values (Le Feuvre, 2007). This masculine socialization is not a product of de-
18 valuing women and stresses positive representations of women. This is ob-
19 served in their ability to highlight an interest for the mystery and/or magic of
20 delivery and birth. For example, Fabrice respects the "magic of birth" that he
21 experiences in his work, the fact that he "sees the reaction of the parents," and
22 that he "is present at a special moment in the life of a family, the moment when
23 a family becomes a family. At that moment something extraordinary happens,
24 and I think it's wonderful" (Fabrice, 35, hospital midwife).

25 These men have often been distanced from what is called hegemonic mas-
26 culinity (Connell, 2000). They more closely identify with "soft masculinity" as
27 previously described in work by Castellain-Meunier (2005), Welzer-Lang
(2004), Holyoake (2002), and Galbraith (1992).

28 Meanwhile, the students who entered the profession via the PCEM1 and
29 therefore have a general knowledge of medicine, demonstrate other forms of
30 awareness. Many confirm their separation with their "medical vocation," be-
31 cause what they experienced in school did not meet their expectations. Many
32 are critical of medical practices that distinguish between the "care" and "cure"
33 provided to patients. However, this does not mean there is a reverse gender-
34 socialization (Mennesson, 2004) in the sense that they also show allegiance to
35 male socialization, especially through participation in sports activities despite
36 the demands of their studies. At this point they show similar comportment as
37 the male nurses interviewed by Loughrey (2007). Facing challenges to their
38 masculine identity, the reaction of these men seems to include maintaining cer-
39 tain signs that are traditionally masculine. For example, William and Philip
40 have long practiced boxing and rugby, while Nicolas is a distinguished alpine
41 skier, and Louis still regularly plays football with his friends. These elements
42 of physicality and masculine sociability are known to be critical elements in
43 the construction of masculine identities (Davisse & Louveau, 1998).

44 Similarly, the careers and professions they imagined when they were young
are often categorized as "masculine" careers. For example, Christopher wanted
to be a helicopter pilot:

01
02 It was my childhood dream. And in reality, I failed my high school
03 diploma. I wasn't expecting to fail. I tried to pass the pilot exam, since in
04 France, if you want to become a helicopter pilot, you have to be rich or go
05 to the United States for training, or you have to join the army. Once you're
06 in the army, you have to serve for ten years. (Christopher, 37, private prac-
07 tice midwife)

08 Midwives—students and professionals—emphasize that they have made the
09 right decision and even renounce their original aspirations, especially if they
10 were related to the medical field.

11 *Search for Autonomy*

13 While male midwives might undergo a unique form of gender socialization
14 relative to the evolution of the social construction of the male gender, do they
15 perform differently once established in their profession? This question led us
16 to search for the distinguishing characteristic in the professional integration of
17 male midwives in the professional world: autonomy.

18
19 *Types of Activity*

20 The first hypothesis we developed was based on the idea of the formation of
21 a specific segment of the professional population that differentiate itself by the
22 way midwives carry out their responsibilities and where they work. As far as
23 the types of activity carried out by male midwives is concerned, if we perceive
24 any gender distinctions, they are marginal (Table 3). Men do not stand out sig-
25 nificantly from women, based on their type of practice. Though they were pres-
26 ent in hospitals more often in 2002, this difference was negligible five years
27 later. The same is true for private clinics, where the presence of both men and
28 women decreases.

29 Private practice work is becoming more equally dispersed between male and
30 female practitioners. Globally, about 15% of the midwife population in works
31 private practice. The distinctions between men and women are more notice-
32 able in marginal practices, such as PMI, and the "other" category (primarily
33 including instructors). The tendency to accept temporary work is still coded
34 as masculine, but this is easily understood when one considers the low average
35 age of the population. Temporary work is considered to be a way to enter into
36 a stable professional practice.

36 We cannot confirm that men are more likely to invest themselves primarily in
37 a professional sector. The way they are spread out across many different types
38 of activity is very similar to the situation of female midwives. Therefore, we
39 were not able to show masculinization taking place in terms of professional
40 choices.

