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The doctor–nurse relationship: how easy is it to be a female doctor co-operating with a female nurse?

Elisabeth Gjerberg^{a,*}, Lise Kjølørød^b

^a *Work Research Institute, Box 8171 Dep, Stensberggt 29, N-0034 Oslo, Norway*

^b *Department of Sociology, University of Oslo, Box 1096, Blindern, N-0317 Oslo, Norway*

Abstract

The doctor–nurse relationship has traditionally been a man–woman relationship. However, in recent years, the number of women studying medicine has increased in all West-European countries, and in 1997, 29% of active Norwegian doctors were women. The doctor–nurse relationship has often been described as a dominant–subservient relationship with a clear understanding that the doctor is a man and the nurse is a woman. This article examines what happens to the doctor–nurse relationship when both are women: how do female doctors experience their relationship to female nurses? It is based on two sets of data, qualitative interviews with 15 doctors and a nationwide survey of 3589 doctors. The results show that in the experience of many doctors, male and female, the doctor–nurse relationship is influenced by the doctor's gender. Female doctors often find that they are met with less respect and confidence and are given less help than their male colleagues. The doctors' own interpretation of this is partly that the nurses' wish to reduce status differences between the two groups affects female doctors more than male, and partly that there is an "erotic game" taking place between male doctors and female nurses. In order to tackle the experience of differential treatment, the strategies chosen by female doctors include doing as much as possible themselves and making friends with the nurses. The results are considered in light of structural changes both in society at large and within the health services, with emphasis on the recent convergence of status between the two occupational groups. © 2000 Elsevier Science Ltd. All rights reserved.

Keywords: Doctor–nurse relationship; Gender differences; Female physicians

Introduction

One of the most striking differences between doctors and nurses has been that of gender. Over generations and until the middle of the 1970s, the medical profession has been predominantly male-dominated, while nursing has been regarded as one of the most archetypal female occupations. Hence, the doctor–nurse relationship has mainly been one of male versus female. While the medical profession is still male-dominated, there has been an increasing entry of women into medicine in

Norway, as in other Western countries. In 1997, 29% of active Norwegian physicians were female (Norwegian Medical Association, 1997).¹ Male entry into nursing, on the other hand, has been considerably less significant. Nursing has always been and continues to be a predominantly female occupation. In Norway only 8% of all nurses are male.²

There is a vast amount of literature addressing the doctor–nurse relationship; much of which is anecdotal

*Corresponding author. Tel.: +47-22-46-16-70; fax: +47-22-56-89-18.

E-mail addresses: gjel@afi-wri.no (E. Gjerberg), lise.kjolsrod@sosiologi.uio.no (L. Kjølørød).

¹The proportion of female physicians in the other Nordic countries vary: in Finland 47% of the physicians are women, in Sweden 37%, in Denmark 33%, in Iceland 18%, and in Great Britain 32% (Norwegian Medical Association, 1997).

²The Norwegian Board of Health 1997 — personal communication.

(Sweet & Norman, 1995). Studies on the doctor–nurse relationship have employed a variety of research methods, particularly interviews and observations (Hughes, 1988; Porter, 1991, 1992; McMahan, Hoffman, & McGee, 1994; Sweet & Norman, 1995; Svensson, 1996). The doctor–nurse relationship has been characterised as a dominant–subservient relation with a man–woman constellation, and gender has been found to be of considerable importance when explaining the position of nurses (Gamarnikow, 1978; Carpenter, 1993). Some authors have discussed the relationship between doctors and nurses when both are males (Savage, 1987; Porter, 1992; Mackey, 1993; Sweet & Norman, 1995), but few have addressed the relation between members of the two occupations when both are females (Porter, 1992; Mackey, 1993). How easy is it to be a female doctor co-operating with a female nurse? The purpose of this article is to illuminate how female doctors experience their relationship to female nurses: how do doctors interpret issues of gender in this relationship and does gender affect power relations between the two categories?

The first part of the article briefly describes the traditional doctor–nurse relationship with reference to the historical development of nursing and recent work on profession and gender. The second part presents a theoretical framework for analysing the doctor–nurse relationship of today. After describing the methods, we will present doctors' opinions of how female nurses interact with male versus female doctors, the doctors' own interpretations of this, and the strategies some female doctors make use of in their relationship with nurses. The last part of the article suggests an interpretation of the results.

The traditional doctor–nurse relationship: a historical background

The doctor–nurse relationship has been characterised as essentially patriarchal (Dingwall & McIntosh, 1978) and as a dominant–subservient relationship (Gamarnikow, 1978; Carter, 1994). It has been argued that it is impossible to obtain an understanding of the doctor–nurse relationship without an awareness of relationships between men and women in society through time (Carpenter, 1993; Sweet & Norman, 1995). The sexual division of labour within medicine has been seen as a logical extension of the male–female role–relations in society at large, where women have been expected to possess expressive, emotional, and caring qualities. In the first of the three developmental stages of British nursing, the Nightingale era, the goal was to transform the nurses according to the ideal of the Victorian “good woman” (Carpenter, 1993). Good nursing care was equated with caring for the patient and efficient

fulfilment of the doctors' orders. Gender definitions were thus fundamental to the definition of what constituted a “good nurse”, even though they did not completely define its limits. It was still seen as necessary to add certain nursing skills through training (Carpenter, 1993). Also Gamarnikow (1978) equated the 19th century's doctor–nurse–patient relationship with a husband–wife–child relationship within the Victorian patriarchal family. Dingwall and McIntosh (1978) argued that the shadow of these old relations between doctors and nurses still remains in the 20th century.³ The idea that nurses were unproblematically subservient to doctors seems to have been widespread until Stein's article (1967) on “the doctor–nurse game”, a game that enabled the nurse to inform and advise the doctor without challenging the doctor's position:

