Nursing, Power, and Gender in Interprofessional Collaboration

by

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A thesis submitted in conformity with the requirements for the degree of Master of Science

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Abstract

This research explores how power and gender are used to construct professional hierarchies between nurses and physicians and therefore influence interprofessional collaboration. Through directed content analysis and constant comparison analysis, I analysed top-cited articles about interprofessional collaboration involving nurses and physicians and contextualized the relationship between gender and professional hierarchies with Witz’s occupational closure theory.

In my first theme, *The invisibility of gender*, most authors considered gender incidentally or not at all. In my second theme, *Interprofessional hierarchies in nursing work are reinforced by gendered strategies*, nurses jockeyed for power by ‘playing the game’, a usurpationary strategy. Physicians used exclusionary and demarcationary strategies, as interprofessional collaboration represented a threat to their hegemonic control over health care. Despite the enduring presence of gendered strategies, gender gradually slid from analytic view. Gender is not recognized in most research as an avenue of potential hegemony that impinges on effective interprofessional collaboration.
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Chapter 1
Introduction and Literature Review

Interprofessional collaboration in health care has been proposed as a solution to improve patient care (World Health Organization, 2010), patient outcomes (Orchard et al., 2010), improve patient satisfaction (Paradis & Whitehead, 2017), and address problems such as medical errors (Kohn, Corrigan, & Donaldson, 1999) and the need for effective complex care (Paradis & Whitehead, 2017). Nurses are often at the heart of collaborative health care initiatives as they not only outnumber all other healthcare professions, but they also play a central role in providing and coordinating patient care. However, despite increased attention to practices of interprofessional collaboration, that collaboration is also a source of conflict for nurses (Coombs & Ersser, 2004; Paradis & Whitehead, 2015; Tang, Chan, Zhou, & Liaw, 2013). One proposed explanation is that superficial interventions are targeted at changing professional collaborative behaviour on an individual level while ignoring structural influences (Paradis & Whitehead, 2017) such as the influence of historical professional hierarchies and gendered expectations of labour.

My research challenges the commonly understood conception of interprofessional collaboration as a group of health professionals working together towards a common goal. Rather, I argue that current conceptualizations of interprofessional practice have been over-simplified, and that these simplified models obscure how interprofessional practices are impacted by the social and historical relationships between the health professions. In this research, I have adopted a theoretical lens that explores how power and gender are used to construct professional hierarchies between nurses and physicians and therefore influence interprofessional collaboration. I use Witz's (1992) occupational closure theory to contextualize gendered structures and professional hierarchies in writing about interprofessional collaboration, and I then draw conclusions about how these ideas have been constructed over time. I have chosen the specific case of nursing based on nurses’ historically subordinate position in the hierarchy of health professions and the gendered nature of the nursing profession (Kitson, 2001; Peplau, 1966). My research questions are:

How does the writing about collaboration in articles about nurses, physicians, and interprofessional collaboration reflect professional struggles and hierarchies? How are these struggles gendered? How have theses struggles evolved over time?
Social constructionist methodology (Hacking, 1999) allowed me to consider how collaboration between nurses and physicians is constructed and described. To answer my research questions, I completed a theoretically informed directed content analysis (Hsieh & Shannon, 2005) and constant comparison analysis (Boeije, 2002) of relevant articles from three nursing journals and an interprofessional collaboration journal.

1 Interprofessional Collaboration between Nurses and Physicians – A Conceptual and Historical Background

This literature review first outlines the conceptual underpinnings of this project, and then explores these concepts historically. Both conceptual and historical backgrounds will be linked to a thematic frame that explores historical gender and hierarchical power dynamics as ongoing obstacles to collaboration. In the conceptual section, I will first give a brief description of growth and changes in the field of interprofessional collaboration from the 1970’s to the present, and then offer some definitions of interprofessional collaboration. Next, I will define power and hierarchy and how they affect interprofessional collaboration. After that, I will explain how power and gender interact, and explore existing literature on the effect of gender on interprofessional collaboration. In the historical section, I will outline a brief history of nurse-physician relations, followed by a history of collaboration between the two professions. Then, I will illustrate the ways in which the history of nurse-physician relations informs the current state of collaboration.

In describing both the concepts of interprofessional collaboration and historical accounts of collaboration between nurses and physicians, I am anchoring my own research in history and the present. In social constructionist methodology, knowledge is constructed in a social space by people who are influenced by their current and historical contexts. In my research, I will look to the past to understand the ways that gender and hierarchy are influencing collaboration in the present.
1.1 Conceptual background—Interprofessional Collaboration, Power, and Gender

1.1.1 Interprofessional Collaboration

Interprofessional collaboration is frequently suggested as a health system strategy to maximize health outcomes or improve quality of care (Canadian Interprofessional Health Collaborative, 2010; Kohn et al., 1999; World Health Organization, 2010). The idea of collaboration as an ideal for effective health care has grown rapidly over the last two decades (Haddara & Lingard, 2013; Paradis et al., 2013). However, the most recent Cochrane Review, *Interprofessional collaboration to improve professional practice and health care outcomes*, found that while the number of types of interventions for interprofessional collaboration has increased since the previous review on the same topic in 2009, there is no clear evidence that interprofessional collaboration improves health outcomes (Reeves, Pelone, Harrison, Goldman, & Zwarenstein, 2017).

Despite evidence that interprofessional collaboration may not be improving health care or patient outcomes, the area of interprofessional collaboration research continues to grow. Paradis & Reeves, (2013) assessed publication trends in the area of interprofessional collaboration as a measure of how the field of interprofessional collaboration research was growing. From 1970 to 2010, publications about interprofessional collaboration in PubMed increased almost 2300%, compared to an overall growth rate of 500% in the same time period for PubMed overall. One of the journals that is a source of documents in my research, the *Journal of Interprofessional Care*, ranked third in publishing interprofessional collaboration articles – just after longstanding esteemed publications *British Medical Journal* and the *Journal of American Medical Association*. Paradis and Reeves analysed words in interprofessional articles’ titles and found that use of words such as ‘team’, ‘social’, and ‘relationship’ have declined over time and the terms hierarchy and hierarchical decreased rapidly early in their sample (personal correspondence, E. Paradis). The use of individual professions in titles has also declined over time. Perhaps illustrating maturing of the research field on this topic, methodological words such as ‘review’ and ‘qualitative’ began to rise in the mid-1990’s, while ‘quantitative’, which had been present across the time period, also rose in the 1990’s. Possibly demonstrating nursing’s central role in interprofessional collaboration, ‘Nurse/nursing’ was the 3rd most used code in
article titles after ‘United States’ and ‘care/caring’. Further, ‘nurse/nursing’ is used twice as often as ‘GP/doctor/MD/physician’ (Paradis & Reeves, 2013).

Published peer-reviewed research is the established and recognized form of knowledge production in science and health care, and yet often reproduces societal values and the current beliefs and norms of the research community. As Paradis and Reeves (2013) explain, word choice in titles reflects academics’ ideas of what is legitimate and valuable and is a strategy to entice readers. Authors write about ideas and topics that resonate with readers during a particular historical period. Over time, as new ideas spread and gain traction, the relative importance of individual topics shifts. In Paradis and Reeves’ analysis of 40 years of interprofessional collaboration journal article titles, they demonstrate a decreased representation of titles concerning professional relationships, professional roles, and hierarchies. This suggests that the agents of collaboration and their relationships to each other are no longer considered as highly significant to understanding interprofessional collaboration.

1.1.2 Definitions of Interprofessional Collaboration

There have been numerous definitions of interprofessional collaboration posed by both Canadian and international healthcare organizations. The World Health Organization (WHO) describes:

…collaborative practice in health-care as occurring when multiple health workers from different professional backgrounds provide comprehensive services by working with patients, their families, carers and communities to deliver the highest quality of care across settings. (World Health Organization, 2010)

In the WHO definition, it is not clear that health care workers even need to interact or share goals while working in collaborative practice, let alone navigate professional hierarchies. From Canada’s National Interprofessional Competency Framework, interprofessional collaboration is:

…the process of developing and maintaining effective interprofessional working relationships with learners, practitioners, patients/clients/families and communities to enable optimal health outcomes. Elements of collaboration include respect, trust, shared decision making, and partnerships. (Orchard et al., 2010)

In the Canadian Competency Framework, health care staff need ‘effective interprofessional working relationships’, and collaboration includes ‘respect, trust, shared decision making’. These
elements are divorced from the practitioners who would enact collaboration, and no mention of hierarchies or power occurs in the definition.

The Canadian Nurses Association (CNA) position statement on interprofessional collaboration, while not defining what collaboration is or entails, provides a rationale to implement the practice:

Nurses collaborate with other health professionals to develop a moral community and to maximize health benefits to clients, recognizing and respecting the knowledge, skills and perspectives of all. Shared decision-making, creativity and innovation allow health-care professionals to learn from each other and enhance the effectiveness of their collaborative efforts. (Canadian Nurses Association, 2011).

These definitions of interprofessional collaboration can be interpreted in terms of two major discourses (Haddara & Lingard, 2013) identified to categorize interprofessional collaboration literature. A utilitarian discourse aligns with positivist research and explores features of interprofessional collaboration that produce desired health system outcomes such as improved patient care or improved health outcomes. The second discourse is an emancipatory discourse where interprofessional collaboration is necessary because it addresses medical dominance and levels the professional playing field (Haddara & Lingard, 2013). The previously listed definitions of interprofessional collaboration arise from the utilitarian discourse. They outline a view of individual practitioners working together to improve client care that elides the potential for conflict in collaboration, and notably avoids mentions of power and hierarchies. However, there is evidence that nurses face conflict in collaborative relationships with other professionals in health care practice, which is often attributed to power imbalances between the professions (Coombs & Ersser, 2004; Hancock & Easen, 2006; Manias & Street, 2001; Salhani & Coulter, 2009). While power imbalances influence the effectiveness of collaboration in practice, definitions of interprofessional collaboration frequently do not acknowledge the impact on collaboration of power imbalances between professions. The discourses of utilitarian and emancipatory collaborations each have distinctive language and values. Health care practitioners, researchers and organizations may tacitly align with a specific discourse. As Haddera and Lingard (2013) explain, acknowledging and attending to the discourses of collaboration and the ways these discourses inform how interprofessional collaboration is understood, implemented and assessed could improve the effect of interprofessional collaboration initiatives.
An example of a definition of interprofessional collaboration in the emancipatory discourse comes from Petri (2010). Drawing on the international literature, anecdotal reports and philosophical viewpoints, Petri conducted a concept analysis of how the term interprofessional collaboration has been used and applied in the literature. From this analysis, Petri defines interprofessional collaboration as:

an interpersonal process characterized by healthcare professionals from multiple disciplines with shared objectives, decision-making, responsibility, and power working together to solve patient care problems (p.79).

In Petri’s definition, elements of collaboration are directly linked to health care professionals who share ‘objectives, decision making, responsibility and power’ together. In this definition, the responsibility for effective collaboration lies with all involved health care professionals, and includes the recognition of power. Because my research examines power and hierarchy, and thus is centred in the emancipatory discourse, I have elected to use Petri’s definition of collaboration.

1.1.3 Power and Hierarchies

Power is the capacity to act or to exert influence over others (Lukes, 1986). Specifically, power provides autonomy to those who have it and can be wielded to influence people and events. Power imbalances also create and reproduce hierarchies between different groups of social actors (Lukes, 1986) – in this case, the health professions. Hierarchy can be defined as a gradient in authority between practitioners in health care (Cosby, 2004). While professional hierarchies can impact the relationships formed between different members of the health professions, they are also reproduced through institutional policies and professional norms. Power therefore has implications in interprofessional collaboration because power has been distributed unequally between the health professions, particularly in the context of the gendered distribution of labour. Physicians have greater authority over their work and over nursing work compared to nurses, who have less autonomy over their own work and no control over physicians’ work. Hierarchical institutional policies, behaviours and professional norms, which evolved from early nurse-physician relations, are the sources of interprofessional power differences between nurses and physicians. Power creates barriers between the professions and leads to ineffective interprofessional working relationships.
To explore the degree to which power, hierarchies and interprofessional collaboration are significant investigation topics in the peer reviewed literature ‘conversation’ about interprofessional collaboration, I performed a literature scan in MEDLINE using the MeSH term for interprofessional collaboration, “Interprofessional Relations” and a title/keyword/abstract search for power, which yielded 1003 results (1.6% of a total of 64163 articles). This result echoes a similar search by (Paradis & Reeves, 2013), who found that ‘power’ was used in 0.3% of titles in the interprofessional education literature from 1970-2010, once they had removed titles referring to ‘statistical power’ from their dataset. Even more sparse was the use of the term ‘hierarchy’. “Interprofessional Relations” and title/keyword/abstract hierarch* yielded just 507 results, or 0.8% of the total articles. While this may not reflect how often power and hierarchy are acknowledged in writing about interprofessional collaboration, this count does reflect how seldom those words are used in titles, keywords and abstracts. This finding raises questions about what is missing from our understanding of interprofessional collaboration when authors may not be acknowledging the role of power and hierarchical relationships in interprofessional collaboration.