41 *Avoidance of Clinical Work, Autonomy Assurance*

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43 At this point, it is necessary to enter into a qualitative interrogation concern-
44 ing the motivations and the idea that these men have regarding their profes-

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Table 3
Types of Midwife Activity (2002 and 2007)

Sector of Activity	2002				2007					
	men	women	men & women	% men	% women	men	women	men & women	% men	% women
	Public Hospitals	82	8,575	8,657	59.9	55.2	116	9,876	9,992	58.0
Private Clinics (attached to the public hospital service)	3	632	635	2.2	4.1	7	753	760	3.5	4.4
Private Clinics	26	3,027	3,053	19.0	19.5	34	2845	2,879	17.0	16.5
Individual Private Practices	13	1,741	1,754	9.5	11.2	19	1948	1,967	9.5	11.3
Private Group Practices	7	519	526	5.1	3.3	10	658	668	5.0	3.8
Temporary Agency Employed	—	—	—	—	—	7	149	156	3.5	0.9
Maternal and Infant Protection, Family Planning	1	330	331	0.7	2.1	3	389	392	1.5	2.3
Regional, County or Local Civil Servants	0	254	254	0.0	1.6	2	311	313	1.0	1.8
Others	5	469	474	3.6	3.0	2	354	356	1.0	2.0
Total	137	15,547	15,684	100.0	100.0	200	17,283	15,684	100.0	100.0

Source: DREES

01
02 sional practice. While conducting our interviews, we noticed how the mid-
03 wives described their experiences with private clinics. While some had per-
04 sonal experience, having practiced or currently practicing in private clinics,
05 there was a generally negative perception of this kind of work. It was portrayed
06 as restrictive or as a default choice—and as something to be avoided by any
07 means possible. They often work in fixed-term contracts, as replacements, or on
08 a temporary basis. The idea of a work mandate for male midwives is based on
09 these observations. This mandate underscores the idea of remaining au-
10 tonomous, which is a desire among male midwives.

10 Autonomy in the workplace is often highly valued among men (Collins &
11 Hearn, 1996). With regard to professional expectations, autonomy clearly sep-
12 arates men and women. Lyndsay (2007) suggests that male dominance in U.S.
13 anesthesiology can be explained because of being able to work autonomously.
14 According to Snyder and Green (2008) men may enter into specialized profes-
15 sions traditionally considered to be feminine because they often find ways to
16 make the work “less feminine” by insisting on the maintenance of certain lev-
17 els of autonomy. This would explain the reluctance of male midwives to work
18 in clinics, since they consider such a setting compromising their autonomy.

19 In any event, after graduation, it's most important to start working, to start
20 delivering babies. Of course, you want to be able to independently man-
21 age your own work. In a clinic it's hard to do that because you are always
22 being managed by the doctors, who tell you what to do. (André, 32, hos-
23 pital midwife)

24
25 Above all, men consider themselves to be professionals demanding auton-
26 omy. While for male midwives this independence is of capital importance, it is
27 less pressing for female midwives. Women are less likely to list autonomy
28 among the traits that they look for in their profession. In the study from 2009-
29 2010, we asked the participants about their current expectations: work auton-
30 omy was chosen by only 18.9% of women.

31 In analyzing the interviews, we observed three trends in how male midwives
32 exercise autonomy. First, the desire for autonomy can be linked to the desire to
33 have a private practice. Working with a private status allows for much more au-
34 tonomy. Therefore, it is unsurprising that there is a link between wanting to
35 work private practice and the theme of autonomy:

36 P.C.: What attracted you to private practice?

37 S.: Autonomy, I think. Autonomy.... There's no hierarchy, you can really
38 work in a way that is good for you. You can accompany couples as you see
39 fit. I say that because in obstetrics there are lots of different approaches ...
40 and why private practice? [*Thinks*] Yes, I think it's the desire to work as
41 you like. (Sébastien, 30, private practice midwife)

42 The independence sought after by these men can also be explained by the
43 particular nature of their relationships with obstetricians which often includes
44 conflict.

