THE GENDER DIVISION of labour is characterised by the employment of women in part-time, semi-skilled or unskilled roles and men in positions of supervision or management with greater career opportunities. This ‘gendered hierarchy’ emphasises male domination and marginalisation of women in society (Radtke and Stam 1994). Nursing is a predominantly female occupation and, although there are increasing numbers of female doctors, 60% of registered doctors are male (General Medical Council 2010). This division of labour may place nurses in a subordinate position to doctors.

The public inquiry into the high mortality rate of infants undergoing cardiac surgery at Bristol Royal Infirmary between 1984 and 1995, found that the occupational hierarchy made it difficult for nurses to voice their concerns (Department of Health (DH) 2001). There was also a failure to develop effective multidisciplinary teams and poor communication was evident in the paediatric cardiac surgical service. Following publication of the report of the public inquiry (DH 2001), NHS organisations were expected to implement measures to develop a culture of openness about mistakes, where patients and staff work in partnership and patient safety is prioritised (DH 2002).

Concern about harm caused to patients as a result of medical errors (Donaldson 2008) raises the question about the extent to which nurses feel confident to voice their concerns about doctors’ practice.

This article explores factors that encourage and discourage nurses from challenging doctors’ practice in everyday situations in an acute NHS hospital. The historical relationship between doctors and nurses and the gender division of labour are discussed. The ‘doctor–nurse game’ (Stein 1967) is examined to demonstrate how, in the past, nurses have attempted covertly to influence medical decision making.

Nursing’s subordinate status

Historically, nurses have subordinate status in the workplace with the division of labour controlled by the medical profession and influenced by the state (Abel-Smith 1979, Rafferty 1996). ‘Full professional’ status occurs when a particular occupation has control over the division of labour and is able to decide what tasks it performs and what tasks other occupations perform. Doctors are seen to have full professional status because they have exclusive theoretical knowledge, which enables them to have a certain level of power and control over nurses, who have subordinate status (Freidson 1970). Control over the division...
of labour has been described as a ‘gendered strategy of demarcationary closure’, in which female-dominated occupations are enclosed within related, but discrete, areas of competence, and are subordinate to male-dominated occupations (Witz 1992).

Women’s virtual exclusion from universities in the 19th century gave them an educational disadvantage, reducing the opportunity for female-dominated middle class occupations to create a theoretical or scientific knowledge base (Witz 1992, Macdonald 1995). Scientific knowledge was viewed as superior to other types of knowledge by its social construction, which was based on the gendered ideas of masculine rationality as opposed to feminine irrationality (Hekman 1990).

The status of male-dominated occupations was, therefore, raised relative to occupations such as nursing and teaching, which were composed mainly of females. Women were not excluded from the workforce, but were included instead in a manner where their contribution was hidden or subordinate, for example through ill-defined, support roles, therefore encouraging the idea of the rational, autonomous, usually male professional (Davies 1996).

The autonomy achieved by an occupation with full professional status, such as that accorded to medicine, arose from the exclusivity of its theoretical knowledge. Specialised occupational skills made it difficult for non-specialists to judge the performance of practitioners. This knowledge imbalance created relationships of dependence on the skills of others, which gave power, in the producer-consumer relationship, to the producer and led to the potential for consumer exploitation (Johnson 1972). Examples of such exploitation in health care include the events at Bristol Royal Infirmary, which resulted in the unexpected deaths of children undergoing open heart surgery (DH 2001), and the retention of children’s organs without parental consent at Alder Hey Children’s Hospital (Dyer 2005).

The Bristol Royal Infirmary inquiry (DH 2001) recommended that there should be a partnership between healthcare professionals and patients, in which the patient and the professional meet as equals with different expertise, and that access to medical schools should be widened to include people from diverse academic and social class backgrounds.