To investigate how authors represent power in writing about their research, I looked to interprofessional collaboration review papers. Power and hierarchy are deeply related to the environment – the context – in which health care professionals work. Because context is best explored with qualitative methods (Paradis et al., 2014), I anticipated I would find power, hierarchy and interprofessional collaboration discussed in review articles that included qualitative methods. However, this assumption was not entirely borne out in the literature. Looking at interprofessional collaboration reviews through the lens of Haddera & Lingard (2013), I found that both utilitarian and emancipatory discourses were represented.

**Qualitative reviews in the utilitarian discourse**

Several qualitative reviews followed the utilitarian discourse and did not acknowledge the role of power and hierarchy as impacting interprofessional collaboration. In a literature review of qualitative observational studies examining collaboration in primary care teams (Morgan, Pullon, & McKinlay, 2015), the authors develop a thematic analysis of how top-down organizational factors and bottom-up intrinsic factors such as frequent informal communication opportunities contribute to collaborative practice in primary care (Morgan et al., 2015), highlighting structural
and organizational processes that could build effective collaboration. Although they discuss ‘top-down’ and ‘bottom up’ factors, the authors fail to mention professional hierarchies, power, or differences in how professions may access or engage with the solutions they propose.

A systematic review on collaborative care and depression identified a series of barriers to collaboration, including poor attitudes and poor communication between staff including a report of a professional group that avoided communicating with other professionals despite communication pathways. In that study, facilitators of collaboration included integrated information systems and having case managers who were co-located with patients. Power and professional hierarchical differences were not mentioned, despite conflict between professions that could be related to hierarchical power struggles (Wood, Ohlsen, & Ricketts, 2017).

A review of interprofessional teamwork in chronic care found that teamwork was enhanced by interventions to improve it, but did not discuss power or professional hierarchies (Körner et al., 2016).

It is not always clear if the authors of articles included in the review elected not to consider power and professional hierarchies as aspects of collaboration, or if the review authors did not report on power and interprofessional collaboration. Either way, the absence of power and hierarchies in these reviews situates them firmly in the utilitarian discourse. This weakens the effectiveness of their findings because it fails to acknowledge the differential access that different professions have to proposed solutions.

**Qualitative reviews in the emancipatory discourse**

One review does mention professional hierarchy or power as problematic in collaboration, but doesn’t explore issues of power in depth. This situates it in the emancipatory discourse, but towards the positivist, utilitarian side of the continuum of discussions of power. Xyrichis & Lowton's (2008) thematic analysis of qualitative and quantitative literature on what fosters or prevents interprofessional teamwork in primary and community care settings contained just one participant quote about power made by a general physician on letting nurses have more responsibility: “It’s sometimes difficult for us to let go of our power base and as they (nurses) take on more responsibility for developing the service, we can feel that our role is being eroded”.

(p. 149, Cook et al., 2001, in Xyrichis & Lowton, 2008). This lack of recognition of hierarchical power as a factor suggests that their list of barriers to interprofessional teamwork is incomplete.

In contrast, some reviews address power and hierarchy more directly, though still as a minor topic. In a qualitative systematic review of enablers and barriers to collaborative care for anxiety and depression, one reviewed study discussed hierarchy as a potential factor affecting care by primary care physicians. The review authors summarized: “some of the non-[primary care physician] respondents speculated that [primary care physicians] may have had concerns about their clinical autonomy and status in the professional hierarchy due to increased interference from [case managers] and psychiatric specialists” (p. 10, Overbeck, Davidsen, & Kousgaard, 2016). Coming close to discussing the contextual influence of power, the authors acknowledged that interventions occur in a social, political and financial context and thus collaborative care interventions should be targeted to specific situation (Overbeck et al., 2016).

In a systematic review of the interprofessional care provided in intensive care units, Paradis et al., (2014) examined the role of power and hierarchy from studies taking an ethnographic approach. Paradis et al. argue that because interventions aimed at promoting collaboration are enacted in a social context, they are ideally suited to be captured through ethnographic methodologies. Notes about professional power, stereotypes, gender, and hierarchy appear separately in text boxes in the article to guide readers towards potential contextual factors in collaboration research, but are not central to the summary.

Several reviews explicitly examine interprofessional collaboration with a focus on power and hierarchal relationships, situating them firmly in the emancipatory discourse. In a review of nurses and midwives’ struggles to collaborate during birthing care, (Macdonald et al., 2015) found that problems with collaboration were related to the oppressed status of each profession, and recommended that power between nurses and midwives should be explored using a critical feminist methodology.

Authors of a systematic review which examined the barriers and enabling factors of interprofessional collaboration as perceived by actors in primary health care noted that “perceived hierarchy” (Supper et al., 2015) is the main barrier hindering collaboration. The authors explain: “The notion of a perceived hierarchy reflects the asymmetry of the possible gains accessible through collaboration” (p 724), framing collaboration as explicitly about
professional gains and therefore most beneficial to high status care providers such as general practitioners. Power in this article is conceived of as a commodity benevolently shared by those with autonomy and authority.

In a qualitative and quantitative review of studies on the views and experiences of health care practitioners, Schadewaldt, McInnes, Hiller, & Gardner (2013) outline several aspects of hierarchical relations and conflict over the control of tasks between nurse practitioners and medical practitioners in primary health care. In the review, the authors found that medical practitioners felt they needed to supervise nurse practitioners, which contributed to nurse practitioners feeling the need to constantly justify their competence. The authors characterized medical practitioner’s limits on nurse practitioner work as paternalistic. In addition, nurse practitioners stated that they often took on a leadership role in initiating almost all collaborative consultations, meaning medical practitioners rarely turned to the care team for advice or support. Nurse practitioners expressed that they originally had thought they were entering a collegial work environment and instead, were surprised by hierarchical professional relations.

In an integrative review of facilitators and barriers to collaboration between GP’s and nurses in primary care, McInnes, Peters, Bonney, & Halcomb (2015) also reported on nurses who said hierarchical relationships with GP’s limited their ability to collaborate. For Tang et al. (2013), unequal power between physicians and nurses was a key theme in the review of collaboration between nurses and physicians in hospitals. In all three of the preceding reviews, the authors found that hierarchical relations affected attitudes towards collaboration and the experience of collaborating.

While power and hierarchy are underrepresented in definitions of collaboration and also as an area of research interest, in a far subtler manner, power and hierarchy also influence how collaboration is written about. Authors often implicitly reinforce medical authority in their writing. In a linguistic analysis of 50 years of writing about interprofessional collaboration in the journal Medical Education, (Paradis & Whitehead, 2017) noted a subtle bias in use of language. They found that physicians were consistently conceptualized as leaders or active participants in collaboration, while other members of the team were located as subordinate to physicians. Paradis et al. draw a direct connection between patterns of language and implicit values in health care. In their analysis, doctors were linguistically placed in active positions, while other
professions such as nursing were often linguistically placed in a passive position in relation to doctors and collaboration, or amalgamated into a non-specific category and thus erased. In current and historical writing about interprofessional collaboration in *Medical Education*, power and professional hierarchies were implicitly enacted in writing about interprofessional collaboration, primarily by centring physicians as key players. The authors conclude that when issues of power in collaboration are ignored, the essential systematic conflict inherent in interprofessional collaboration is obscured and thus collaboration is unlikely to be successful in achieving its articulated goals. While Paradis and Whitehead provide compelling analysis of reified medical hegemony in writing about collaboration, they do not make any note of gender in their analysis.

### 1.1.4 Power and Gender

Gender refers to socially constructed roles and behaviours of men and women and gender diverse people (people who identify as a gender that is different from man or woman, such as people who are agender, transgender, or gender fluid) (Canadian Institute for Heath Research, 2018). Gender influences power and resource distribution in society (CIHR, 2018). Gender is distinct from biological sex, which describes a set of physical and physiological attributes. Gender affects how people perceive others and are perceived, and how they act and interact, and those social interactions and expectations influence how individuals and groups can access power.

Historically, the role of nursing has been characterized as feminine, versus a masculine construction of medicine. Nursing was feminized because the work was carried out by women and because it involved caring, which has traditionally been ascribed to a feminine role (Nelson & Gordon, 2009; Ogren, 2001). Nursing work was often performed by women who came from lower class or immigrant backgrounds, putting them in an additionally disadvantaged position (Peplau, 1966). Contemporary nursing work has become socialized by these gendered expectations, and has also become role-socialized to reinforce nursing work as nurturing and conflict-avoiding (Nelson & Gordon, 2009; Peplau, 1966; Warelouw, 1996). Medicine, which, since the late 1800’s, was the purview of men educated in exclusive medical schools, involved adopting the masculine traits of being decisive and taking action (Warelouw, 1996). This led to medicine being socially constructed as associated with men and masculinity, and nursing with women and femininity. Historically, as men had more presence and capacity to influence
medicine and the subordinate profession of nursing than women did, a patriarchal system of power developed (Warelow, 1996).

Medicine and men’s domination over nursing and women stems from socialized gendered roles in society (Dombeck, 1997; Stein, 1967; Taylor–Seehafer, 1998; Warelow, 1996), as well as from efforts by physicians to discredit or control nursing knowledge and education (Peplau, 1966; Seenandan-Sookdeo, 2012; Sweet & Norman, 1995; Witz, 1992). Peplau (1966); Taylor–Seehafer (1998), Warelow (1996) argue that nurses are complicit in their own domination due to socialization and that nurses accept domination by physicians and institutional rules. These outdated arguments are no longer common in the literature, as arguing that nurses are complicit in their own subjugation is a case of blaming the victim (Bowman, 1993). Rather, an alternative argument is that nurses operate within the constraints of a patriarchal system, and nurses’ actions reflect the limited choices available within a constrained patriarchal system (Ogren, 2001).

1.1.5 Gender and Interprofessional Collaboration

In Canada, nursing is the largest health care profession and remains dominated by women. In 2016, there were 298,743 registered nurses in Canada (Canadian Institute for Health & Information, 2016), more than five times the number of physicians, and 92% of nurses were women (Canadian Nurses Association, 2018). Conversely, in 2017 the overall gender composition of medicine was 42% women (Canadian Medical Association, 2017). While the gender composition of medicine has shifted significantly over time, medical culture continues to promote stereotypically masculine characteristics such as decisiveness as hallmarks of professional competence (Warelow, 1996). While women have entered medicine in unprecedented numbers, a comparable infiltration of nursing by men has not occurred, since only 8% of nurses were men in Canada in 2016 (Canadian Nurses Association, 2018). Nursing remains a profession that is not desired by men, which suggests there is a gendered penalty for men who enter nursing.

Stein (1967) and Supper et al. (2015) argue that gender is no longer relevant between nurses and physicians because medicine has become a mixed gender profession. The authors seem to make two assumptions: first, that women physicians do not have gendered relationships with nurses, and second, that men physicians no longer enact power from gender when women are part of the profession. Their argument suggests that the presence of women physicians eliminates gendered
behavior towards nurses by both men and women physicians. While gender influences may be more obvious when a profession consists of a homogenous sex, the idea that gendered behavior is only enacted between genders obscures the many ways in which within-gender interactions across power differentials can disrupt or enforce gender roles (Davies, 2003; Gjerberg & Kjølstrød, 2001; Wear & Keck-McNulty, 2004). Historically, gender was relevant to the effectiveness of interprofessional collaboration, and gender continues to be relevant to interactions between nurses and physicians, even as medicine has become a mixed-gender profession. Gender and professional hierarchy interact to create entwined hierarchies of power between nurses and physicians.

Bell, Michalec, & Arenson (2014) offer a theoretical and historical analysis based on expectation states theory of why gender matters to interprofessional collaboration. They characterise gender as a status inequity, since stereotypes lead people to ascribe less value to women and more value to men. The authors propose that gender inequities are reproduced in interprofessional collaboration and may hinder the success of the collaboration. Bell et al. conclude that gender hierarchy is a current and critical aspect of collaboration that must be addressed to improve interprofessional collaboration.