The cardinal rule of the game is that open disagreement between the players must be avoided at all costs. Thus, the nurse can communicate her recommendations without appearing to be making a recommendation statement. The physician, in requesting a recommendation from a nurse, must do so without appearing to be asking for it (Stein, 1967, p. 699)

The idea of covert decision-making gained widespread acceptance, and is quoted in numerous works. However, the empirical evidence of this combination of influence and subservient position of nurses has been challenged in recent years. Hughes (1988) shows in his study that the doctor–nurse relationship appears in many variations, dependent on different contextual features. Keddy, Gillis, Jacobs, Burton, and Rogers (1986) argue that although doctors previously possessed a remarkable degree of power over nurses, this is no longer so. Stein, Watts, and Howell (1990) revisited the doctor–nurse game to evaluate changes in the doctor–nurse relationship, and concluded that major changes have taken place over the past two decades: the nurses have unilaterally decided to stop playing the game and have instead consciously and actively attempted to change nursing and its relationship to other health care professionals. Later studies of the doctor–nurse relationship in Irish and British hospitals confirm that changes have taken place: Nurses now influence decision-making more openly (Porter, 1991; MacKey, 1993). Drawing on data from interviews with nurses from five Swedish hospitals; Svensson (1996) claims that the doctor–nurse

³This assertion is illustrated in a study of medical students in USA, showing that a vast majority of third and fourth year students seemed to assume that, in practice, nursing was essentially a lower level of the practice of medicine, dependent on the physicians' instigation and supervision, rather than a separate role (Webster, 1985).

relationship has changed dramatically, and that the traditional model of understanding the relationship as a doctor–nurse game is inappropriate. He argues that a more suitable theoretical framework is to understand contemporary doctor–nurse relations in a negotiated order perspective (Strauss, 1979);⁴ stressing that negotiations between actors take place in all areas in a ward. Positions in the organisation, rule systems, regulations, laws, and other instructions explain only part of the social interactions in the ward. He claims that key changes in the health care context, such as increased prevalence of patients with chronic illness and organisational reforms with new areas for co-operation and more face to face interactions with doctors, have affected the conditions for negotiations between doctors and nurses, providing the nurses with more “negotiation space”.

Although the centrality of the relation between gender and interoccupational relationship of dominance and subordination in the doctor–nurse relationship is suggested by some authors (Gamarnikow, 1978; Carter, 1994; Sweet & Norman, 1995), the mainstream sociology of profession has until recently, with few exceptions (Crompton, 1987; Witz, 1992; Riska & Weagar, 1993; Davies, 1996), paid little attention to the gendered politics of occupational closure. Reworking theoretical perspectives on profession and professionalisation developed without reference to gender (i.e. Freidson, 1977), both Crompton (1987) and Witz (1992) argue that professional projects are not only projects of occupational closure, but that closure strategies are gendered. Closure strategies do not only aim to control the supply of entrants to an occupation, but also involve tactics of domination vis-à-vis related occupational groups. There is a difference between strategies of exclusion which aim for intra-occupational control and demarcationary strategies which are mechanisms of inter-occupation control. Strategies of boundary demarcation are of special interest to the medical division of labour, in this context to the doctor–nurse relationship. Any demarcation is facilitated by access to power, and Witz (1992, pp. 47–48) argues that the men to women ratio in occupational groups engaged in inter-occupational, demarcationary struggles, is an important factor in explaining both form and outcome of such struggles, in terms of regulating the work of other occupations. Occupational groups, who are subject to closure strategies, may contest these in different ways. Applied to the doctor–nurse relationship, nurses may respond to the doctors’ demarcation practices by “dual closure

strategies”. Such strategies involve a two-way exercise of power, both in an upward direction in claims for changes in the doctors’ regulations of their work, and in a downward direction seeking to consolidate their own position, for example in their relations to auxiliary nurses.

Davies (1996) suggests, however, that the central issue to understand today is not so much the exclusion of women, but their inclusion in support-roles. In emphasising the centrality of autonomy to the cultural concepts of both profession and masculinity, she argues that the image of the autonomous professional is enhanced by the additional work of others. “The notion of what it is to act and to be competent, derives from the masculinist vision that fails to recognise its partial and dependent character” (Davies, 1996, p. 671). Davies points out that the medical profession entails visions of the social organisation of work that valorise the masculine, repressing qualities usually regarded as feminine. Physicians’ autonomy often requires preparatory and servicing work which is carried out by nurses, consequently nursing has much in common with the support work of clerical or secretarial work in the bureaucracy, i.e. work mostly done by women and characterised as unacknowledged in this regard. Emphasising the strong link between gender, power and professional projects, both Witz (1992) and Davies thus (1996) present a theoretical framework to analyse how changes in the men to women ratio in occupational groups may affect the inter-occupational interactions between doctors and nurses.

Although until recently the doctor–nurse relationship has been analysed in terms of a division of labour according to gender, heavily influenced by sexual stereotypes, the position of nurses should also be understood in light of the fact that only doctors are responsible for decisions on diagnosis and treatment. This significantly affects negotiations and other relations between the two categories of personnel:

Doctors’ responsibility for defining people as patients and having legal responsibility for them continues to be an important issue influencing power relations between doctors and other health care professions, including nurses (Sweet & Norman, 1995, p. 169).