Medical dominance in health care has resulted in the work of other healthcare professionals being largely requested and supervised by doctors through control of referral systems; dominance of the biological, biochemical and physiological knowledge base of medicine and medical research; and over-representation of doctors in policy formulation and NHS senior management positions (Adamson et al 1995). Such subordination has arguably acted as a barrier to nurses challenging doctors’ practice by denying nurses a legitimate voice to question openly doctors’ decisions when they have concerns (DH 2001, Finn 2008).

**Doctor-nurse game**

The term ‘doctor-nurse game’ was coined by Stein (1967) to describe the hidden manner in which nurses influenced decision making by providing information and making suggestions to doctors without upsetting the occupational hierarchy. Nurses had to influence covertly doctors’ decision making, thereby avoiding open disagreement and allowing the doctor to think that he or she had made the decision. Using this strategy, nurses were able to make recommendations about patient care without appearing to undermine the doctors’ omniscient status (Hofling et al 1966, Stein 1967). By playing the game successfully, teamwork and mutual respect were, arguably, maintained. Failure to play the game might lead to professional conflict or impede a nurse’s professional development through loss of career prospects (Fagin and Garelick 2004).

Historically, becoming a good nurse was equated with the fulfilment of doctors’ wishes and instructions (Stein 1967, Fagin and Garelick 2004). Nurses unwilling to do this were viewed as undermining or damaging the doctor-nurse relationship. This may have been particularly problematic for doctors if their status was relatively low owing to inexperience, youth, gender or race (Hughes 1988, Marsden 1990).

Stein et al (1990) identified that social change, including less public deference to the medical profession, more female doctors and more degree-educated nurses, changed doctor-nurse relationships. They argued that such relationships were no longer characterised by domination and subordination, but instead by ‘mutual interdependence’ (Stein et al 1990). However, some authors have suggested that, while nurses perceive themselves to be assertive, observational data demonstrated they were unassertive (Bushby and Gilchrist 1992) and that clinical decision making remained under medical control (Coombs and Ersser 2004). Other evidence indicated that nurses’ involvement in decision making had increased (Svensson 1996, Allen 1997). Another study found that doctors used the language of teamwork to maintain their privileged position in the division of labour (Finn 2008).

Occupations are subject to social, political and economic changes in the wider society, and the dynamics of the doctor-nurse relationship are constantly evolving (McHale and Tingle 2007).
Aim
To explore the extent to which nurses are willing to challenge doctors’ practice in everyday situations in an acute NHS hospital.

Method
The research used in-depth, qualitative interviews with a purposive sample of 12 nurses working in a 400-bed acute NHS hospital in the south of England, with a catchment population of 450,000. Acute and emergency services, including the emergency department, intensive therapy and theatres are based on site. The research was carried out in 2008, after gaining approval from the local research and ethics committee.

The rationale for choosing a qualitative approach was based on the need to explore participants’ points of view and the meanings they attribute to their behaviour (Bryman 2008). Data collected through in-depth interviews permitted an exploration of nurses’ subjective experiences, including individual and organisational factors that encourage and/or discourage nurses from challenging doctors’ practice.

Nurses were asked: ‘Can you tell me of an occasion when you have challenged a doctors’ practice?’ If a nurse was not able to give an example, prompts such as drug prescribing, discharge planning and informed consent to treatment were given. Nurses were then asked: ‘Can you describe an occasion when you would have liked to challenge a doctors’ practice, but did not?’ Where appropriate, standard description prompts such as ‘tell me more about that’ or ‘what happened next?’ were used to obtain a complete and coherent story.

Fifty-five nurses were randomly selected from a list of all registered nurses in the hospital and sent an information pack and an invitation to participate in the study. Table 1 shows the demographic data of the 12 female nurses who agreed to participate.

No male nurses agreed to participate in the study. This was not unexpected and reflects the gender distribution of the occupation – the ratio of females to males on the nursing register is 89% to 11% of nurses, respectively (Nursing and Midwifery Council (NMC) 2008). The employment ratio of registered nurses at the hospital at the time of the study comprised a female-to-male ratio of 93% to 7%. The average age of participants was 47 years, with six participants in the age range of 40-49 years. The youngest was 34 years. This age range would not be unexpected as, with increasing numbers of nurses entering the profession at an older age, nursing has an ageing workforce (International Council of Nurses 2008).