1.2 Historical Background of Nurse-Physician Relations and Collaboration

Now that I have established context for power, hierarchy and gender in interprofessional collaboration, I turn to the history of nurse-physician relations and the collaboration between them. Power, hierarchy and gender are woven into the history of nursing and medicine, and inform the effectiveness of collaboration today.

1.2.1 Nurse-physician relations: a gendered and hierarchical history

Interprofessional collaboration in health care occurs between people in professional settings built from historical practices, and historical events influence current health care structures (Reeves, Macmillan, & Van Soeren, 2010). An exploration of the collaborative relationships between nurses and physicians must first consider the historical patterns of professional relationships. In Canada, the USA and the UK, physicians became organized as a profession in the late 1800’s, well before nursing. The College of Physicians and Surgeons of Ontario and the Canadian
Medical Association were formed between 1847 and 1869 (Reeves, Macmillan, et al., 2010). Nursing was historically slower to organize professionally, in part because of early control by physicians over nursing work (Keddy, Jones, Burton, & Rogers, 1986; Reeves, Macmillan, et al., 2010; Witz, 1992). In Ontario, nurses achieved self-regulation as a profession in 1963 (Reeves, Macmillan, et al., 2010).

Florence Nightingale is credited with creating ‘modern’ nursing in the late 1800’s. She advocated for middle and upper-class women to take up nursing as a respectable profession. Nightingale described the nurse’s roles as assisting medical superiors and maintaining a hygienic environment for patients. She originated the phrase ‘handmaiden’ as it applies to nursing (Nightingale, 1859). Gender was used to shore up threatened power relations in medicine by positioning nursing as feminine:

In the particular case of nursing, the structure of the profession and everyday work relations in it inscribe patriarchy in a particularly pristine way. (Gamarnikow, 1986)

Of necessity, because women could not yet vote, and because family structures were patriarchal, physicians became de facto men patriarchs of working nurses (Kitson, 2001). Patriarchal relations between the physician, nurse and patient echoed power dynamics in patriarchal families of father, mother, child. The nurse role was expected to embody the values of a ‘good woman’, and her work included traditional domestic tasks of hygiene and cleaning. (Gamarnikow, 1986). Nurses were positioned as ‘handmaidens’ to physicians, and nursing work consisted of helping the physician and following orders (Keddy et al., 1986; Peplau, 1966). Nursing was subordinate to medicine in a hierarchical relationship, a relationship which also reflected the patriarchal relationships between men and women and the sexual division of labour reflected common patterns of sexual division of labour of the time before World War II (Keddy et al., 1986; Peplau, 1966; Sweet & Norman, 1995). At the time, women physicians were “something of an embarrassment” (p. 160, Pringle, 1996), because they could not claim group membership with men physicians, nor with nurses, because in each case “they were on the ‘wrong’ side of the gender divide” (p. 160, Pringle, 1996). Peplau (1966), writing about nursing in the United States, reported that most nurses were not troubled by their subordinate position but rather were grateful for the opportunity to learn. Keddy et al. (1986) on the other hand, historically described nurses
engaged in subversive acts of care not ordered by physicians, suggesting that nurses in Canada, at least, were not content with the status quo.

Continuing from the late 1800’s through several pathways, medicine came to supervise and control the profession of nursing, maintaining the notion that medicine was a pursuit for men only (Keddy et al., 1986; Peplau, 1966; Witz, 1992). For instance, physicians composed committees that made policy and expenditure decisions that affected nursing work (Devine, 1978). Physicians also directed nursing work and reinforced the gender stereotype of nurses as compliant helpers. These stereotypes were reproduced through hospital organization policies that impacted nursing work (McMahan, Hoffman, & McGee, 1994).

Up until world War II physicians also controlled how nurses were trained and educated, (Keddy et al., 1986; McMahan et al., 1994) especially in hospital-based nursing schools (Peplau, 1966; Sweet & Norman, 1995). Medicine aimed to control nursing knowledge, while still having access to their expertise and role in providing healthcare (Pringle, 1996). By controlling nursing education, medicine was able to control the amount and depth of nurses’ learning, “and therefore the product of the teaching” (p. 62, Peplau, 1966). Physicians also influenced nurse hiring practices in hospitals and private practice, and would hire ‘good’ nurses who pleased them (Keddy et al., 1986; Peplau, 1966). This enabled physicians to hire nurses who were more obedient and compliant (Peplau, 1966) and allowed physicians to maintain patriarchal control over nursing activities. Physicians coerced compliance through control of hiring and requesting specific nurses for work shifts (Keddy et al., 1986; Peplau, 1966). In early nursing, physicians controlled almost every aspect of nursing work.

As Peplau (1966) describes, after World War II, there was a significant shift in nursing education. The G.I. bill (also called the Servicemen’s Readjustment Act; G.I. initially stood for ‘Government Issue’ but also became a signifier for the American Army (Olson, 1973)) in the United States enabled masses of returned army nurses to attend baccalaureate and graduate level degree courses at college-level institutions. Ex-army nurses had had greater professional autonomy, and funded nursing programs began to give rise to expert nurse clinicians and educated nurse educators. In the late 1940’s physicians began to complain that nurses were overeducated and that physicians were no longer being asked to teach nurses (Peplau, 1966). As nurse education shifted to collegiate schools, the focus of nursing education shifted from the
meeting the needs of the physician and hospital, and began to focus on the needs of the nurse-learner. Previously, nursing students at hospital nursing schools had been required to work for low or no wages as a requirement of their education. The focus of nursing work also shifted fundamentally, from ‘handmaiden’ to an advocacy role based on ‘the needs of the patient’ (Peplau, 1966).

Writing in 1966, Peplau reported a steady growth of publications in nursing starting from the 1940’s. College-educated nurses had been educated in a philosophy that promoted nursing autonomy, and saw themselves as competent independent practitioners. However, Peplau also wrote of continued barriers to this newfound nursing autonomy. Nurses continued to have their activities restricted by physicians. Nurses who witnessed unethical practice by physicians felt unable to report, as physicians controlled the reporting investigation process. To promote professional autonomy through systemic change, Keddy et al. (1986) proposed that nurses should join hospital committees, promote university-level nursing education, and advocate for higher salaries in order to challenge gendered work expectations and move towards being recognized as equal team members in current nursing practice.

Through the 1960’s to present day, the status of nursing has continued to shift for several reasons. Physicians have become less revered, while feminism has brought attention to inequities in the status of women in society and at work. Advance practice nursing and expanded educational requirements have also shifted the status of nursing in relation to physicians (Price, Doucet, & Hall, 2014; Stein, 1967; Sweet & Norman, 1995), though no authors claim that medicine and nursing have achieved equal status. Despite these changes, Taylor–Seehafer (1998), writing in the late 1990’s, reported that nursing education at the time had not taught nurses to trust their own judgement, ideas, or values, and lack of self-esteem was an accepted characteristic of nurses. (Taylor–Seehafer, 1998) also notes that nursing expertise was devalued in professional settings. Status differences and hierarchy between nursing and medicine have affected nursing work and relationships between nurses and physicians over their entire professional histories.

In a literature review characterizing the socio-historical context of the relationship between nursing and medicine, (Price et al., 2014) identified several common narratives. They found that nursing and medicine were often positioned in opposition to each other, despite a long history of
working in close proximity. Further, they commented that physicians have been revered for their knowledge and perceived as key decision makers in health care, while nursing has been socially positioned as inferior to medicine, despite improvements in nursing status over recent decades. The authors also characterized a more recent narrative of nurse-physician collaboration, where improved relations between the professions can result in better outcomes for patients, promote staff retention and increase job satisfaction. Price et al. warn that changes to the way nurses and physicians relate professionally require policy and legislative changes from health care organizations, professional bodies and institutions. In other words, effective collaboration requires systemic change and not merely skilled individuals. In this narrative of collaboration, relationships between nurses and physicians are not immutable despite their history of knowledge, power and gender hierarchies.

Historical gendered and hierarchical structures of power between nurses and physicians influence hospital and health care roles, responsibilities and communication, so the broader social context in which nurses and physicians do their work, as well as direct power hierarchies, influence professional collaborative interactions (Paradis et al., 2014; Reeves, Lewin, Espin, & Zwarenstein, 2010). Nursing has a history of gendered patriarchal relations with medicine, and the effects of that long history is still evident today in the structural and interpersonal relations between the two professions. The historical origins of current day relations and structures must be considered in research about interprofessional collaboration. To characterize how nurse-physician relations have affected collaboration, I turn next to the history of collaboration between nurses and physicians.

1.2.2 History of Collaboration in Health Care

Collaboration in health care has been cast as a solution to physician-nurse professional conflict (McMahan et al., 1994), as well as a solution to current health system woes. Taylor–Seehafer (1998) described the history of collaboration in her review of the collaboration literature. In the 1960’s and 70’s, collaboration through interdisciplinary health teams was considered to be economical and efficient, and the literature on collaboration at the time focused on organizational theory and team functioning. Collaboration with physicians was seen as a potential threat to growing nursing autonomy. Conflicts over medical dominance and nursing authority to practice were evident (Taylor–Seehafer, 1998). During the 1980’s, nurse-physician relationships were a
focus of research, and barriers to collaboration were explored. The hierarchical relationship between medicine and nursing continued to affect collaboration. At the time, the women’s movement inspired nurses to become more assertive, autonomous and accountable. Barriers to collaboration identified in the literature at the time were medical hegemony over nursing practice and nurses’ complicity in their own powerlessness due to their discomfort with responsibility and their behaviours of indirect communication (Taylor–Seehafer, 1998). In the 1990’s, literature on collaboration continued to grow, and writing about collaboration shifted towards representing more collegial relations between nurses and physicians (Taylor–Seehafer, 1998). However, power dynamics between the professions were still in evidence and flat hierarchies for collaboration were lacking. (Taylor–Seehafer, 1998). In her review Taylor-Seehafer draws connections between nurse-physician relationships, feminism and advancing nursing-specific research.

Several authors note that hierarchical communication patterns affect collaboration. Stein (1967), argued that both nurses and physicians worked to preserve an impression of medical omniscience. Nurses avoided making direct recommendations to physicians, and physicians avoided directly requesting information from nurses. Taylor–Seehafer (1998) suggests that traditional patterns of communication maintain hierarchical power dynamics. Baggs & Schmitt (1988) also identify communication as a significant contributor to successful collaboration. They conclude that a pattern of dominance and deference between physicians and nurses led to poor communication, and poor communication led to increased costs. Coeling & Wilcox (1994) made express links between professional communication styles and the historically gendered history of nurses and physicians. They propose that male/physician communication is task-based, and that males/physicians consider the purpose of communication is to improve status. In contrast, female/nurse communication is relationship-based, and nurses communicate to exchange ideas. They propose that gendered norms influence professional standards for behaviour and communication in both nursing and medicine.

Coeling & Wilcox (1994) contrast nurse and physician communication styles thus: nurses believe they are providing in-depth relevant information about patients, while to the physician nurses are being imprecise. These authors reveal an implicit bias when they make recommendations to improve communication between the professions. They propose that nurses can compromise to improve their collaboration skills by learning to present “only relevant
content in organized ways” (p. 53), while physicians can compromise to improve collaboration “by looking directly at nurses and acting as though they are interested in hearing what nurses have to say about patients” (p. 53, my italics). Having pointed out that the origins of communication patterns within each profession was gendered, they unselfconsciously then propose that nurses take up more male communication patterns. Indeed, the authors’ solutions reinforce medical hegemony, since nurses are encouraged to take up physician standards of communication, while physicians need only pretend (i.e. ‘act as though’) an interest in nurses’ professional reports.

The suggestion that nurses need to change their behaviours in order to be respected by physicians (Stein, Watts, & Howell, 1990; Taylor–Seehafer, 1998) is not uncommon in the literature, and is based on the assumption that indirect communication results from the cowardly or evasive characteristics of individual nurses and their inability to be professionally succinct. This assumption misdirects attention away from the work context and blames the individual. The result of this redirection is that patriarchal rules and expectations of the institution go unseen and unexamined. Indeed, Stein (1967) wrote about the harsh personal and professional consequences of nurses who spoke out in his time, and Keddy et al. (1986) described similar consequences for nurses who practiced in the 1920’s and ‘30s. In a more subtle form, in contemporary articles, individual nurses still face consequences for expressing professional opinions (Coombs, 2003; Gilardi, Guglielmetti, & Pravettoni, 2014; Miller et al., 2008) or speaking out. Indirect communication can therefore be an adaptive strategy for nurses, and not a personal or professional failing (McMahan et al., 1994). To understand interprofessional collaborative relationships between nurses and physicians, we must attend to the constraining effect of context and hierarchical power relations on nursing work.