It is also a fact that the medical profession has exercised considerable control over teaching in the nursing profession (Freidson, 1970; Hughes, 1988; Martinsen, 1989). The Norwegian medical profession has participated actively in shaping nursing education through their teaching positions and text books (Haugen, 1984; Martinsen, 1989). Until recently, nurses have been trained in nursing schools, which have usually been linked to hospitals. Although there has been a move into the realm of higher education in the last

⁴ According to Strauss (1979) all social orders are negotiated orders, stressing that negotiation at the microsocial level is very important in understanding social organisations. Negotiations occur especially when there is uncertainty about rules and policy.

decade, most schools of nursing are still hospital based. Beyond this, medicine and nursing have different educational requirements. Medical education is a 6-year university-based academic training course, emphasising theoretical and scientific components of medical knowledge, and involves commitment to continuing education. Nursing training is usually 3 years of school-based, theoretical education combined with practical training.⁵

To summarise, the literature has described the doctor–nurse relationship as dominant–subservient, mostly in terms of the division of labour according to gender, but also influenced by the fact that doctors have both a monopoly over diagnosis and treatment and an influence on the knowledge available to the nursing profession. Later studies have demonstrated ongoing changes in the doctor–nurse relationship, mainly explained by structural changes in the health care context and organisational reforms. However, surprisingly little attention has been paid to the effect of the increase in the number of female physicians. If the esteem and relative power of doctors in relation to nurses is greatly influenced by the doctors' gender, one would expect that doctor–nurse interaction would change when the doctor is a woman.

“Femininity” as a “new” trait in the medical profession

In one of his classical articles on the sociology of work, Everett C. Hughes argues that there tends to grow up about a status,⁶ in addition to its specifically determining traits, a complex of auxiliary characteristics which come to be expected of its incumbents:

If one take a series of characteristics, other than medical skill and licence to practice it, which individuals in our society may have, and then thinks of physicians possessing them in various combina-

tions, it becomes apparent that some of the combinations seem more natural and acceptable than others (Hughes, 1945, p. 354).

Gender is one such characteristic. Hughes claimed that expected combinations of characteristics are deeply embodied in different stereotypes of language, conversation, pictures, etc., but also in attitudes and expected behaviour. Entry of new categories into established positions creates a status contradiction, and may also produce a status dilemma for the persons involved. In other words, the expectations people carry in their minds concerning the auxiliary traits associated with a position will be disturbed. Although a century has passed since women were first permitted to study medicine in Norway, medicine is still a predominantly male dominated profession, and medical authority may still be equated with male authority. For a long time, physicians have been coded as males in the minds of nurses as well as in the minds of patients. When a group advances to new positions, as the increase of women in medicine, stereotypes do not fade away automatically. Thus, a male physician may still appear more “normal” and acceptable than a female physician to most people, including other health care personnel. The counter-argument to this perspective is that new groups of nurses enter the arena. These nurses have no experience of a “different world”, i.e. that doctors were almost always men. But changes have occurred quickly. When today's nursing leaders started their career, things were different. The doctor–nurse relationship was predominantly one of male versus female, and the nurses were socialised into a different relationship. Today however, young nurses enter a world of both female and male physicians, and this will probably lead to some changes, especially if the young nurses disengage themselves from the attitude of their seniors.

Characteristics that have been more or less stereotyped as manly, such as decisiveness, competitiveness, and action orientation, have also been considered important in doctors. Bluntly put, those who co-operate with a female physician may experience a dilemma of having to choose between treating her primarily as “a member of the medical profession” or as “a woman”. When entering a male-dominated profession, the female physician herself must try to fulfil classical expectations both of “the doctor” and of “the woman”. But why is this status–incongruence important? Although most of the division of work between doctors and nurses is regulated, there are a lot of tasks and zones which are not. There are numerous situations where interaction has to be played “by the ear”.

There is a large grey area in which it is unclear as to who does what and how much. In this area the

⁵During the last decades, nursing has got increased autonomy and influence within their own professional subjects. They have expanded their field of responsibility (Martinsen, 1989) and they exercise considerable control over the educational base of knowledge, which is an international trend (Fagin, 1992). Younger nurses are socialised in their education to play a more independent professional role (Svensson, 1993) and in addition, nursing has been made significantly more “academic”. Developments such as university based nursing degrees represent a move away from the traditional practical educational tradition. It is probable that these developments are contributing to altering the power relations between doctors and nurses.

⁶Status — a defined social position for whose incumbents there are defined rights, limitations of rights and duties. Since statuses tend to form a hierarchy, the term has the additional meaning of rank (Hughes, 1945).

boundaries are constantly tested between the two parties (Svensson, 1996).

A lot of necessary work in this area does not require formal competence: cleaning up after a medical examination, fetching case records, getting some equipment required for an examination, etc. These are the kind of tasks that both doctors and nurses want to bring to a minimum. According to Witz (1992), to leave the supportive work to nurses might be a part of the physicians' demarcation strategies in the interoccupational relationship between doctors and nurses, and as such vital to confirm the physicians' autonomy. Autonomy and competence stand at the heart of professional work, linked to the cultural concept of masculinity (Davies, 1996). When the link between profession and gender is changed, this may possibly affect both the demarcation strategies and the interoccupational negotiations. That is, negotiations are always affected by the actors' relative status. Not only occupational position matters, the space for negotiating what is possible and legitimate may then be affected by the doctors' gender.

Material and methods

The empirical material consists of two sets of data, one derived from qualitative interviews with 15 physicians, the other from a nation-wide survey of 3589 randomly selected physicians in Norway.

The qualitative interviews took place over a period of three months during 1996. Fifteen physicians were interviewed, 4 men and 11 women of different ages, specialities, and positions. The same interview guide was used in all interviews. It was based on 15 open-ended questions, designed to find out which aspects were important in the choice of career.⁷ The interviews were arranged as dialogues, and were stopped after 15 interviews because many of the same concepts and attributes mentioned in the early interviews were repeated. The data obtained in these interviews were analysed by qualitative methods; themes and concepts were systematised. Important themes and issues that emerged are illustrated by quotations. Most emphasis is put on the statements by female physicians.

⁷Apart from describing their own careers, informants were invited to discuss gender differences in choice of speciality and whether particular circumstances influenced male and female doctors' choices. Aspects that were referred to included aspects of the study-situation, first choice of job, career visions, the organisation of work at different institutions, networks at place of work, whether there were aspects of the larger specialities and of hospital culture that fail to attract women, the combination of work and family life, partners' attitudes to career choice, and the relationship to nursing assistants.