More than 65% of those on the nursing register are over 40 years of age and only 9% are under 29 years (NMC 2008).

Six of the participants were employed at a senior level and five were practising at a senior specialist or nurse practitioner level. Seven

<table>
<thead>
<tr>
<th>Age (years)</th>
<th>Highest qualification</th>
<th>Months or years in nursing</th>
<th>Present role</th>
<th>Work status</th>
</tr>
</thead>
<tbody>
<tr>
<td>44</td>
<td>Registered</td>
<td>23 years</td>
<td>Staff nurse</td>
<td>Part time</td>
</tr>
<tr>
<td>40</td>
<td>Degree</td>
<td>19 years</td>
<td>Specialist nurse</td>
<td>Part time</td>
</tr>
<tr>
<td>45</td>
<td>Masters degree</td>
<td>25 years</td>
<td>Specialist nurse</td>
<td>Full time</td>
</tr>
<tr>
<td>52</td>
<td>Degree</td>
<td>29 years</td>
<td>Staff nurse</td>
<td>Part time</td>
</tr>
<tr>
<td>43</td>
<td>Registered</td>
<td>22 years</td>
<td>Staff nurse</td>
<td>Part time</td>
</tr>
<tr>
<td>52</td>
<td>Registered</td>
<td>30 years</td>
<td>Ward sister</td>
<td>Full time</td>
</tr>
<tr>
<td>41</td>
<td>Registered</td>
<td>12 years</td>
<td>Specialist nurse</td>
<td>Part time</td>
</tr>
<tr>
<td>51</td>
<td>Masters degree</td>
<td>32 years</td>
<td>Specialist nurse</td>
<td>Full time</td>
</tr>
<tr>
<td>59</td>
<td>Registered</td>
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<td>Staff nurse</td>
<td>Part time</td>
</tr>
<tr>
<td>58</td>
<td>Degree</td>
<td>12 years</td>
<td>Specialist nurse</td>
<td>Full time</td>
</tr>
<tr>
<td>48</td>
<td>Degree</td>
<td>9 months</td>
<td>Staff nurse</td>
<td>Full time</td>
</tr>
<tr>
<td>34</td>
<td>Diploma</td>
<td>2 years</td>
<td>Staff nurse</td>
<td>Full time</td>
</tr>
</tbody>
</table>
participants had been qualified for more than 20 years. All nurses were self-selecting, and the response from a high proportion of senior nurses may have been because of their confidence in discussing such a sensitive issue. Five participants were specialist nurses and four of these nurses had a first or higher degree. All interviews were tape-recorded and each took around one hour. Written consent was obtained before and after each interview and participants were assured that interviews were anonymous.

Data analysis

Analysis involved a thematic approach to the coding and breakdown of data. This supported the identification of core themes, sub-themes, repetitive words and differences in the text. Transcripts were read and re-read to gain a comprehensive view of each interview. At each reading, marginal notes were made about significant words, sentences or statements (Bryman 2008). Key words and sentences were circled and themes highlighted. Similarities, patterns, consistencies and inconsistencies were identified. Data collection and analysis were carried out repeatedly by comparing and contrasting different accounts (Silverman 2010). Analytic themes were identified and tested in depth to generate a small number of theoretical concepts supported by evidence (Rubin and Rubin 2005).

Findings

The findings are organised under two key themes that emerged from the data: the ‘battle of challenging’ and ‘playing games’.

Battle of challenging

Participants used battle metaphors to describe how they felt they needed to prepare and protect themselves from the supposed threat of psychological injury when questioning doctors’ practice. One specialist nurse described it as an ‘uphill battle’ that involved ‘sticking to my guns’. Another participant said that there was a need to have ‘ammunition’ as evidence of the deterioration in a patient’s condition before approaching a doctor. Nurses talked about feeling intimidated because of doctors’ aggressive attitudes, their status in the occupational hierarchy or their perceived level of knowledge. One nurse stated that she felt ‘quite intimidated’ by some of the consultants:

‘It’s easier to challenge a junior doctor because they do not have much experience, especially if they are new... and they don’t know any better’ (Staff nurse).