In more contemporary writing about collaboration and power (D’Amour, Ferrada-Videla, San Martin Rodriguez, & Beaulieu, 2005), the authors describe effective collaboration as a true partnership created through negotiation and flat hierarchies, noting that it is not sufficient to simply bring people together. The authors explored the determinants of collaboration, and characterized collaboration as an opposing force to the ‘professional system’. In the professional system, professions strive for power, autonomy and control, but in their review the authors see equality between professionals as a hallmark of collaboration. They note that collaboration is impeded when there are power differences based on social status and gender stereotypes.
Perhaps unsurprisingly, due to their different locations in the professional hierarchy, nurses and physicians have different experiences of collaboration and different attitudes towards collaboration, as seen in two separate reviews. In the first review, (Sollami, Caricati, & Sarli, 2015) noted a decrease in difference in attitudes towards collaboration by the two professions over time, which the authors suggest is related to organizations successfully working to improve collaboration. Physicians reported fewer problems with collaboration and more satisfaction. Physicians perceived more existing collaboration than nurses did (Sollami et al., 2015), and physicians were more likely to rate the quality of collaboration as high compared to nurses (Tang et al., 2013). Conversely, nurses felt collaboration was more important than physicians did (Sollami et al., 2015; Tang et al., 2013). Tang et al. reported that physicians conceived of collaboration as nurses who enacted physician orders, while nurses, on the other hand, were dissatisfied with their lack of autonomy and thus with the quality of collaboration. Unequal power was one of the factors both sets of authors identified that influenced physician and nurse attitudes towards collaboration, and both sets of authors recommended policy and regulatory changes to grant nurses more autonomy in clinical decision making to address unequal power between the professions (Sollami et al., 2015; Tang et al., 2013). These results suggest that physicians perceive more collaboration and rate it higher quality because they occupy the dominant position in the hierarchy and do not struggle to do their work under the status quo. Nurses, on the other hand, want more, higher quality collaboration that results in nurses having more power and authority over patient care. Nurses bump up against the higher authority of physicians and find collaboration processes more frustrating. From both reviews, the key point is that nurses’ and physicians’ experiences of collaboration are influenced by their position in the hierarchy of professions.

Falk-Rafael (1996) enters the debate about caring and nursing from a different angle. She genders both power and caring. Power is consistent with masculinity, while caring is consistent with femininity. These constructed norms affect nursing, because there is a patriarchal relationship between power and caring. She argues that power and caring are contrary identities when caring is assimilated by patriarchy. Power can only be accessed by taking on masculine characteristics, which, in nursing knowledge, means leaving behind personal experience as knowledge and embracing a medical model of positivist research.
While the role of gender in professional hierarchies has become more complex as the gender composition of medicine has changed, gender is still a formative factor in interprofessional collaboration, whether it is acknowledged or not. Medicine has a history of being monolithically masculine, just as nursing has a history of being monolithically feminine, and the impact of this gendered history continues to impact interprofessional relationships. The profession of medicine continues to reproduce a gendered masculine orientation of authoritative professional behaviours, while the profession of nursing is still associated with subservience and caring, stereotypically feminine traits. In interprofessional collaboration, I argue that both gender and hierarchical power mediate professional relationships, and that they collide to be mutually reinforcing. Published literature about interprofessional collaboration between nurses and physicians often fails to consider influence that hierarchy and gender have on nurses’ and physicians’ ability to collaborate, and thus potentially patient outcomes. This is the gap in the literature to which this research aims to contribute.

1.2.3 Sociology of the Professions

(Freidson, 1988) defined professions as occupational categories that require specialized skills and knowledge and thus theoretical understanding and discretionary judgment to employ. The skills and knowledge of a profession are acquired through university-level education, which differentiates professions from a trade or craft. Other hallmarks of a profession are state-given control over education and professional control over knowledge production. Professional control of knowledge is intended to codify and develop a body of knowledge to serve their profession and to remain professionally relevant (Freidson 1988, 2001). Professional control over knowledge production and control over what knowledge is valued in the professional sphere is part of establishing and maintaining a profession.

Professions compete for control over the tasks and boundaries of their work in an interrelated system of professions, such as health care, with conflict over competing territorial claims arising from interactions with other professions (Abbott, 2014). Control over professional tasks and professional knowledge is a defining characteristic of professional status. Applied to collaboration in healthcare, Abbott’s work highlights why members of various professions are likely to protect and control the skills and knowledge of their profession as they jockey for
jurisdictional control, regardless of policies or norms requiring the professions to work together collaboratively.

Collaboration in a health care work environment by its nature brings together different health care professionals. However, some scholars argue that healthcare professions come from different social and historical locations, and are inherently structured hierarchically in relation to one another (Freidson, 1988; Witz, 1990). This dynamic sets the precedent to understand how different health professionals collaborate during interprofessional practices. For example, in a qualitative review of articles on collaboration between physicians and nurses in hospitals (Tang et al., 2013), several studies note how modern day nurse-physician interactions are affected by the traditional role of nurses as subservient to physicians. In addition, Witz (1992) highlights how the profession of nursing is also subservient to medicine due to gendered historical origins (Witz, 1992). Witz’s work highlights the importance of understanding the role of gender as a contributing factor in reproducing hierarchical power relations amongst the health care professions. Says Witz, “the gender relations of patriarchy assume historically, culturally, spatially variable forms” (p.10, Witz, 1992), meaning that the influence of patriarchy is pervasive but the form of patriarchy is variable.

1.2.4 Occupational Closure Theory

Witz’s (1992) theory of occupational closure describes how the interactions between the professions are influenced by institutionalized gendered hierarchies of power. According to Witz, professions use strategies to protect or expand their professional boundaries, control access to resources, and maintain professional autonomy. For Witz, this protection and expansion occurs through closure strategies. Professions with greater control and institutional power will leverage this power in order to limit the capacity of other professions in accessing resources and control over their work. For Witz, the relationship between gender and closure needed to be surfaced in order to understand how both gender and class influenced professionalization processes.

In the following section, I draw on the work of Freidson (1988), Abbott (1988), and Larson (1977), to explore the characteristics of the professions and the historical process that shape the relationships between the professions. As these theories neglect the role of gender, I draw on the
work of Witz (1990, 1992) to explore how contemporary collaboration in nursing is influenced by historical hierarchy and gendered relations between the professions.

The term ‘professional project’ was coined by Larson (1977) to describe how a profession controls the market for a specific expertise by credentialing members and creating a need for its services. The term bounds a profession into an entity with concrete and historical limits. Professionalization was, in her view, a process of joining a specialized knowledge base to market forces for social and economic gains. A profession’s power arose from their ability to negotiate for market monopoly using profession specific, specialized knowledge (Larson, 1977). In Professions and Patriarchy, Witz (1992) expanded Larson’s concept of professional projects by redefining occupations as concrete, historical processes bounded by gendered institutionalized hierarchies of power, which are, in her model, defined by patriarchal capitalism. Witz is careful to distinguish between structures and strategies. Constraining structures prevent women from accessing certain resources of power. This lack of access arises from codified rules in institutions that benefit men or disadvantage women. Courses of action in this environment become gendered strategies when actors attempt to navigate access to power. Strategies to advance the professional project are enacted through tactics, with the purpose of acquiring power and control over aspects of their work.

Arguing that woman-dominated professional projects use different strategies and achieve different results than man-dominated professions do, Witz (1992) described how gendered occupational closure strategies are used by professions to enclose specific knowledge and skills within their professional scope. In the simplest form, dominant groups use exclusionary strategies “excluding [women] from routes of access to resources such as skills, knowledge, entry credentials, or technical competence” (p. 44, Witz, 1992). such as requiring specific certifications to define and limit their membership, while subordinate groups use inclusionary strategies to attempt to enter and join the dominant space. For example, women in the late 1800’s and early 1900’s aspired to attend medical school and wrote the exams to become certified physicians. They pressured governments to change the laws (an inclusionary strategy) that prevented women from attending university (and thus from becoming physicians) in order to gain entry to the exclusive all-men space of medicine and become physicians (Witz, 1992).
A dominant occupational group can also use demarcationary closure strategies of inter-occupational control to create and control boundaries between the professions through “the encirclement of women within a related but distinct sphere of competence in an occupational division of labour, and, in addition, their possible (indeed probable) subordination to male-dominated professions” (Witz 1992, p. 45). The creation and maintenance of interprofessional boundaries may have patriarchal power consequences, and therefore gender is an important factor is considering the form and ultimate outcome of demarcationary strategies. Nursing is an example of a distinct, related and subordinate gendered profession in relation to medicine. Therefore, according to Witz, physicians will use strategies in their relations with nurses that delineate and enforce a separate subjugated sphere of work, and these strategies will be gendered and often exclusionary. Nurses will also use gendered strategies to try to navigate the patriarchal system and advance their professional power.

A subordinate group such as nurses can also be expected to use usurpationary strategies that push upwards against limits from medicine and exclusionary strategies that push downwards to prevent other occupations from entering their jurisdiction to protect their jurisdictional space (Figure 1). This dual closure strategy involves a bi-directional exertion of power in response to demarcationary pressures. (Witz, 1992). Usurpation is a counter-strategy to a dominant exclusion strategy. When dominant-group strategies are gendered boundary creation and control may be mediated by patriarchal power (Witz, 1992). Gendered strategies can be expected when the actors are gendered, when entry to the professions is restricted by gender, and when gender is the basis of solidarity in the profession (Witz, 1992).
1.2.5 Occupational Closure Theory and Nursing

Witz’s occupational closure theory is useful in this research, first, because it brings a historical view to understand the influence of gender in shaping the professional work between physicians and nurses. Secondly, her work provides a mechanism for identifying patriarchal structures in health care institutions that favour doctors, medicine, and medical knowledge, and subordinate nurses and nursing knowledge. Witz’s theory provides a lens to view the actions of physicians and nurses as gendered responses to institutional structures with historical roots, and as means to reproduce or challenge hierarchical power structures that privilege the dominant group.

Examples of strategic actions to navigate professional hierarchies are evident in the literature. For example, Salhani and Coulter (2009) describe how nurses in a mental health team advanced professional autonomy and professional dominance through micro-struggles to gain administrative, organizational and content control over their work while using exclusionary tactics to prevent other professions from entering their jurisdictional space. While dual closure
strategy was not specifically mentioned, the dual use of usurpationary and exclusionary strategies described in the paper exemplifies Witz’s occupational closure theory.

Occupational closure theory has been applied in research on a variety of settings in health care (Baker, Egan-Lee, Martimianakis, & Reeves, 2011; Hollenberg & Muzzin, 2010), and thus provides a useful lens to consider how institutional structures and gendered strategies are represented in writing about interprofessional collaboration. Witz’s theory of occupational closure genders the context and purpose of the use of power in interprofessional relationships, and points to professional actions as being intended to protect and expand control over work.

Through Witz’s occupational closure theory, collaboration can be imagined as a space where professions attempt to consolidate power for their professional project and compete for professional power using institutional structures and tactical actions which may also be gendered. In my research, I looked for evidence of power enacted through hierarchies and gender and I sought examples of strategies and tactics used by individuals and groups to advance their own profession’s professional project. In categorizing tactics and strategies as exclusionary or inclusionary, demarcationary or usurpationary, I demonstrate how gender and professional hierarchies are evident in writing about collaboration, even when authors do not specifically address power, gender or hierarchy in their writing.

Interprofessional collaboration involves “respect, trust, shared decision making, and partnerships” (Orchard et al., 2010), which, for nurses, is an opportunity to step out from a subordinate professional position, while for physicians involves diminished hierarchical authority. In this situation, based on Witz’ theory, I expect that physicians would use exclusionary and demarcationary tactics to maintain authority in collaborative settings, and I expect nurses to use usurpationary tactics to try to access greater professional authority and autonomy.
Chapter 2
Methods

2 Methods – Directed Content Analysis and Constant Comparative Analysis

2.1 Methodology

My historical analysis is located in what Hacking (Hacking, 1999) has called a “rebellious constructionist paradigm”. In a constructionist understanding of knowledge, scientific knowledge is not an objective and absolute understanding of the world, but represents current and historical social contexts, and thus is seen as constructed in a particular social space which influences how and what is studied, known, and valued (Hacking, 1999). Rebellious constructionists critique current and historical understandings of a concept and advocate for transforming the current construction of the object or idea. In my research, I shine a light on the role of power and gender in influencing the strategies nurses and physicians use to navigate interprofessional collaboration. I analyzed top-cited articles over the life course of three nursing research journals and a journal about interprofessional collaboration, and I used Witz’s theory of occupational closure to guide directed content analysis as I constructed an interpretation of how writing about professional hierarchies and gender in interprofessional collaboration has changed over time.