The working conditions of Norwegian physicians were studied in a representative sample of 3589 physicians of whom 2629 responded (73.3%). The questionnaire sent to the physicians included questions about the doctor–nurse relationship.⁸ The study was part of The Survey of Norwegian Physicians' Health, Sickness, Working and Living Conditions, undertaken by the Norwegian Medical Association in 1993.⁹ The significance of cross-distribution was tested by chi-square tests. All statistical calculations, including the logistic regression analysis were carried out by SPSS, version 6.1.

The present article thus draws on two different sets of data, although the main presentation is based on the qualitative interviews. Interviews with doctors give us insight into their experiences and reflections on the doctor–nurse relationship, as well as providing us with detailed accounts of situations in their daily working life with nurses. Survey data will be used as a supplement when available and considered relevant to the subjects that emerged during the interviews. Unlike interviews, survey data provide information on how widespread specific experiences are among doctors, and on how often they occur in different groups of doctors.

Implications of changing gender relations — a surprisingly difficult relationship

How female physicians perceive their relationship with the nursing staff depends on the actual division of labour, on their earlier experiences with such relations, on which group they use as their reference group, and on their expectations of their professional role. In medical school, expectations and self-conception as doctors are built up. A doctor's role is expected to involve both obligations and rewards. Besides high status and salary, the reward system includes the authority to make medical decisions, including the authority to give orders to nurses, and to receive respect from the staff. If these expectations are not met, there may be a feeling of loss of status in one's own eyes, a threat to one's self-concept as a doctor. Given equal socialisation during their years of study, female physicians will primarily compare

⁸The actual questions were: "Do you get as much assistance from nurses as your colleagues of the opposite gender do?" "In your experience, do female doctors ask for assistance to a lesser extent than their male colleagues?" "In your experience, do nursing staff approach female doctors more often than male doctors with their personal problems?"

⁹Each doctor in the sample, which comprises more than 90% of the Norwegian physicians in Norway, received four questionnaires. The overall response rate was 72%. Details on selection, sample loss etc. are described elsewhere (Aasland & Falkum, 1994).

themselves with male colleagues of about the same age and position, i.e. their perception of their relationship to nurses, including assistance and support, is influenced by their experience of the relationship between female nurses and male colleagues. Female physicians have frequent contacts, not only with nursing staff, but also with male colleagues. These relationships differ: the relationship between colleagues is characterised by similarity in position, which probably means that, regardless of difference in sex, female physicians compare themselves with colleagues at the same level. The relationship to nurses is different: it is characterised by difference in position, but likeness in sex.

The fact that the doctor–nurse relationship for so long had been a male–female relationship, made us expect that the relationship between female doctors and female nurses would be different, but it came as a surprise to find how difficult female physicians found their relationship to female nurses. Of the 11 female physicians, nine described the relationship between female doctors and female nurses as clearly different from, and more difficult than, the relationship they felt existed between male doctors and female nurses. Some used other doctors' experiences to describe this subject rather than examples from their own lives. Also male doctors had experienced that female nurses acted in a different way in relation to female than to male colleagues.

The interviewees' description of the nurse–doctor relationship covered three main topics: (1) the extent of assistance in practical situations, (2) respect and confidence and (3) female doctors' experience of being "different".

The amount of assistance

Female physicians often feel they get less help and assistance than their male colleagues. Examples include when nurses are asked to fetch equipment, find case records, lay out papers to be signed, introduce new doctors to the ward, or provide some form of assistance:

When you are working in an outpatient clinic, who gets assistance from the nurse? First it's the male doctors, then the females. If a nurse is assisting me in sewing and a male colleague enters the room and asks for a case record, the nurse immediately drops what she is working with, and leaves the room to help him. I am left on my own" (Female physician, specialising in surgery, 40 years old.)

According to one of the younger female physicians, the experience of being subject to differential treatment start as a house officer:

It's not easy to make the nurses do what we want them to. When I was a house officer working with a

patient and asked the nurses to fetch the case record, to go and get the ECG, to order some blood gases, or something else, they answered: "You can fetch the case record yourself, the patient isn't that ill!" Of course I can fetch the case record myself. I can do everything, but that is not an adequate division of labour. It is a quite impossible conflict." (Female physician, 32 years old, researcher).

Almost all informants emphasised that female doctors received less help and assistance from nursing staff than their male colleagues. Most female informants mentioned this because they had experienced it themselves, others refer to episodes from female colleagues:

I do believe that the doctor–nurse relationship is influenced by the doctor's gender, but I perceive it a bit differently than some of my female colleagues. They find it hard that the nurses don't give them the same amount of assistance as they give their male colleagues. And, of course, they don't wipe my forehead as much as they wipe my male colleagues', but my experience is that it has been quite easy to cooperate with nurses. The fact that I have no need to push myself forward has resulted in a lot of positive feedback, i.e. they say that I'm an easy and straight person to co-operate with (Female anaesthesiologist, 45 years old.)

These kinds of episodes, describing female physicians' feelings of getting less assistance, were confirmed by the male doctors; two had observed such episodes themselves. None of the men denied that this was the case.

The effect of a doctor's gender on the amount of assistance she or he considers to have received from nurses is also confirmed in the nation-wide survey of Norwegian doctors.¹⁰ Although most doctors experienced they got the same amount of assistance as their colleagues of the opposite sex, about one third of the female doctors felt that they received less assistance than their male colleagues (see Table 1).

However, there was an age difference between the female physicians. As in the qualitative interviews, it was mainly the younger women who felt that they received less help: While 40% of the women under 35 years of age reported this, 29% of the women between 35 and 44 years of age, 17% of the women between 45 and 54 years of age, and only 9% of the women over 55 were of this opinion. This age difference between female physicians may be explained by the fact that older female physicians are often established in higher positions in the medical hierarchy. The status differences between

¹⁰The question was: "Do you get as much assistance from auxiliary staff as your colleagues of opposite sex do"?

them and female nurses are thus bigger than between young female doctors and nurses, which implies a higher probability of getting the assistance they ask for. But it can also be seen as an effect of the existence of more females among younger physicians, especially in lower positions. Differential treatment by gender will then be more obvious and less private.