One nurse encouraged the consultant to introduce his junior staff to her so that ‘we’ll be seen on the same side, rather than them and us’. A specialist nurse said:

‘Whenever you go to them [doctors], they are not really listening if you’re moaning, or they think you are moaning... I get tired and fed up of battling and not getting anywhere and I know my colleagues feel the same’ (Specialist nurse).

Another nurse commented:

‘I notice surgeons sort of brushing over what nurses say or just not noticing nurses... They [doctors] never acknowledge what the nurse has said or that the nurse had done something that might have been helpful, might have been useful’ (Staff nurse).

A junior nurse recounted an incident when a consultant had come to see a patient after vascular surgery and had taken off the patient’s wound dressing without wearing gloves. The nurse recounted how the surgeon then walked out of the ward without washing his hands or using alcohol gel. Senior nurses had witnessed this behaviour, but had not challenged the consultant. The nurse believed that the other nurses were afraid of the doctor because of his temperament.

Playing games

Nurses discussed using a variety of methods or games involving doctors to achieve what they felt was an appropriate outcome for patients. Nurses influenced doctors’ decision making by making subtle suggestions, but making it appear as if any recommendations were initiated by doctors. One nurse described this:

‘Through my ignorance, if you like, it raised a doubt in his mind and therefore he basically came up with the end result’ (Specialist nurse).

The use of ‘female charm’ and humour ‘as a cloak for throwing in a sideways message that may permeate his thinking’ were said to be other methods that nurses used to influence doctors’ decisions. ‘Maintaining the ego because people can be really nasty if their egos are ruffled’, as described by one nurse.

Participants likened some of the behaviour of their medical colleagues to that of children throwing occasional temper tantrums and ‘playing up’ to get attention and the outcome they wanted. Surgeons, in particular, were said to ‘throw their toys out of the pram’ if a nurse refused to put another patient on an already oversubscribed theatre list, as identified by one participant. They were said to ‘strop down the corridor’ on occasions when they were not able to add another patient to a theatre list.

There also appeared to be a continuation of the nurse’s role as the doctor’s handmaiden as described by Kitson (1996). However, participants...
ascribed this type of behaviour to their colleagues and not to themselves. It was explained that by providing a cup of tea at the beginning of the day and treating doctors as ‘gods’, nurses ‘got the best out of them’, as described by one nurse. This approach was aimed at helping clinics to run on time, which nurses believed was in the best interests of the patients.

One specialist nurse in the emergency department described a situation when, in one particular hospital, she was not allowed to perform suturing procedures although competent to do so. Instead, she was expected to set up suture equipment for the doctors. She questioned this practice, but was informed by the nursing sister to ‘shut up’.

Participants stated that nurses were subservient especially with surgeons. According to one participant ‘nurses take on an almost little girl stance, their voices change and their whole demeanour changes’ and they behave like ‘little girls, scuttling around doctors hoping not to get in the way or get noticed as this was associated with doing something wrong’. The relationship between doctors and nurses was also described as one of school teacher and pupil where the doctor is the school teacher and the nurse the pupil who needs to learn the relevant skills while not aggravating or disobeying the teacher. Therefore, it appears that nurses themselves, and some senior nurses in particular, are complicit in their own subordination through their behaviour in supporting deference to the medical profession.

A nurse with 32 years’ experience said she was comfortable questioning doctors’ practice. However, she gave an example of a situation where she challenged a consultant’s care of a terminally ill patient. As a consequence this consultant did not refer any patients to her for a couple of months after their disagreement. The nurse complained to her manager, but was not informed of what action, if any, was taken. She commented:

‘I think it was dealt with within the culture and closed doors of “doctorology”’ (Specialist nurse).