In keeping with my epistemological stance as a critical scholar, I distinguish between biological sex and socially constructed gender. Biological sex (relating to external genitalia and described with the words male, female, intersex) is not relevant to this research. In this writing I use words that describe constructed gendered roles, such as men/women, masculine/feminine, except when I quote or refer to authors’ use of words that signify sex or gender, in which case I will use the words of the author.

2.2 Data Collection and Analysis

2.2.1 Data Collection strategy

In Canada, nursing practice is informed by research from both the Canadian and international communities. I sampled top-cited articles at regular intervals from the entire publication history of two leading Canadian nursing research journals, the Canadian Journal of Nursing Leadership.
and *The Canadian Journal of Nursing Research*. As these journals are comparatively small publications, I also sampled top-cited articles from the *Journal of Advanced Nursing* and the *Journal of Interprofessional Care*, which are highly-ranked international nursing research and collaboration journals, respectively (Table 1). These journals are widely known, research-based, and peer-reviewed journals, and were selected in consultation with Canadian nursing scholars to be representative of the field of nursing scholarship.

Table 1

*Journal Information and Journal Search Results*

<table>
<thead>
<tr>
<th>Journal</th>
<th>Inception Date</th>
<th>Publication schedule</th>
<th>Current Impact Factor 2016</th>
<th>Country of Publication</th>
<th>Journal holdings</th>
<th>Total IPC articles</th>
</tr>
</thead>
<tbody>
<tr>
<td>Canadian Journal of Nursing Leadership</td>
<td>Early 1990's</td>
<td>4 issues per year</td>
<td>N/A</td>
<td>Canada</td>
<td>From January 1999</td>
<td>88 (Scopus)</td>
</tr>
<tr>
<td>Canadian Journal of Nursing Research</td>
<td>1969</td>
<td>4 issues per year</td>
<td>N/A</td>
<td>Canada</td>
<td>As Nursing Papers/Perspectives en Nursing from 1967-1987, as CJNR from 1988 to present</td>
<td>288 (Scopus)</td>
</tr>
<tr>
<td>Journal of Advanced Nursing</td>
<td>January 1976</td>
<td>12 issues per year</td>
<td>1.917</td>
<td>UK</td>
<td>From 1976</td>
<td>2746 (Scopus)</td>
</tr>
<tr>
<td>JIC</td>
<td>1986</td>
<td>6 issues per year</td>
<td>2.205</td>
<td>United Kingdom</td>
<td>As Holistic Medicine, 1986-1991, as JIC 1992 to present</td>
<td>1161 (Scopus)</td>
</tr>
</tbody>
</table>

Using the Scopus database, I searched the entire publication record of each journal for common search terms related to interprofessional collaboration. These search terms were developed from previous research (Paradis & Reeves, 2013) (Table 2). To sample articles over time, articles from each journal were divided into 10-year intervals beginning from July 2017 back to the inception of each journal. To reduce bias in citation rates due to time-since-publication, I created two 5-
year slices for the most recent 10 years, from 2008-2012 and 2013-2017, to collect more recently published articles that may be significant but not yet have high citation counts.

Journal articles are a major format for research ‘conversation’, representing the exchange and critique of knowledge and ideas to advance scientific thought. In selecting the most-cited articles from each journal over their history, I reviewed the papers that most influenced researchers and thus contributed most to developing the current construction of knowledge about interprofessional collaboration. Articles with fewer than five citations were excluded as they were not considered to be influential in the conversation of nursing and interprofessional collaboration.

Table 2

<table>
<thead>
<tr>
<th>Journal</th>
<th>Search Terms</th>
</tr>
</thead>
<tbody>
<tr>
<td>CJNL, CJNR, JAN,</td>
<td>(interdisciplinar* OR inter-disciplinar* OR interprofessional* OR inter-professional* OR multidisciplinar* OR multi-disciplinar* OR multiprofessional OR multi-professional* OR transdisciplinar* OR trans-disciplinar* OR transprofessional* OR trans-professional* OR team* OR collabora* OR (integrated delivery of care) OR (interprofessional relations) OR (health care teams))</td>
</tr>
<tr>
<td>JIC</td>
<td>(interdisciplinar* OR interdisciplinar* OR interprofessional* OR interprofessional* OR multidisciplinar* OR multidisciplinar* OR multiprofessional OR multiprofessional* OR transdisciplinar* OR transdisciplinar* OR transprofessional* OR trans-professional* OR team* OR collabora* OR (integrated delivery of care) OR (interprofessional relations) OR (health care teams)) AND (nurs*)</td>
</tr>
</tbody>
</table>

Citation data for each IPC article for all four journals was collected from the database Scopus (Elsevier) and exported to Excel spreadsheets. Within each journal sample, articles were sorted by publication date and then citation count, and the most-cited articles in each 10-year or 5-year interval were reviewed manually for relevance to IPC (see selection criteria below). Irrelevant articles were discarded and the next most cited was reviewed until five relevant articles were identified for each time interval.
Early issues of one journal, the *Canadian Journal of Nursing Leadership* (pre-1998), were not held by any database or the U of T library. Attempts to contact the original publisher by phone and in person in Ottawa failed. Data analysis therefore did not include early articles published by that journal.

All selected articles were imported into the text analysis program MAXQDA for qualitative data coding and analysis. The final collection included 10 articles from the *Canadian Journal of Nursing Leadership*, 10 from the *Canadian Journal of Nursing Research*, 25 from the *Journal of Advanced Nursing*, and 20 from the *Journal of Interprofessional Care*, for a grand total of 70 articles (Table 3).

**Table 3**

*Citation Range of Included Articles in Each Series and Journal*

<table>
<thead>
<tr>
<th>Journal</th>
<th>Date Interval</th>
<th>Number of articles</th>
<th>Citation range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Canadian Journal of Nursing Leadership</td>
<td>Series 1 2013-2017</td>
<td>0</td>
<td>n/a</td>
</tr>
<tr>
<td></td>
<td>Series 2 2008-2012</td>
<td>5</td>
<td>12-30</td>
</tr>
<tr>
<td></td>
<td>Series 3 1998-2007</td>
<td>5</td>
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<td>Journal of Interprofessional Care</td>
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<td>5</td>
<td>15-27</td>
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<td>5</td>
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</tr>
<tr>
<td></td>
<td>Series 5 1978-1987</td>
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</tr>
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</table>
2.2.2 Inclusion and exclusion criteria

To identify relevant articles, I adapted criteria from a previous review of interprofessional research (Paradis & Reeves, 2013). I included articles that assessed or discussed collaboration between health care practitioners of different professions in regards to care as a major component of the paper, then narrowed my focus to collaboration between nurses and physicians only. Research collaboration, collaboration for knowledge translation and collaboration to implement evidence-based practice were also excluded, since the focus of this thesis is on care delivery. Articles about interprofessional education were also excluded, as were articles about intra-professional collaboration (including between nurses and nurse-practitioners, as they are both nursing professions regulated by the same body), given the focus on inter-professional collaboration. Future research might choose different points of focus, and thus use different criteria.

2.2.3 Data Analysis

2.2.3.1 Coding

All articles were coded using directed content analysis (DCA), the goal of which is to validate or conceptually develop a theory or framework (Hsieh & Shannon, 2005). DCA is a systematic coding method where initial categories are derived from a theoretical framework and operational definitions of each category are developed. The initial coding framework is then refined iteratively as analysis progresses (Figure 2). In this method, theory informs the initial coding framework and findings provide supporting and non-supporting evidence for the theory. This method also encourages new findings and theory development through an iterative and responsive coding process. My initial coding framework was derived from Witz’s occupational closure theory (Witz, 1992). Initial categories were: institutional structures that influence nurses in IPC, types of closure strategies described by nurses, evidence of professional hierarchies, and the influence of gender on collaboration (Appendix A). My final coding categories included concepts such as professional knowledge, caring, and trust (Appendix B). Additional thoughts and observations were noted in memos both within the coding program MAXQDA and in a reflective journal. For each article I also noted the name, profession, and affiliation of the first and last author of each article, as well as the professions involved in collaboration and the area of practice of the collaborative enterprise as described by the authors.
1. Identify key concepts of the theory as initial coding categories
2. Generate an operational definition for each category
3. Code document with predetermined codes
4. Review and refine codes iteratively throughout coding process
5. Generate new codes for uncoded text

Figure 2. Process of Directed Content Analysis

After all articles were coded, I decided to exclude all seventeen quantitative papers from this analysis as there was a major disconnect between the qualitative and quantitative literatures. Specifically, in the quantitative articles collaboration was defined and measured in ways that were incompatible with my research question. One further article (Smith, Tallman, & Kelly, 2006) was excluded because all quotes were converted into numerical scales and quantitatively analyzed. Nine review papers were also excluded, since they are not a consistent whole: they weave the voices of many authors together. It was difficult to determine how review authors conceptualized gender and hierarchy distinctly from the work of authors they reviewed. 46 articles remained in my data set from my original corpus, and I evaluated all of the quotes in the remaining articles for pattern and meaning. The vast majority of articles discussed nurse-physician collaboration or included nurses and physicians, so I decided to focus on nurse-physician relations. Three further papers were excluded due to this decision, leading to a final set of 43 articles. The distribution of the final set of articles by journal is shown in Figure 3.
In content analysis, text is envisioned as a representation of interpersonal exchange of ideas, and the effect of that dialogue (Vaismoradi, Turunen, & Bondas, 2013). The purpose of data analysis is to interpret meaning from how the text is represented as a communication tool (Vaismoradi et al., 2013). After my initial rounds of coding were finished, I began to abstract codes into categories and sub categories of related ideas, which became my themes and subthemes. I selected quotes from within my coding categories to support my emerging themes of hierarchy and gender.

2.2.3.2 Historical Patterns of Closure Strategies

Following directed content analysis to identify occupational closure strategies I inductively compared findings using Boeije's (2002) constant comparative method. I looked for patterns in topics of research within and between the four journals, and for changes in how power through professional hierarchies and gender have been depicted by authors of the selected articles. Because my final data set had an uneven distribution across the initial 10 year intervals, I used the publication date of the influential report *To Err is Human* (Kohn et al., 1999) by the Institute of Medicine as a dividing line for comparison through time. The report was published in 1999, and had a significant influence on the perceived importance of interprofessional collaboration as a means to reduce preventable medical errors, though much of that effort has gone into
improving patient systems rather than human factors (O’Daniel & Rosenstein, 2008). In my data set, 13 articles were published before the year 2000, and 30 were published in the year 2000 or later.

2.3 Reflexivity

I am an outsider to nursing; however, I have experience working in health care as part of a woman-dominated profession from attending midwifery school. My own epistemological location is feminist critical scholar. I am interested in examining historic and current power dynamics between the professions, to characterize the structures that limit professions and the actions taken to challenge or navigate these limiting structures.

Though I don't know nursing well, my whole professional life has been shaped by gender. In my first profession, I was a fully-qualified young dynamic woman science teacher, and I lost my job when the principal offered my job to someone else (a man, unqualified) as a permanent position. She did this because she thought I would probably love being a mother so much that I would not come back from parental leave. I left midwifery school due to a pregnancy-induced chronic health problem, and I recently took a semester off during my degree to care for a parent through a health crisis, as many women do when their parents get older. As I study the way that gender is variously acknowledged or ignored in writing about nursing and interprofessional collaboration through time, I experience echoes of my own travel through my professional life in my own gendered body. I see women facing power and hierarchy at work, women performing gendered caring roles. I am familiar with the ways that gender, in small ways and large, affects the work, power, and professional trajectories of women. My own experiences of being a woman struggling with imposed gendered limitations in professional settings has influenced my choice of research questions in this research project, and more importantly, pushed me to take on a critical research stance. In this investigation, I hope to illustrate how power, hierarchies and gender are represented in writing about interprofessional collaboration involving nurses.