The men's age had no significant effect, although younger male doctors were somewhat more likely to say that they received more assistance than their female colleagues. On a bivariate level, both position (outside hospital, senior consultant, consultant, registrar, and house officer) and speciality (non-specialist, GP, surgeon, internist, psychiatrist, and community medicine) had a significant correlation with the amount of assistance they reported on receiving from the nursing staff. In order to evaluate the relative predictive importance of sex, age, position, and speciality, logistic regression was carried out, with amount of reported episodes of assistance as the dependent variable (get less assistance than colleagues of the opposite sex = 1, get same or more assistance than colleagues of opposite

sex = 0), (see Table 2). Both sex and age had a significant effect on the doctors' experience of the amount of assistance received, while speciality and position had no effect. Controlled for age, speciality, and position, the odds that female physicians belong to the low amount of assistance group is 15.12 times that of male physicians belonging to this group. Thus, the data from the survey confirm the doctors' accounts in the interviews, i.e. female physicians' experience of getting less assistance than their male colleagues. However, in the multivariate analysis position had no significant effect, nor did it come out significant when we looked at female doctors in hospitals only. This deviates from what the qualitative data indicates: that female physicians working as consultants get the assistance they ask for by virtue of their position. The difference is probably due to the fact that age as well as position may explain why female physicians in higher positions did not experience the lack of deference which female physicians working as residents did. In the hospital hierarchy a higher position is very often synonymous with higher age.

Table 1

Do you get as much assistance from nurses as colleagues of the opposite gender do?

	Female physicians	Male physicians	Sum
Equal amount of help and assistance	67%	92%	84%
More help and assistance	3%	6%	5%
Less assistance	30%	2%	11%
Sum	100%	100%	100%
	<i>N</i> = 655	<i>N</i> = 1338	<i>N</i> = 1993

Table 2

Predictors of less amount of assistance than colleagues of opposite sex. Logistic regression. (*N* = 1982)

Variable	Category	<i>B</i>	Odds ratio	Wald	<i>p</i>
Sex	Men = 1				
	Women = 2	2.7158	15.116	171.6716	0.000
Age		-0.0395	0.9613	8.0888	0.0045
Specialty	Ref. group = not Specialist = 0			1.9510	n.s
	GP = 1				
	Lab = 2				
	Internal medicine = 3				
	Surgery = 4				
	Psychiatry = 5				
Position	Community medicine = 6				
	Ref. group = outside Hospital = 0			1.4874	Ns
	Chief consultant = 1				
	Consultant = 2				
	Resident = 3				
	Intern = 4				

Respect and confidence

In the qualitative interviews about two-thirds of the female doctors report having experienced that nurses treated female doctors with less respect than male doctors.. This is closely tied to female doctors' experience of receiving less help and assistance than their male colleagues did. Both younger and older female physicians described situations in which they had to fight to have their decisions respected by the nurses. Especially during the first period in a new job, they felt they had to work hard to be treated with the same respect as their male colleagues. Several claimed that their decisions were questioned by the nurses for a long period:

Especially when you have just started in a department, the nurses question what you are doing. They say: "Do you really mean that? - we don't trust your decisions." They wouldn't say that to a man. However, now I feel it's all right, but I worry about it when I get a new job. Then I have to adjust my profile to the nurses again. (Female physician, 33 years old, specialising in internal medicine.)

It's not only that I have to be as highly qualified as my male colleagues. I even have to be more qualified than them. All along I have to defend what I'm doing. Every day the nurses ask why I'm doing this or that. My male colleagues do not get such questions. An order is simply taken, although it can be quite wrong. (Female physician, specialising in surgery, 40 years old.)

It is not only in the most male dominated area of medicine that female physicians experience less respect and confidence from the nurses. Another female physician, working at a municipal health care centre, said:

The leader position has previously been occupied by male physicians. Especially in the beginning, I felt it was a challenge to the staff to relate to a female leader. Female leaders have to use more time to win authority and confidence, and it's more ambiguous and threatening to exercise one's authority if you are a woman. It's not accepted in the same way as it is with men (Female 45 years old, specialist in general practice and public medicine.)

Some of the male doctors had also experienced that female colleagues had problems in achieving respect:

I believe that female colleagues are more vulnerable in a hospital structure where leadership is a controversial issue. As long as the other professions

are dominated by women, especially the nurses, female colleagues have to work hard to maintain their leadership. They feel that just because they are female, they are not treated as seriously as their male colleagues (Male, 60 years old, specialist in psychiatry and general practice.)

These quotations leave no doubt about the strong feelings of differential treatment in practical situations. They illustrate a clear sensitivity to not being granted the expected respect and a consciousness of being less honoured than their male colleagues.

Female doctors' experience of being "different": where do they belong?

After six years of socialisation in medical school one would expect the occupational identity of the doctors to be clear.. However, about half the female informants "asked themselves where they belong", especially those who had been the only female physician in the ward. In describing problems with their social grouping at work, they recognised themselves as a sort of third category. "The others" consist on the one hand of the medical men, their male colleagues, and on the other hand of the women, the female nurses:

It is frustrating that I actually feel a stronger sense of belonging to nurses than to my own colleagues. I have sort of "floated" a little. I think that is difficult, because I want to belong more to the doctors. Now, it depends on whether or not there are more female colleagues. Being a single female doctor among anaesthesiologists and surgeons is not easy. (Female anaesthesiologist, 45 years of age.)

This female doctor has found a kind of belonging to the nurses' group, a social fellowship she enjoys. In daily work, she feels that she has an uncomplicated relationship with the nurses, but says she knows of such problems with other female colleagues. But not all female doctors manage to relate socially with nurses:

I feel excluded from the nurses' fellowship. You are not one of them, but nor are you one of your colleagues, because they are men. I think that this is difficult for female doctors. I think it's a problem (Female doctor, specialist in internal medicine, about 50 years of age.)