01
02 It's true that on occasion I fight to get our point of view heard. When I did-
03 n't agree with something—just last night there was only one thing to do....
04 He [the obstetrician] had made a decision ... but even so, I told him, and
05 I'll repeat it if necessary, that I didn't agree. In fact, it is the doctor and the
06 person in charge who have the last word, but that doesn't stop me from
07 telling him. (Fabrice, 36, hospital midwife)

08 This example shows to what extent men feel the need to insist on their au-
09 tonomy, at the risk of disrupting professional hierarchies. In contrast, as seen
10 in the 2009-2010 study, most female midwives (61.6%) describe themselves as
11 being in a cooperative relationship with the obstetricians and gynecologists
12 and therefore do not share Fabrice's feelings. Only 29% of females saw their
13 working relationship as one in which they could contribute to the decision-
14 making.

15 Secondly, men's desire for autonomy is reflected in representations and
16 working conditions of the midwife profession. Men either emphasize the fact
17 that they work independently or complain that they do not have enough in-
18 dependence at work.

19 I consider myself to be totally independent at X, despite the fact that it is
20 a big center. What I mean to say is that we have a fair amount of freedom.
21 As long I have don't have any problems, my patients are doing well, and
22 my children are doing well, I think that my boss, or at least the head of the
23 department, will leave me alone to work as I like. (Fabien, 35, hospital mid-
24 wife)

25
26 Thirdly, although male midwives' opinions are divided on this topic, there is
27 one common critique of the way that natal care is organized and managed in
28 France. Men are uniquely placed to respond to this question. Not only do they
29 have to evaluate their personal work, but also are they responsible for evalu-
30 ating the general efficiency of the system. This task provides a further canvas
31 for the valuation of independence, largely as positive:

32 We're going in the right direction. [...] Apparently the Minister is in agree-
33 ment with the proposals. I don't know how that will change the reality of
34 the situation. In any event, it's a movement towards more autonomy for
35 midwives, as well as an indication that public services have understood
36 that they have an important role in public health, including prenatal
37 health. They want to be able to rely on midwives. (Christopher, 37, private
38 practice midwife)

39 There is a clear motivation to guarantee autonomy and even independence
40 among male midwives. The expectation of autonomy is not solely based on a
41 demand for masculinity or even on the idea of guaranteeing masculinity, but
42 on a global view of the profession. This attitude has been observed in other
43 professional situations where men are in the minority, giving it the appearance
44 of a typically male trait.

01
02 *Overcoming a "Predisposition" for Empathy*

03 Although men may be able to cultivate "masculinity" at the site of their as-
 04 serted independence, when it comes to the question of empathy, the question
 05 is more delicate. Empathy is at the heart of the profession and is one of the jus-
 06 tifications for the significant female presence among midwives. Empathy is the
 07 capacity to build a relationship based on the (possibility of a) shared experience
 08 of delivery, something that allows female midwives to have a special relation-
 09 ship with their patients.¹² Of course, men cannot lay claim to the experience of
 10 giving birth, qualifying claims to empathy. However, this is only a partial def-
 11 inition. There are two ways to evaluate empathy in the light of *care* (Paperman
 12 & Laugier, 2005; Tronto, 1993). The first way is to consider it as a predisposi-
 13 tion. The second is to see it as a combination of practices. Taken in the former
 14 sense, empathy cannot be masculine. Professional discussions, such as within
 15 the Order of Midwives, have tended to privilege this view, matching that of
 16 female midwives who resent male presence, basing their argument on the in-
 17 ability of men to establish a sociable, caring relationship with a pregnant
 18 woman or a woman in labor (Jacques, 2007, p. 83). Yet in our 2009-2010 study,
 19 82% of midwives considered that men had a legitimate place in the field. Al-
 20 though 43.6% of female midwives think that their male counterparts have a
 21 specific challenge in their relationship with patients, almost as many (42.3%)
 22 find that male and female midwives have the same degree of professional chal-
 23 lenges.