Hacking (1999) writes that the social space is affected by current and historical contexts. In health care, the relationship between medicine and nursing, physicians and nurses, has origins that were strongly decided by hierarchical authority and gendered roles. When that hierarchical and gendered history is not acknowledged to have an influence in the present, it becomes impossible to identify how hierarchical relations are currently enforced and therefore, how to
effectively change them. In examining hierarchies and gender in interprofessional collaboration, I hope to influence what is studied, known, and valued about hierarchical power relations in interprofessional collaboration.

2.3.1 Limitations

In my research I aimed to investigate articles that contributed to the research conversation about interprofessional collaboration, with a focus on Canada. I selected three nursing journals (two Canadian, one international) and a journal of interprofessional collaboration. Further research could explore how gender and hierarchy are represented in a more international collection of journals, or focus on trends in national research publications. I elected to include only articles with five or more citations, in keeping with my aim to analyze research that resonated in the nursing and interprofessional collaboration research communities. Given the invisibility of gender in interprofessional collaboration in my dataset, articles about gender and collaboration may have been cited less frequently than topics of greater interest to the research community, and thus been excluded. Future research on whether articles about gender and collaboration are less cited is warranted.

My decision to use Witz’s occupational closure theory for my theoretical framework directed my attention to problems of power. While Witz’s conflict theory allowed me to characterize problems of collaboration as gendered structural barriers rather than individual failings, the theory limited my ability to theorize about effective collaboration and examples of successful teams.
Chapter 3
Results

3 Descriptive and Thematic Analysis

3.1 Description of my Data Set

I selected two Canadian nursing journals (Canadian Journal of Nursing Leadership, CJNL and The Canadian Journal of Nursing Research, CJNR), an international nursing journal (Journal of Advanced Nursing, JAN), and an international journal on interprofessional health care (Journal of Interprofessional Care).

In the seven articles from CJNL that met inclusion criteria, all first authors have nursing certifications except one, a medical student (Smith, 2006). Research in all studies was conducted in Canada. Four articles concerned nurse practitioner integration, three of which came from a special supplement on the nurse-practitioner role. Two articles addressed issues of nursing scope and role, and one considered nurse decision making in care.

Five articles met my inclusion criteria from the journal CJNR. All first authors had nursing certifications, and all research was conducted in Canada. Research topics included two articles on palliative care and one each on genetic nursing, leg ulcers, and a single theoretical paper. While interprofessional collaboration was not the main focus of any of the articles from either of the two Canadian journals, interprofessional collaboration was considered in each of the articles.

15 articles from JAN were included in my document analysis. Authors of all articles but three (Evers, 1977; Gilardi et al., 2014; Miller et al., 2008) have nursing qualifications, and eight of fifteen articles had interprofessional collaboration as the primary focus of the article. Five articles had research set in Canada, three in England, and one each in Ireland, Italy, Norway and the Netherlands. Several papers were about different aspects of nurse-physician relations (6), while two concerned geriatrics. Two articles were concept analyses—one on collaboration and one on teamwork, and two articles were on the topic of discharge planning. There was also a paper on emotion work in general internal medicine, and one on nurse-practitioner integration.
In the journal *JIC*, degree qualifications were not listed until 2005, and even then not regularly included for the sixteen articles in my set, so I am not able to report consistently on author professional qualifications. Of the seven articles with degree qualifications listed, only two have a lead author with a nursing certification. In this journal, the research of eight articles was located in the UK, three in Canada, and one in each of Sweden, New Zealand, and Australia. Common article topics were team interactions and communication (6), and professional identities and collaboration (7). The remaining topics were new physicians learning skills from nurses during care and patient participation in care.

Even beyond the Canadian journals, where one would expect Canadian research to be published, Canadian research on interprofessional collaboration is well represented in the international journals. There is a possible trend that research about nursing and collaboration in the journal *JIC* is frequently not authored by people with nursing qualifications though only seven of 16 articles listed author qualifications. Furthermore, *JIC* has only two of 16 titles with the word nurse or nursing in it, while *JAN* has just over half, at eight of 15. This may be partially explained because *JIC* is not a nursing journal, however, as part of my inclusion criteria for *JIC*, I specifically selected articles where nursing was a significant part of the research.

### 3.2 Thematic Analysis

As I coded all of my documents, I was struck by my infrequent use of the code ‘gender’. I wanted to know how often authors referred to gender in my data set, where in the article they referenced gender, and what role gender played in their article. I developed a system of three degrees of visibility of gender for my first theme, *The invisibility of gender*. Authors discussed gender in their analysis in Degree 1: *Gender as an analytic construct*. In Degree 2: *Gender as an incidental or participant characteristic*, I placed articles where gender was mentioned in relation to participants or in the introduction but not the analysis section of the article. Degree 3: *Invisible gender*, contains all of the articles where gender did not appear.

My second theme, *Interprofessional hierarchies in nursing work are reinforced by gendered strategies*, developed as I noticed that physicians located nursing work as ‘in service’ to physician work. Nurses, on the other hand, described obstacles to sharing their professional opinions, and used strategies such as avoiding conflict and presenting their ideas in ways they felt would be taken up by physicians. Themes 2a, *physicians ascribe the role of handmaidens to*
nurses and 2b, *Nurses ‘play the game’ to access power in the professional hierarchy*, illustrate gendered strategies used by members of each profession as they jockey for power in interprofessional collaboration.

### 3.3 Theme 1: The Invisibility of Gender

This theme discusses how gender is represented within my data set. In order to flag the studies in which gender was considered, I used the following terms to search all articles in the data set: sex, gender, male, female, men, women, masculine, feminine. Out of 43 articles, 18 made at least one mention of words related to sex or gender. I created coding categories based on degree of reference to gender. In the first degree, gender is used as part of the authors’ analysis and the author makes a meaningful statement regarding gender and interprofessional collaboration (4 articles, 9%); in the second degree, gender has an incidental mention or is used to describe study participants and is not factored into authors’ analysis, (14 articles, 33%); and in the third degree, there is no mention of gender throughout the research paper (25 articles, 58%). Overall, very few authors used gender in their analysis, about a third of authors mentioned gender incidentally, and the majority of authors did not mention gender at all. Reporting about gender in interprofessional collaboration is relatively rare in my data set.

<table>
<thead>
<tr>
<th>Articles Classified by Degree of Significance of Gender</th>
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</thead>
<tbody>
<tr>
<td>Author</td>
</tr>
<tr>
<td>--------</td>
</tr>
<tr>
<td>Degree 1</td>
</tr>
<tr>
<td>Devine, B.A.</td>
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<td>Keddy et al</td>
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<tr>
<td>Dombeck, L.</td>
</tr>
<tr>
<td>Burford et al</td>
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<tr>
<td>Degree 2</td>
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<tr>
<td>Evers, K.</td>
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<td>Name</td>
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<tr>
<td>Waters, K.L.</td>
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<td>Oberlé, K., Hughes, D.</td>
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<td>Kvarnstrom, S Miller, K.-L., et al</td>
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<td>Suter, E. et al</td>
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<td>Reeves, S. et al</td>
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<td>Kaasalainen, S. et al</td>
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<td>Gelinas, C, et al</td>
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<td>Bleijenberg, N., et al</td>
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<tr>
<td>Lègaré, et al</td>
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<tr>
<td>Allen, M.</td>
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<tr>
<td>Udén, G., et al</td>
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<td>Jones, R.V.H.</td>
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Degree 3 Invisible Gender
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<th>Journal</th>
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<tr>
<td>Meyer, J.</td>
<td>Lay participation in care: A challenge for multidisciplinary teamwork</td>
<td>1993</td>
<td>JIC</td>
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<td>Pearson, P., Spencer, J.</td>
<td>Pointers to effective teamwork: Exploring primary care</td>
<td>1995</td>
<td>JIC</td>
<td>N/A</td>
</tr>
<tr>
<td>Boblin-Cummings, S., et al</td>
<td>Critical elements in the process of decision making: a nursing perspective.</td>
<td>1999</td>
<td>CJNL</td>
<td>N/A</td>
</tr>
<tr>
<td>Bull, M.J., Roberts, J.</td>
<td>Components of a proper hospital discharge for elders</td>
<td>2001</td>
<td>JAN</td>
<td>N/A</td>
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<tr>
<td>Hudson, B.</td>
<td>Interprofesionality in health and social care: The Archilles' heel of partnership?</td>
<td>2002</td>
<td>JIC</td>
<td>N/A</td>
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<tr>
<td>Parke, B., Brand, P.</td>
<td>An Elder-Friendly Hospital: translating a dream into reality.</td>
<td>2004</td>
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<td>Martin-Misener, R., et al</td>
<td>Collaborative practice in health systems change: the Nova Scotia experience with the Strengthening Primary Care Initiative.</td>
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<td>CJNL</td>
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<td>Lorimer, K.</td>
<td>Continuity through best practice: Design and implementation of a nurse-led community leg-ulcer service</td>
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<td>Coombs, M., Ersser, S.J.</td>
<td>Medical hegemony in decision-making - A barrier to interdisciplinary working in intensive care?</td>
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<td>Bottorff, J.L., et al</td>
<td>Establishing roles in genetic nursing: Interviews with Canadian nurses</td>
<td>2005</td>
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<td>Hall, P.</td>
<td>Interprofessional teamwork: Professional cultures as barriers</td>
<td>2005</td>
<td>JIC</td>
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<td>Oelke, N.D., et al</td>
<td>Nursing workforce utilization: an examination of facilitators and barriers on scope of practice.</td>
<td>2008</td>
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<td>Xyrichis, A., Ream, E.</td>
<td>Teamwork: A concept analysis</td>
<td>2008</td>
<td>JAN</td>
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<td>Pullon, S.</td>
<td>Competence, respect and trust: Key features of successful interprofessional nurse-doctor relationships</td>
<td>2008</td>
<td>JIC</td>
<td>N/A</td>
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<tr>
<td>Akeroyd, J., et al</td>
<td>Perceptions of the role of the registered nurse in an urban interprofessional academic family practice setting.</td>
<td>2009</td>
<td>CJNL</td>
<td>N/A</td>
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<td>Donald, F., et al</td>
<td>Clinical nurse specialists and nurse practitioners: title confusion and lack of role clarity.</td>
<td>2010</td>
<td>CJNL</td>
<td>N/A</td>
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<td>DiCenzo, A., et al</td>
<td>Utilization of nurse practitioners to increase patient access to primary healthcare in Canada--thinking outside the box.</td>
<td>2010</td>
<td>CJNL</td>
<td>N/A</td>
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<tr>
<td>MacKinnon, K.</td>
<td>Learning maternity: The experiences of rural nurses</td>
<td>2010</td>
<td>CJNR</td>
<td>N/A</td>
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<tr>
<td>Kilpatrick, K., et al</td>
<td>Conceptual framework of acute care nurse practitioner role enactment, boundary work, and</td>
<td>2013</td>
<td>JAN</td>
<td>N/A</td>
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</table>
perceptions of team effectiveness

<table>
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<tr>
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<th>Year</th>
<th>Journal</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gillespie, B.M., et al</td>
<td>Team communications in surgery: creating a culture of safety</td>
<td>2013</td>
<td>JIC</td>
<td>N/A</td>
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<tr>
<td>Gilardi, S., Guglielmetti, C., Pravettoni, G.</td>
<td>Interprofessional team dynamics and information flow management in emergency departments</td>
<td>2014</td>
<td>JAN</td>
<td>N/A</td>
</tr>
</tbody>
</table>

(dotted line indicates division after the 1999 publication date of the report *To Err is Human*)

3.3.1 Degree 1: Gender as an analytical construct

In this category, four authors, Devine (1978, *JAN*), Keddy et al., (1986, *JAN*), Dombeck (1997, *JIC*), and Burford et al. (2013, *JIC*), make a meaningful statement regarding gender and interprofessional collaboration. Each of these authors also acknowledges the historical influence of gender on nurse-physician relations. I will discuss each article in depth in chronological order.

**Devine. 1978. Nurse-physician interaction: Status and social structure within two hospital wards**

While not mentioning gender in her background writing, Devine (1978) poignantly brought gender into her final analysis of status and social structures in nurse-physician interactions in a hospital setting. Devine anticipated Witz’s gendered interpretation of the professions and linked earning disparity between nurses and physicians to sex-based division of labour that is reinforced by economic class:

> The economic gap that exists between physicians and nurses presents a major problem within the organizational structure. There are multiple factors, which must be considered, pertaining to this economic disparity, an important one being that physicians are primarily male and nurses predominantly female. The male and female inequality is a sexual division of labour reinforcing the class system. (p. 293, Devine 1978) *JAN*

Devine further noted that physicians, who earned much more than nurses, were able to access power in the hospital setting. This gendered income and status gap limited nurses, as nurses were not able to accumulate wealth from their earnings and were not able to leverage their lower status to secure autonomous control over their work in the hospital. Limited power over their own work influenced nurses’ work and worth, and contributed to maintaining the class order between physicians and nurses (Devine, 1978). Interpreted through Witz’s occupational closure theory,
nurses’ lesser earnings and lack of autonomy is the result of interrelated exclusionary and
demarcationary class and patriarchal structures that allowed physicians to limit nursing work and
declare nursing work as worth less than physician work.