Female doctors may feel that they constitute a separate category. In some situations there is a feeling of "we" and "the others", and "the others" may comprise both male colleagues and nurses of both sexes. Female doctors are not necessarily a homogenous group with strong internal coherence. They are scattered in the

hospitals, often without a network of their own. Some feel that they have to work hard to find social ties to their colleagues. The doctor just quoted also said:

A network is lacking. Whatever you say, male doctors do have a network because they are men. At meetings and congresses they know each other and talk together in another way. And they can go out together for a night on the town in another way than they can with female colleagues. In the absence of a network, some of my female colleagues have talked about what we can do about it. How we can support each other.

Female physicians' feeling of being "different" illustrates that status incongruencies occur when categories of people advance to a new level of positions (Hughes, 1945), and involve not only those who deal with them, but also the individual concerned.

To sum up, with the exception of psychiatrists who seldom presented the doctor–nurse relationship as problematic, the physicians' descriptions illustrate that most female and male physicians experienced the doctors' gender as a trait that influenced the relationship between doctor and female nurse. According to my informants, this resulted in systematic differences in the nurses' attitudes and behaviour towards a female compared to those towards a male physician. The fact that psychiatrists seem to experience these problems to a lesser degree than their colleagues can probably be explained both by psychiatry being less hierarchical than other parts of the health care system and that people working here are very preoccupied with interpersonal relations. Apart from this, the proportion of female doctors in the psychiatric field has traditionally been much higher than in a lot of other specialities in Norway,¹¹ nurses thus have been more used to interacting with female doctors and their expectations are not "disturbed" in the same way as in general surgery and internal medicine.

How do doctors interpret issues of gender in the doctor–nurse relationship?

The difficulties female doctors experience in their relationship with nurses are partly tied to a feeling of lack of respect and of receiving less help with their work, and partly to a feeling that it is sometimes difficult to find one's place within the hierarchy of the health care system. But the informants do not only describe their own feelings about this. A majority also have a clear

idea of the reasons for such attitudes and behaviours. The doctors' interpretations have a number of similarities regardless of speciality or position. When describing their experiences, two types of interpretation are offered:

- (1) Deferential treatment is connected to status differences between the two groups; consequently, deference increases when the female doctor's status increases.
- (2) Differences in interaction are connected to "sexual games" between male doctors and female nurses.

Status differences

Most female physicians thought that their experience of discrimination was due to the traditional status conflict between nurses and doctors. By refusing to do things for the female doctors, either by neglecting orders or by telling them to do things themselves, the female doctors believe the nurses are trying to cut the doctor "down to size". Female doctors do not take this personally, but see it as a strategy directed at doctors in general. By choosing to strengthen their position vis-à-vis a female doctor, the nurses have a somewhat easier match because of similarities in sex. As a female doctor said:

... It's not that they don't have time to help you. They want to tell you that you can't come here and make yourself important. (Female doctor, 32 years old, researcher.)

The hierarchical system doesn't favour women. Female physicians do not have the authority to execute an order... Female doctors in surgical departments do not get the same service and attention as their male colleagues. When a female surgeon arrives at the department, the nurses blow their top off, i.e. they co-operate in a very aggressive way. (Female doctor specialist in gynaecology, 48 years of age.)

According to the female doctors, the nurses are trying to reduce the differences in status between doctors and nurses by making a point of their similarities to female doctors. At the same time, some doctors believe that the female doctors themselves have problems showing that they are leaders, and are unable to give clear orders and show firmness in attitude and behaviour.

Also male doctors were of the opinion that the difference in status between doctors and nurses contributed to deferential treatment by gender:

The nurses are a rival group, and there are a lot of conflicts between health professions, much of which

¹¹In 1996 the proportion of active female physicians in psychiatry was 33%, and in child psychiatry 60%, compared to 4% in general surgery and 11% in internal medicine.

are directed at the auxiliary nurses, but at the doctors too, not least the female doctors. Women doctors may be more jovial and more understanding about women's problems, but when it gets down to realities, there's a tough conflict between professions where they suffer the most. (Male surgeon, head of a department, 55 years old.)

In elaborating the "status explanation", female doctors emphasised that deference is dependent on the doctor's position in the medical hierarchy. The position as student, house officer, registrar, consultant, or head of department, regardless of gender, determines the amount of assistance one receives. Female consultants seldom experience that nurses express lack of trust and respect. Two of the older female doctors, both well-established as heads of department, had reflections on this subject:

...It's not like that any more, but when I was a younger doctor, the nurses assisted the doctors more than they do today. I experienced very strongly that, because I was a woman, nobody would bother to help. I had to find things myself, clean up, and do everything myself, while they helped my male colleagues. But this has gone now because attitudes have changed, so now they think that men can find things themselves as much as women can, I believe. I'm now in a position of authority, and the leader sees the department in another way than everyone else does. I get service and I expect to get it, and if I don't get it, then I demand it. (Female gynaecologist, 55 years old.)

She has experienced a change in the nurses' attitudes that she explains partly as a result of her position as head of the department. One of the younger women also commented that women in higher positions are unlikely to notice this lack of deference. This means that a higher position implies authority, which reduces the chances of the nurses trying to lessen the distances in status between the two professions.

While some female doctors believe that the position they hold affects the manner in which nurses treat them, other factors such as age and length of employment can modify this behaviour. Another expression of this is the view that younger doctors have to work hard to establish their positions vis-à-vis adult, experienced nurses. This was illustrated by a young doctor:

...In many cases the nurses have worked for 10–20 years and they're really good. They are very confident, and have a right to be. These women, who are 40 to 50 years old, with loads of experience, are supposed to take orders from younger women

who are insecure about what's the right thing to do. But the nurses have to take orders because the doctor is responsible, so if anything goes wrong then at least the doctor knows that it's up to her. These situations are very difficult. (Female doctor, 32 years old, researcher.)