23 Negotiating the empathy question, male midwives claim that empathy is,
 24 above all, based on social and professional practices. In the data collected in
 25 our study, we noted three primary means of conceiving empathy in this man-
 26 ner, respectively stripping empathy from its qualification as "gendered capac-
 27 ity" (Schweyer, 1996). Some male midwives minimize empathy's pertinence
 28 by calling into question its psychological dimension—the idea that one can
 29 share the mental state of the patient. Some men are explicit on this point, giv-
 30 ing credence to the idea of empathy but not the notion of being able to ex-
 31 change or share the mental state of another. As Guillaume explains regarding
 32 pain experienced during labor, listening to women in labor without judging
 33 the subjective experience of pain is how one shows empathy, since judgment
 34 is possible if empathy is seen as a gender-based character trait:

34 The fact that I am a man in this profession means that I cannot—even sub-
 35 consciously—permit myself to say: "she's exaggerating. It doesn't hurt
 36 that much," since I can't and never will be able to share this experience.
 37 However, based on what she tells me and what she shows me pushes me
 38 to ask: "Does it really hurt? Does it hurt just a little? Where? Do you want
 39 to change position?" and so on.... I have to believe it, always. Which, in my
 40 opinion, allows me to really accompany her through the process. That is,
 41

42 ¹² This definition is more limited than that proposed by Berthoz and Jorland, which
 43 gives priority to a cognitive and relative outlook "the psychological capacity to put one-
 44 self in the place of another" (2004, p. 19).

01
02 I do not allow myself to think for the patient. (Guillaume, 44, private prac-
03 tice midwife)

04 Others engage with the empathy question by conforming to the classic model
05 of the professional, therapeutic, medical relationship (Freidson, 1984). In this
06 model, empathy comes from professional technique. It is not a question of two
07 members of opposite genders that enter into a relationship, but a woman who
08 expects a professional service. A male midwife can therefore see himself as
09 asexual in his professional relationship:

10
11 It's funny, because I don't think that my patients see me as a man. That's
12 what I aim for. I think they see me as a professional: I am a man or a
13 woman. (Francois, 33, hospital midwife)

14 Francois here puts his gendered role on hold. This is how an empathetic pre-
15 disposition based on gender is hedged. Seeing oneself as a professional does
16 not prevent the development of an empathetic relationship.

17 A third solution underlines the continuing transformation of strangeness in
18 being a man in this profession. One is obligated to define the rules of working
19 relationships. Male midwives address the fact that they must establish a con-
20 tract with the patient. They benefit from increased confidence, as well as from
21 a positive affirmation of their professional activity.

22
23 Most of the time, it is good that I am a male midwife, as far as my work re-
24 lationships are concerned. In fact, that forced me to introduce myself and
25 define a contract. "Hello, I'm a midwife, I am here for that reason." So we
26 establish a contract each time, and that helps enormously with the rela-
27 tionship. When you are a female midwife, based on what I've observed,
28 this contract is understood and there is no need to introduce oneself. I
29 don't agree with that [this way of doing]. Because they don't need a con-
30 tract: the contract is implicit. In my case, I have to define the contract every
31 time: my mission, why I'm there, how I can help [women] with my serv-
32 ices. (Christophe, 38, private practice midwife)

33 This male midwife is an example of trying to render explicit something that
34 is typically implicit. Rather than acting like empathy is a gender-related pre-
35 disposition, he makes a stand for active empathy. Men feel they must render
36 explicit, to the point of self-justification, their presence in the profession by mo-
37 bilizing their empathetic capacity. This explains their insistence on introducing
38 themselves and their mission, which is a way of distinguishing themselves
39 from their female counterparts. Some male midwives think that women do not
40 always find this step necessary, while men must always construct this relation:

41 P.C.: Do you do anything in particular to establish a relationship with your
42 patient?

43 S.F.: Well, I start off by introducing myself. That breaks the ice, I suppose,
44 the fact that you say, "Ok, I'm the midwife." I give my first name. This

01 brings us a little step closer. It creates a little link. (Frédéric, 32, hospital
02 midwife)
03

04 DISCUSSION AND CONCLUSIONS: A RESPECTFUL MASCULINIZATION
05

06 Looking at the ways in which male midwives integrate into the profession, we
07 observe little desire to be seen as different from the female counterparts; nor
08 does there appear to be a sentiment of being downgraded. None of these men
09 regrets his professional trajectory.¹³ Of course one must bear in mind that mid-
10 wives enjoy a positive public image, even if some consider that their profession
11 is undervalued, especially in comparison with other medical professions (ob-
12 stetrics, anesthesiology). The job market is growing and there is a low rate of
13 unemployment. This profession is not among the classically undervalued areas
14 of female work; to the contrary, it is generally considered a prestigious field.
15 Therefore we cannot interpret male presence and masculinization of the field
16 responsible for a status change. It is also difficult to affirm that male midwives
17 are using the “glass elevator” strategy (Williams, 1992).