**Keddy et al. The doctor-nurse relationship: an historical perspective.**

Keddy et al’s (1986) grounded theory study contained the most comprehensive discussion of
gender and professional work of any in the set. The authors used Stein’s (1967) gendered
conception of “the doctor-nurse game” to frame their understanding of nurse-physician
relationships in the 1920’s and 30’s, as the following quote shows:

> For years nurses have longed for the opportunity and encouragement to use their
> knowledge, intellect, judgement and viewpoint in the workplace to improve care
delivered to patients. Nurses have felt they have more to offer than what they
> have been permitted to give. Why have they been relegated to this subservient
> role? Could it be in part because of the rules of the ‘doctor-nurse game’? (Stein
> 1967). (p.748, Keddy et al., 1986) J-AN

Nurses reported having knowledge they were not permitted to contribute towards patient
decision making. The authors characterized nurses as being limited by gendered expectations of
behavior and communication that protect the image of physicians as omniscient practitioners.
Keddy et al. derived three general rules for nurses that align with Stein’s ‘game’: “Rule 1: Show
doctors respect” (p 748), “Rule 2: Nurses cannot openly diagnose or make recommendations to
doctors” (p 749), “Rule 3: No open disagreement or confrontation allowed” (p.749). Rules 1 and
3 are demarcationary strategies that reinforce nursing as a lesser profession under the control of
medicine, while Rule 2 is an exclusionary tactic that prevents nurses from entering the diagnostic
arena and acquiring professional legitimacy or autonomy over diagnosis.

Physicians had the professional power to assume an educational role over nurses and to use
hiring practices to encourage nurses to comply with the rules of ‘the game’, a practice Keddy et
al. (1986) say contributed to gendered relationships between nursing and medicine:

> It was found that because nurses were educated primarily by doctors and because
> they were hired by doctors if they were considered to be ‘good’ nurses, a sex role
> stereotype of the nurse emerged. Historically these roles have influenced and
> continue to influence the nursing profession. (p.745 Keddy et al., 1986)
Physicians' hiring discretion over a work done exclusively by women served to sexualize the profession. Keddy et al. also note how the desirable qualities of a good nurse parallel the conception of a good wife:

Thus we can see that nursing depended greatly on the approval of the physicians at its outset, and the doctors had the power to either prove or disprove nursing's worth. Worthiness was equated with helpfulness to the doctors, much as the wife was considered to be the appendage of the husband since she was his helpmate. From the beginning we can see a marked power differential or gradient between nurses and doctors related to the sexual divisions of labour in society (Navarro 1977) (p.746, Keddy et al., 1986) J-4N

This comparison positions nurses as simultaneously in a professional hierarchy and a gendered hierarchy. From the authors’ descriptions of early nursing, nurses were dependent on physicians for work opportunities, and work opportunities were related to successfully performing their work to a gendered nursing standard defined by physicians. From these highly gendered origins, when physicians had near total interprofessional control over nursing work, Keddy et al. identified the historical impact of sex role stereotypes as a fundamental influence on nurses’ status in professional relationships:

What each profession is taught about the other - that is, role expectations, place in the hierarchy and duties - affects the doctor-nurse relationship and interactions and reflects the sex and class distinctions of the society. The women in this study provided facts which constitute history. They were part of a sex-segregated labour force and they occupied low-paying positions. (p.750, keddy et al., 1986), J-4N

In order to transform this vexing situation, which they saw as continuing during the time of publication in 1986, Keddy et al. make suggestions for improved interprofessional relationships that align with Witz’s occupational closure theory of usurpationary strategies. For instance, the authors suggest that nurses join organizational committees in hospitals and governments. The authors also support the move to higher education and higher pay for nurses. In essence, the authors argue that nurses should work to make structural change in order to access more decision-making power professionally. They warn that physicians may not support nursing’s move towards more autonomy because it encroaches on medicine’s territory and involves a loss of power and status for medicine. While gender is an essential element of analysis in this article, the authors do not specifically address how nurses should navigate institutional structures of power which are likely to be gendered and therefore also a setting in which nurses may be required to ‘play the game’.

In *Professional personhood: training, territoriality and tolerance*, Dombeck (1997, *JIC*) explain that gender plays a role in interprofessional relations, as “professional personhood” is socially constructed and informed by the history and training of professions. Dombeck defines professional personhood as the idea that roles and relationships are enacted in professional arenas and learned through training and professional groups over time. Dombeck describes how this socialization into professional roles affects interprofessional collaboration:

…interprofessional relations will involve general social issues like territoriality, authority, integrity and gender (my emphasis). Superimposed on these are added issues of professional language, historical traditions, belief systems and ethical values. (p.10, Dombeck 1997), *JIC*

Dombeck (1997) argues that professional personhood—professional role training—gets in the way of effective collaboration. She locates Stein’s ‘doctor-nurse game’ within a brief historical overview of professional training for nursing as a suitable career for women, and one that is often in moral and ethical conflict with medicine due to their respective training on how to manage illness:

“Yet, when physicians and nurses find it most difficult to work together, it is not only because of differences in theoretical models but also, and especially because of, their learned understandings of who they are and how they are expected to be toward their patients and other professionals. (p. 11, Dombeck, 1997) *JIC*

Gender is a factor in interprofessional relations because it is a social issue that informs professional identity; an identity that is learned and reinforced in their training programs and placements. Dombeck continues:

Most physicians and nurses, whatever their level of cooperation and collaboration, know how to play ‘the doctor-nurse game’ (Stein, 1967). Both groups see their concerns in terms of ethical issues, because they see discrepancies between how they ought to act and how circumstances permit them to act (p. 11, Dombeck, 1997) *JIC*

Here, Dombeck suggests the doctor-nurse game arises from a conflict between their professional personhood values and the system in which they actually work. Later, Dombeck acknowledges gender as a factor that affects individuals and their relationships, which thus has the potential to impact interprofessional relationships:

“Professional personhood does not refer to attributes or qualities of a person; rather it is a process that a particular individual experiences and integrates into
other personal processes and experiences. For example, as a lay person becomes a nurse through a long series of training experiences acquired over many years, he or she gradually takes on the role and actions of a nurse. She becomes known as Jane Doe, the nurse. If he is a man from the United States where less than 5% of nurses are men, he might think of himself as a nurse, but others might call him ‘the male nurse’ because the history of nursing, and the ascribed image of nursing, is female. This will influence his and other’s experiences of his professional personhood, including his interprofessional relationships.” (p.11, Dombeck, 1997).

Dombeck contextualizes gender as being both an individual characteristic, as in the case above of ‘the male nurse’, and also as a structuring factor that influences how individuals learn to take up their professional roles during professional training and work. She concludes by saying that paradigms are leaned in groups, and only interventions that shift cultural norms will be effective in improving interprofessional collaboration. Like Witz, Dombeck argues that structural forms must shift, but unlike Witz she does not go so far as to suggest that gendered strategies are required to effect change. Instead, she recommends “cultural sensitization” and normative change (p. 20, Dombeck, 1997).

Burford et al. 2013. Newly qualified doctors’ perceptions of informal learning from nurses: implications for interprofessional education and practice

In Burford et al’s (2013, JIC) article, gender was a consideration throughout the article. Two thirds of their sample were women physicians. In their methods, the authors reported that they looked for explicit references to gender and implicit gendered language in their data. They found one report of a gendered event, of a new physician who felt she had been treated differently than her man clinical partner by a consultant on account of her gender. Based on their initial scan the authors concluded they had no basis for a gender-based analysis of their results.

Though the authors noted that other researchers have found that gender is still relevant to medical students and physicians, Burford et al. concluded that gender had become less relevant to the interprofessional hierarchy between nurses and physicians as the gender composition of medicine has changed. However, since their study was only about physicians, they had no way to determine the gender of the nurses their informants interacted with, or whether nurses perceived gendered dynamics. The authors also proposed that their informants may not have been consciously aware of gender issues as their new identity as physicians may have been more important and salient than gender identity at the time of the study. The authors appear to have
understood gender as an individual characteristic affecting individual interactions, and did not consider that gendered relations between nurses and physicians also operates at the interprofessional and system level.

3.3.2 Degree 2: Gender as an incidental or a participant characteristic

In this category, gender is mentioned in a less meaningful way: either incidentally, or used to describe study participants without being factored into authors’ analyses. Of fourteen articles fit in this category, eight studies reported sex or gender in describing their study population only (Table 4).

A further six articles refer to gender inconsistently. In one paper, A participant observation study of power relations between nurses and doctors in a general hospital (1991, JAN), author Porter acknowledged gendered historical relations between nurses and physicians in the introduction to the article. “From its inception as an organized occupation in the nineteenth century, nursing was subordinated to medicine along the lines of the sexual division of labour.” (p.728, Porter 1991), The author explains that nurse-physician relations were very similar to Victorian patriarchal family relationships. However, despite the explicit claim of observing power in interprofessional interactions, the author does not describe seeking or finding gender effects in interactions between nurses and physicians, though they do list the gender of each participant. I placed this study in Category 2 because gender is only present as a historical concept.

In a paper on multidisciplinary teams in geriatric care Evers, (1980, JAN), made a single mention of gender in a parenthetical reference to another author’s work on gender and class order in multidisciplinary teamwork.

Several papers listed the gender of some participants but not all participants. In these cases, when gender was given, it was always to denote men. In Freeman (2000, JIC), the only mention of gender in the article described a male nurse who frequently shared his nursing perspective when he felt the situation required it, in contrast to other nurses who avoided challenging medical decisions, but whose gender is not provided in the text. The authors described nurse-physician interactions:

Direct challenge was rarely seen. However, one male (my emphasis) nurse (who had been in a managerial position in industry) frequently put the nursing perspective forward (or information related to other professional input) if he felt
the decisions being made required it. He felt that all nurses should be prepared to challenge since it ensured that decisions were made on the most comprehensive basis. He was seen to encourage other nurses on the ward to address consultants in the way he did:

“And I think a lot of the time if they know that you are going to talk straight to them, they’ll accept it. But if you’re going to fumble around the bushes, or they know you’ve got a weak spot then that’s it.” (p.243, Freeman et al, 2000, JIC)

The relative privilege of a male nurse pushing back at physicians was not acknowledged. Reeves, (2009, JIC) gave the gender of only two health care practitioners (described as male both times) after two quotes but not for any other quotes in the article. In a different twist on reporting gender of some participants but not others, Kaasalainen (2011, CJNR) interviewed patients, family of patients, and care providers, and listed the gender of patients only. Kaasalainen seems to indicate that the important marker for care providers is their profession, while for patients it is their gender.

In the paper *Nursing emotion work and interprofessional collaboration in general internal medicine wards: a qualitative study* (Miller et al., 2008), gender as an interpretation is absent. This finding is remarkable, since the subject of research is emotion work. Emotion work has been characterized as gendered from the very origin of the term (Hochschild, 1983; James, 1989). In fact, in the entire paper, feminine was the only gender-related word found, and it was used just once, in the background section, as the authors summarised relevant literature:

Consequently, as used here, nursing emotion work includes compliance with display rules associated with the profession’s ideological image of kindliness, feminine nurturance and the suppression of irritation towards patients and physicians (Smith 1992, Mecribeau & Page 1998, Morgan & Krone 2001, Skjørshammer 2003, Mann 2005) (p. 333, Miller et al., 2008, JAN)

Furthermore, the authors cited Stein (1967), and yet did not make reference to the gendered nature of the doctor-nurse game, either:

“Re-examining the doctor–nurse game (Stein 1967, Stein et al. 1990) in light of the emotion work that underpins indirect communication between the professions reveals novel understandings of rules governing overt disagreement.” (p. 334, Miller et al., 2008) JAN

While the authors claim to ‘reveal novel understandings of rules governing overt disagreement’, they make no mention of how disagreement is gendered, which causes their conclusions to run counter to their own citation of Stein (1967). Thus, their relative silence on gender is all the more
remarkable. In leaving gender out of evaluating nursing emotion work, the authors erase a structural element of emotion work, and allow the patriarchal structures that locate emotion work as a feminine/nursing expectation to go unchallenged and unnamed.