"Sexual games"

The possible connection between the women physicians' experiences of being treated differently than male doctors and the "sexual games" that take place between doctors and nurses is mentioned almost only by female doctors. In a number of ways, the female doctors describe their belief that nurses find the doctor–nurse relationship more attractive if the doctor is a man. This relationship is apparently more attractive because of the potential of its having another dimension:

Male physicians get service by flirting and by being bossy. There is an erotic game going on. There are always a lot of expectations of the male newcomer. They are exposed to an enormous flirtation. As a group, the nurses are militant, but on the private level they're quite different. They have something going on with the doctors, not always something erotic or flirtatious, but something. The female physicians have in a way resigned. They are friends of the nurses. They are OK, but they have nothing to show for their trouble. (Female gynaecologist, 48 years old.)

It's quite obvious that female and male physicians have a different experience of "hospital culture". That the nurses are women and degrees of flirt take place between doctors and nurses. I'm not talking about sex or sexual harassment, but in the doctor–nurse interaction there is a male–female tension, which possibly makes the nurses find the relationships with male doctors more exciting. And the male doctors may feel the doctor–nurse interaction more comfortable than the female doctors do. (Female gynaecologist, 55 years old.)

But not only gynaecologists, with their special attention on sex-related issues, offer interpretations of this kind:

As females we are not attractive to men, possibly because a lot of men do not feel attraction to independent, strong women? As a joke, we use to say that male colleagues always find themselves a partner, nurses are swarming, but what do we have? ..I notice that most male physicians get different attention from nurses than female physicians do. We have an unmarried male doctor on the ward now,

and the nurses are very attentive to him. Of course, there is not the same tension when a female doctor enters the ward. (Female physician, 33 years old, specialising in internal medicine)

Here, the female doctors do not interpret the differences in attitudes and behaviour on the basis of gender in a wide sense, but their experiences of the doctor–nurse relationship are seen as being sex-related in a narrower sense. Attitudes and behaviour are influenced by a potential for male–female tension, making it more attractive for the nurses to give male doctors more assistance. Female doctors' comments on flirting suggest that sexualisation of the doctor–nurse relationship is regarded as improving working relations. While female doctors have explicit interpretations of this subject, male doctors only described sexual games indirectly. Elements of “flirt” in the doctor–nurse relationship were also identified by the majority of nurses and doctors in a study by Walby and Greenwell (1994).

Strategies in order to get assistance

Some female doctors described the strategies they use in order to receive the needed assistance from nurses. In part, this includes the establishment of friendship with the nurses, and in part this involves carrying out nursing tasks themselves. The following statement illustrates the former approach:

...I don't think men need to become friends with them, but I have to. I have to be nice and cheerful and make friends with them if it's going to work. It's not because they don't respect me, but... (Female, 32 years old, specialising in internal medicine.)

But this approach is not an easy one, and they point to the difficulties of being a friend on the one hand and being respected on the other. The strategy of becoming friends with the nurses is closely tied to the description of female doctors as a “third group” — slightly marginal from both male doctors and female nurses. Becoming friends can also be seen as a way of achieving a sense of belonging. Such strategies have been identified in American studies, showing that female doctors felt they actively had to court the staff in order to get the assistance that they provide as a matter of course to male doctors (Brown & Klein, 1982). Also among female leaders working in female-dominated organisations, such strategies are familiar (Solberg, 1995; Gran, 1996).

Another, but related strategy is to help nursing staff with more or less private problems. In the survey of Norwegian doctors, 78% of the female physicians answered that their experience was that the nursing

staff more often asked female doctors to help them with personal issues.¹² Only 19% of their male colleagues thought this to be the case (see Table 3).

However, the establishment of friendship is not a strategy used by all female doctors. Some doctors experience that they are not admitted into the nursing group. Others do not wish to be admitted. In both cases the result is that one is left to do what must be done:

In the beginning I got very irritated when the nurses dropped what they were doing for me when a male colleague asked for help. Now I've found out that it's best not to ask them for help and to try to manage as much as possible myself - make myself independent of them. But that triggers reactions too, because then I'm moving into their territory, and that's not good. (Female doctor, 40 years old, specialising in surgery.)

The existence of this kind of strategy is also confirmed in the survey among Norwegian doctors, where roughly 60% of the female respondents, as opposed to 8% of their male colleagues, thought that female doctors asked for less assistance than their male counterparts (see Table 4). Women in male-dominated areas of medicine, such as surgery and internal medicine, thought this was the case more often than female colleagues in other fields.

By being friendly and by acceding to demands which are actually inappropriate, the female doctor creates both a working and a social alliance out of necessity and by personal choice. Making alliances in order to create an optimal collaboration climate is, however, not a female-specific strategy. In most working situations, men and women use strategies to improve their working relations. However, the approach chosen by female and male doctors may be gender specific, due to the traditional strong link between professional power and masculinity (Witz, 1992; Davies, 1996). Making friendly relationships with the nurses or doing things themselves are described as clearly calculated and negotiated behaviour on the part of women physicians to avoid conflicts. According to the female informants, male colleagues do not have to involve themselves in such negotiations; by virtue of being both doctor and man, they automatically get respect and the service work done.

Three elements in an explanation

Although a vast amount of literature on the doctor–nurse relationship has addressed gender issues, comparatively little attention has been paid to the

¹²Inquiries about illness, medical certificates etc.

Table 3

In your experience, do nursing staff approach female doctors more often than male doctors with their personal problems?

	Female physicians	Male physicians	Sum
Yes	78%	19%	36%
No	22%	81%	64%
Sum	100%	100%	100%
	<i>N</i> = 729	<i>N</i> = 1713	<i>N</i> = 2442

Table 4

In your experience, do female doctors ask for assistance to a lesser extent than their male colleagues?