Although some participants stated that they felt confident in challenging doctors’ practice, few examples were given. One nurse felt more confident in challenging doctors’ practice when there were hospital policies to support her position, for example the use of directives or protocols on antibiotic prescribing, and informed consent. This demonstrates nurses’ lack of confidence in challenging doctors’ practice, as they require guidelines or policies to support their actions.

Discussion

Notwithstanding radical changes in the labour market for women generally, such as their greater numbers and apparent success in previously male-dominated professions, male status and privilege continues to be protected. Despite the increasing number of women in dominant professions, such as medicine and law, gendered segmentation and stratification persist and women continue to experience subordination and devaluation (Bolton and Muzio 2008).

Results of the present study indicate that in health care the doctor-nurse game (Stein 1967) is still being used by nurses to appease doctors. The game is played to avoid challenging hierarchical occupational structures and gender roles, thus maintaining established working relationships and averting conflict and stress for nurses. Nurses acknowledged that the ‘handmaiden role’ is still prevalent; nurses make tea, defer to doctors and treat them like ‘gods’. These data support Finn’s (2008) study of operating theatre behaviour, which found that nurses were complicit in their own subordination.

Nursing has not historically had its own theoretical knowledge base, but rather one based on medical knowledge. This is an important reason for nurses’ subordinate status in the division of labour. This hierarchical system has resulted in nurses appearing unwilling to dispute doctors’ decisions (Stein 1967). While nurses in the present study stated that they would question doctors’ practice, those who had done so used protocols or hospital policies to support them. However, there were noticeably more examples of nurses who did not challenge doctors’ practice.

The data indicate that nurses still lack the confidence to question doctors’ decisions. Some participants described how they perceived working with doctors to be like a battle, while others discussed the use of humour, flattery and flirting to manipulate or influence doctors to obtain a favourable patient outcome. The Bristol Royal Infirmary inquiry (DH 2001) highlighted a dangerous hierarchical system in which the use of power made it difficult for staff, including nurses, to express their concerns. The findings suggest that there is a strong medical hierarchy that discourages nurses from challenging doctors’ practice.

Limitations

Limitations of this study should be acknowledged. The research was limited to a small sample in a single hospital and thus the findings could not reflect a specific organisational culture. The study did not include other groups such as midwives,
nurse consultants or male nurses, who may have reflected a different view of the factors that support or deter nurses from challenging doctors’ practice. The study also presented only one side of the relationship and has not incorporated the views of doctors.

Conclusion

This study explored the factors that encourage and discourage nurses from challenging doctors’ practice within everyday clinical situations. Fear of conflict, of experiencing aggressive behaviour or of simply having one’s views disregarded, prevent nurses from challenging doctors’ practice. This implies that the institutional arrangements that define relationships between doctors and nurses engender unequal rewards and opportunities for the two groups. This structural inequality continues to be an important barrier to nurses raising concerns about medical practice. Future studies in this area would benefit from exploring these issues with a larger sample of nurses and in particular by including male nurses. This would help disentangle the effect of gender on interpersonal relationships. Examining the opinions and behaviour of nurses in more senior clinical and managerial positions would enhance understanding of contemporary inter-professional relationships.

Given the ongoing debate about how to improve patient safety, it would also be interesting to explore this issue from a safety culture perspective, to identify the effect on patients of occupational hierarchy and status inequality.

**References**


NHS organisations need to develop a culture of openness and partnership to ensure patient safety is prioritised.

Nurses remain reluctant to raise concerns about medical practice fearing aggressive or dismissive behaviour from doctors.

The structural inequality between doctors and nurses in the workplace means that nurses still find it difficult to express concerns when they believe things are wrong.

**IMPLICATIONS FOR PRACTICE**

- NHS organisations need to develop a culture of openness and partnership to ensure patient safety is prioritised.
- Nurses remain reluctant to raise concerns about medical practice fearing aggressive or dismissive behaviour from doctors.
- The structural inequality between doctors and nurses in the workplace means that nurses still find it difficult to express concerns when they believe things are wrong.

**NURSING STANDARD**

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