18 These men negotiate masculine status through their expressed desire to work
19 autonomously. They also have profiles classifying them as men that have de-
20 veloped “soft” or modern masculinities. Moreover, they manage to get around
21 the idea that empathy is a sex-based predisposition by showing that it can also
22 be a parameter of social and professional practice. These factors taken together
23 demonstrate how men have entered, and can remain, part of midwifery.

24 Male presence does not mean that there is a segmentation of the midwife
25 population (Bucher & Strauss, 1992). At this point in the analysis, new ways of
26 interpretation will need to be presented. The “respectful revolution” concept,
27 developed by C. Marry (2004), is a prime example of a new mode of interpre-
28 tation. As is the case for women engineers, we support the idea that French
29 male midwives integrate into this professional sphere without denying any of
30 their masculine qualities and by contributing to the gradual growth of profes-
31 sionalism of the field. Masculinization can be qualified as “respectful” where
32 not changing the professional practice is already in place. Empathy is neither
33 renounced nor devalued by men, it becomes redefined from gender-related
34 tendency to a collection of correct practices and professional behaviors. In a
35 similar vein, the masculinity expressed by these men reflects neither a hierar-
36 chical ordering of genders, nor an aim to dominate the professional field.¹⁴ This
37 “respectful” dynamic stands out from the majority of studies of masculiniza-
38 tion, generally considered synonymous with *invasion*, or in its less extreme
39 readings, *transformation* of professional practices.

38
39 ¹³ We interviewed two male midwives who no longer practice. One has become a
40 salesperson for obstetrics products, and the other is now teaching biology at a univer-
41 sity. Both explained that they are very attached to their past professions and that they
42 feel that even in their new jobs, they are still part of the former.

43 ¹⁴ Most male midwives interviewed did not necessarily wish to see the number of men
44 in the field increase. This is an indication that they are not in a dynamic hegemonic sit-
uation.

01 This explains itself if we take into consideration the socio-professional con-
 02 text. The increase in women engineers is understandable when referring to
 03 girls' higher academic success rate as compared to boys,' consistent over sev-
 04 eral decades in France (Marry, 2004). Comparably, presence of male midwives
 05 has become possible because midwifery has undergone radical changes for the
 06 past twenty years. There has been a movement towards professionalism, which
 07 is illustrated by the desire for independence in respect to other pre- and post-
 08 natal professions, a growing demand for knowledge, an increase in the length
 09 of training, and an increase in work responsibilities. Midwifery is developing,
 10 offers a myriad of occupational possibilities for independence and autonomy,
 11 all of which factors that attract current and future midwifery students. We can-
 12 not understand the presence and especially the retention of men (indeed: evi-
 13 dent masculinization) unless these are related to a profound evolution in the
 14 professional milieu.

15 Given men's only recent entry to the field and their present numbers, this re-
 16 mains, we have argued, a "respectful masculinization." Midwives in France
 17 hardly work to establish professional hierarchy, whether objectively or sym-
 18 bolically speaking. There is little evidence of distinction or segmentation, and
 19 therefore less opportunity for men to take dominant positions. A different hi-
 20 erarchical structure would probably not have led to this "respectful masculin-
 21 ization."

22 The present study nevertheless demonstrates that research on the presence of
 23 men in careers not traditionally viewed as masculine has a tendency to ignore
 24 seemingly vital parameters. These include practice conditions, hierarchical seg-
 25 mentation, and level of qualification. Reckoning with these parameters per-
 26 mits comparative studies of masculinization, for example juxtaposing the case
 27 of male midwives with that of male housekeepers (Bagihole & Cross, 2000). It
 28 would be pertinent, moreover, for research on masculinity and masculiniza-
 29 tion to deconstruct the category "non-traditional" occupations or professions,
 30 which will often encompass very diverse realities.

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