	Female physicians	Male physicians	Sum
No	41%	92	78%
Yes, because women are used to being self-sufficient	37%	3	12%
Yes, because female doctors are afraid to seem superior	18%	2	6%
Yes, but for other reasons	5%	3%	4%
	101	100	100
	<i>N</i> = 678	<i>N</i> = 1753	<i>N</i> = 2431

relationship when both doctor and nurse are females. The present paper suggests that female physicians feel that their relationships with female nurses differ from those between their male colleagues and female nurses. This agrees with a study of physicians in the Nordic countries (Korremann, 1994),¹³ while other studies of doctors' experiences with the doctor–nurse relationship show inconsistent results (Prescott & Bowen, 1985; MacKay, Matsuno, & Mulligan, 1991; Hoftvedt, Falkum, & Akre, 1998). The inconsistencies are mainly due to the use of different methods and to the fact that different aspects of the doctor–nurse relationship have been investigated.

To fully understand how female doctors and nurses interact, one should ideally use extensive observational methods, which could provide important data in the analysis of the doctor–nurse relationship. Moreover, studies of the doctor–nurse relationship should not rely on data from doctors only. This gives only a partial view. However, as most studies of the doctor–nurse relationship have drawn on data exclusively from nurses, this paper based on information from doctors may present a supplement to the picture of the doctor–nurse relationship in the 1990s.

Structural reforms in society at large obviously influence the health care system and its participants. A number of changes have altered the character of the

health care system in a way that affects the relation between doctors and nurses. Let us briefly point to three important trends of development: (1) Changes in the social position of women, (2) a convergence of status between nursing and medicine, (3) the increasing number of women in medicine.

In all Western countries, the position of women has changed profoundly during the last 20–30 years: an increasingly large number of women complete higher education, employment has increased in all age groups, and more women have full-time employment.¹⁴ In addition to a series of other changes, this has given women increased self-determination and independence from men, and consequently expectations of equal opportunities and the same rights as men in the same positions. Changes in the gendered division of labour in the wider society inter-link with and have an impact on changes within health care: Female doctors expect to be treated as male colleagues, and nurses are challenging the gender-determined subordination of their occupational position. In addition, nursing is no longer only a job before marriage and establishing a family, but a life-long career. Thus, the position of nursing and the occupational identity to the nurse is more important than it was some decades ago.

During the last 10–20 years there has been a convergence of status between nursing and medicine.

¹³A survey to a sample of doctors in the Nordic countries, using some of the same questions as we used in the survey of Norwegian physicians health, sickness, working and living conditions.

¹⁴In 1993, a majority of the students at all levels at the Universities in Norway were females, and more women than men passed their final University examination (Frønes, 1996). In 1970, 33% of all employed were women, compared to 45% in 1990 (Skrede, 1994).

This is partly due to the fact that medicine has lost some of its power and status both in the health care system and in general. In all Western countries the public esteem of physicians has deteriorated.¹⁵ The power aspects of the profession's position have been discussed over the last 20–25 years (Freidson, 1970; Johnson, 1972; Hafferty, 1998; McKinlay, 1988; Wolinsky, 1993; Freidson, 1993). However, changes in relative positions are also taking place because nurses have strengthened their position in the health care system. This is partly caused by important changes in the health care context, changes that have given nurses the possibility of directly influencing patient care decisions, thus affecting the relationship between doctors and nurses (Svensson, 1996). Moreover, many nurses have extensive experience of the practice of special procedures on which doctors in important positions depend (for example in emergency wards and intensive care units). Repeated nursing shortages and life long careers in these areas have focused attention on the value of nursing. Last, but not at least, social movements have arisen among the Norwegian nurses in recent years which have presented a radical challenge to traditional patterns of subordination, thus creating possibilities for reordering the relationship between doctors and nurses and enhancing the positions of nurses.

Although the medical profession is still sex-segregated with male dominance in high-status specialities and more women than men in low-rank positions, in all Western countries there has been an increasing proportion of women in medicine during the last decades (Riska & Wegar, 1993; Lorber, 1993; Gjerberg & Hofoss, 1998). In large specialities such as general surgery and internal medicine, the proportion of women is still very low (5 and 11%, respectively in Norway). The most common relationship between doctor and nurse is thus still a male–female relation.

Conclusion

It is likely that recent controversies in the doctor–nurse relationships can be interpreted as reflections of structural changes both in the society at large and within the health care system. The status convergence between the two occupations combined with an increasing awareness of sex-roles may trigger an increasing sensitivity in the interaction. Nurses may want to resist doctors' traditional ways of marking the boundaries and doctors may feel nurses are getting 'cheeky'.

¹⁵Partly because the public confidence in the profession's devotion to altruistic concerns has been undermined, partly because there has been an increasing recognition of the doctors' fallibility (Stein, Watts, & Howell, 1990).

The fact that this status-convergence seems to have special consequences for female physicians, experienced among other things as differential treatment, can be viewed in light of the contradictions and dilemmas of status that take place when new categories of people enter established positions (Hughes, 1945). The complex of auxiliary characteristics which are expected of the incumbents of specific positions, do not disappear automatically when new categories of people enter the positions. However, the experiences of female physicians may also be explained as implications of ongoing changes in the traditional strong link between profession, gender and power in the medical division of labour. Traditionally, male physicians have had and still have the most powerful positions in the medical hierarchy, because gender signifies relations of power and status; "gender is one cultural resource among others, utilised in daily interaction, available as metaphor in the shaping of organisational and institutional arrangements" (Davies, 1996, p. 665). For the nurses to contest physicians could thus be regarded, more or less consciously, as more risky when the doctor is a man. Service work, ordinarily regarded by nurses as an effect of physicians' demarcation strategies, may be camouflaged as personal gestures in a flirtatious atmosphere, in which male physicians and female nurses confirm each others' gender identity.

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