3.3.3 Degree 3: Invisible Gender

Only 18 of 43 articles in my data set had at least a mention of gender (Degrees 1 and 2), meaning that 25 articles (58%), the majority of my data set of articles about nursing and interprofessional collaboration in my four selected journals did not use the words gender, sex, masculine, feminine, men, women, male, or female. This silence is striking, indicating limited consideration in the literature concerning gender as a current or historical factor in interprofessional relations between nurses and physicians.

One article, (Coombs & Ersser, 2004) is particularly worthy of note in the ‘invisible gender’ category as the author elected to cite Stein’s 1967 ‘doctor-nurse game’, a model of gendered hierarchical relationships between nurses and physicians, without actually discussing gender directly. Stein referenced gender roles as an influencing factor on ‘the game’, and so it would make sense for gender to be considered in the analysis of authors who use his concept.

The topic of Coombs and Ersser’ (2004) ethnographic study was medical hegemony as a barrier to interdisciplinary work in intensive care. However, the authors made no reference to the historical gendered origins of medical hegemony and did not mention either sex or gender in their paper. This absence is all the more striking as, by the authors’ own report, nurses in the study reported using indirect strategies of communication which the authors relate to Stein’s (1967) work on the doctor-nurse game.

“Nurses in the study spoke of the need to understand and ‘play the game’ of that forum if they are to have an active input into clinical management. Through such game playing, nurses had to conform to the norms and values of medicine – the dominant culture – in order to create opportunities to contribute to clinical decision-making. This is entirely consistent with the solutions originally offered by Stein (1967), although in more recent work Stein et al. (1990) observed that younger nursing and medical staff were now cooperating more effectively without playing games.” (p. 251, Coombs and Ersser, 2004) J-AN

Gender cannot be separated from the history of nursing and medicine, and was a major factor in creating medical hegemony historically (Peplau, 1966). Additionally, Stein wrote of gender effects in ‘The Doctor-Nurse Game’ (1967). Coombs and Ersser’s paper exemplifies the silence
3.3.4 Over Time, Gender Analysis Becomes Less Common

I used the publication date of the American report *To Err is Human* (1999), a report that called for effective interprofessional collaboration to reduce preventable errors in health care, to consider differences before and after. In Table 4, a dotted line indicates the publication date of the report. Overall, only 13 articles in the data set were published before the year 2000, and gender was invisible in 7 of those (53%), while of the 30 articles published during or after the year 2000 gender was invisible in 19 (63%). In writing about interprofessional collaboration after *To Err is Human* was published, the appearance of even a single word about gender fades compared to before the report.

While discussing power in professional hierarchical relationships is common in the literature across time, few contemporary articles about interprofessional relationships between nurses and physicians consider the role of gender in either the literature review or analysis. In my discussion below I will speculate on how the broader cultural context may have contributed to these shifts.

Three of the four papers of Degree 1, where gender was considered in the analysis, were published before the year 2000. These three papers where gender is used analytically, represent 23% of all papers published before the year 2000 in my collection (13 articles were published before the year 2000, of 43 total in the data set). Authors of the fourth article, published in 2013, considered gender as an analytic lens and decided it was not needed, despite a participant who reported a gendered incident. Of the 30 articles published in the year 2000 or later in my data set only Burford et al. (2013) considered gender for analysis (3%), and in that paper, the authors elected not to actually pursue a gender analysis. Over time, serious consideration of the effects of gender appears to be acutely diminishing.

Of the articles in Degree 2, where gender was considered incidentally or to list gender of participants only, eight articles only gave gender in relation to describing the participant population. One paper of note was published before the year 2000. In Porter (1991), despite being a participant observation of power between nurses and physicians, gender was not considered in the analysis. For three papers in this category (Freeman, 2000; Kaasalainen et al.,
2011; Reeves et al., 2009) where some participants (men) were described by gender and others left unmarked, all were published after the year 2000. In this category, gender appears to slip from view both before and after the year 2000.

I observed no patterns over time in Degree 3, ‘invisible gender’. Seven of the 13 articles published before 2000 were in degree 3 (53%), while 19 of 30 articles published after the year 2000 (63%) did not contain gender words. The majority of articles published before and after 2000 did not mention gender.

In the introduction to Patriarchy and the Professions Witz explains she wrote the text because she felt that that previous thought on sociology of the professions ignored the effect of patriarchy on professionalization. She felt that the sociology of professions offered limited analytic capacity when patriarchal structures in professional projects were not acknowledged. The works of Miller et al. (2008) and Coombs and Ersser (2004), discussed above, are extreme cases of gender being overlooked in otherwise thoughtful and critical analyses. However, those two authors are not outliers. In my data set, very few authors considered gender as a factor in their analysis. Why is the influence of gender as an avenue of power disregarded in the interprofessional collaboration literature? I will propose some reasons in my discussion.

3.4 Theme 2: Interprofessional Hierarchies in Nursing Work are Reinforced by Gendered Strategies

As discussed in the introduction, present day hierarchical relationships between physicians and nurses have their origins in the past (Peplau, 1966), and relationships of power are enacted during interactions between individual nurses and physicians. In my data, authors described how the hierarchies between physicians and nurses was reinforced by gendered strategies. As the dominant profession, physicians placed nurses in a service role to their own work, a phenomenon I describe in the first subtheme, 2a, Physicians ascribe the role of ‘handmaiden’ to nurses. As the subordinate profession, nurses made a strategic response to access power and influence care despite their subordinate role, as seen in the second subtheme, 2b, Nurses ‘play the game’ to access power in the health care hierarchy.
3.4.1 Theme 2a. Physicians ascribe the role of ‘handmaiden’ to nurses

Florence Nightingale, founder of modern nursing, conceived of nurses as ‘handmaidens to physicians’ (Nightingale, 1859). In this model of care nurses are workers in service to physicians and to the goals of medicine. For instance, of retrospective interviews of nursing practice in Canada in the 1920’s and 30’s, Keddy et al. (1986) wrote:

The role of the nurse in early days was not described in terms of patient care but in terms of proficiency with which she [the nurse] carried out the physician's orders. Good nursing care was often equated with efficient fulfillment of doctor’s orders (Kalish & Kalish 1977). It appears that even the most progressive and humanitarian physicians had perceptions of nurses as handmaidens. (p 748, Keddy et al., 1986) J-AN

“Good” nursing care met the needs of physicians, and nurses were not encouraged to have opinions about patient care. While the previous quote described early-twentieth century relationships between physicians and nurses (i.e. 1920’s-30’s), the next quote from the turn of the millennium illustrates a very similar attitude of nurses’ service to medicine. A physician described nursing as “boring” tasks completed for the physician:

“And so if part of that process involves the practice nurse taking blood, I wouldn't really feel a great bond and sense of gratitude, you know ‘we couldn’t have done it without that,’ because actually she would only have been doing a job I could have done myself, I'm just delegating the boring bit to her.” (p. 244, Freeman et al., 2000) JIC

Here the physician indicated he was in charge of nursing work and could delegate tasks, and also implied that the nurse was doing menial work to free up the physician for more interesting or important work. In the same paper, another physician described a nurse who was a commendable because she did what was needed so the medical work could be done:

When asked about people who stood out as effective team members, he described a ward sister whom he had greatly valued because:

“She knew exactly what I wanted, where everything was, and was willing to run around and get it while we sorted this chap out.” (p244, Freeman et al, 2000) JIC

Collaboration is frequently defined as shared goals and shared decision-making (Orchard et al., 2010; Petri, 2010). For this physician, teamwork involved the ward sister knowing what he needed and being willing to take on a service role. Her work was separate and only relevant in how it was in service to the physician’s work of ‘sorting the chap out,’ or understanding what was going on with the patient. The work of anticipating the physician’s needs and fetching
needed items were what qualified her as a team member of note. The physician values the nurse for her ability to serve as handmaiden and does not mention her professional knowledge, opinions or skills.

In the following quote, nurses prioritize physicians’ needs as they wait to use shared computers at the nursing station:

In all hospitals, status differentials appeared to influence the sharing of computers at the nursing station. Nurses often waited to use the computers while seated medical residents checked not only patient results, but personal email accounts and commercial internet sites. (p.337-8, Miller et al., 2008)” J-A-N

The nurses were literally ‘waiting on’ the residents as the residents mobilized their superior status in the professional hierarchy. In an even more recent article, nurses became a depersonalized tool for physician skill acquisition:

“At the end of the day, I’ve got to learn this stuff, so you start pestering people, you go and see nurses... they’re quite good for teaching.” (newly qualified physician) (p. 397, Burford et al., 2013)” J-I-C

Through choice of language, the newly qualified physician turned nurses into an object for his purpose of acquiring skills. The nurse’s own workload and priorities are ignored in service to the physician gaining needed skills. The implication is that the nurse is there to serve the needs of the physician, whose (learning) priorities take precedence over nursing work.

Of the quotes discussed above in this sub-theme, I propose that in the first three quotes physicians demonstrate occupational closure strategies that demarcate nursing work as a separate and subjugated work. Nurses were expected to meet the needs of the physician, lacked agency over their work, and were not consulted. Physicians used demarcationary closure strategies to delineate and limit nursing work to acts of service for physicians. In the fourth quote, physicians control access to work resources (computers) and disregard nursing work needs and nurses’ time, a finding echoed in the literature (Tellis-Nayak & Tellis-Nayak, 1984). In the final quote of this sub-theme, the physician appears to be oblivious to the work responsibilities of nurses and co-opts nurses’ time to benefit their own learning, treating the nurses as ‘in service’ to the physician for physician learning needs.

Overall, physicians displayed an understanding of nursing work and nurses’ time as being ‘in service’ to medicine. This attitude is stark in articles published early in my data set and becomes
subtle as the writing becomes more contemporary, yet the intention remains the same: nurses and their work serve physicians’ needs.

Interestingly, all of the quotes in this subtheme are by physicians or authors; none are from nurses. In my data set nurses did not characterize their own work in terms of a service role. When nurses are cast in a passive and subjugated service role—as they are in the quotes above—they may turn to indirect tactics to gain access to decision making and other forms of professional power, as we see in the following theme.

3.4.2 Theme 2b. Nurses ‘play the game’ to access power in the professional hierarchy

Stein’s article, ‘The Doctor-Nurse Game’ (1967), describes an interprofessional communication strategy where a nurse must above all appear passive, and “make her recommendations appear to be initiated by the physician” (p. 699, Stein, 1967). The goal of the game is to avoid public disagreement in order not to threaten the physician’s apparent omniscience. Thus, nurses use indirect actions and indirect forms of communication to achieve their care goals for patients. The avenue to power for nurses is to subtly influence the physician’s actions while avoiding conflict, preserving the impression of medical dominance and avoiding appearances that they may threaten the hierarchy. This is what has come to be known as ‘the game’. In a follow-up 1990 article, Stein et al. reported that ‘the game’ had effectively ended due to nurses’ increased professional status, more women becoming doctors, and the relationship between nurses and physicians being “more equal” (p. 549, Stein et al. 1990). In this theme, I give examples of nurses ‘playing the game’ to access power and influence care plans as described by authors of articles in my dataset.

Publishing in 1986, Keddy et al. found the metaphor of ‘the game’ so powerful they framed their findings around the doctor-nurse game (Stein, 1967). From interviews with nurses who practiced in the 1920’s and 30’s, Keddy and colleagues concluded:

> Any show of intelligence and judgement on the nurse’s part is not seen as useful, unless it improves the doctor’s self-concept and feeling of authority. (p 748, Keddy et al., 1986) J.AN

By playing the game and building physicians’ feelings of authority, nurses were perceived as ‘good’ nurses and were rewarded with benefits such as more work shifts and employment
opportunities (Keddy et al., 1986). Despite their knowledge of individual patients and their conditions, nurses needed to avoid direct recommendations:

“Due to the amount of time nurses spend with patients relative to the time that doctors spend, physicians depend a great deal on nurses for information about their patients. However, the rules of the doctor-nurse game dictate that a nurse must never make a direct recommendation or diagnosis to a doctor. This would be considered to be maladaptive interaction (Stein, 1967). Nurses often do make recommendations about patients’ care but doctors either do not acknowledge their ideas or claim the credit for these ideas for themselves. This rule helps to maintain the omnipotent image of the physician.” (p.759, Keddy et al., 1986)

Nurses’ knowledge of the patient was positioned as essential and yet made invisible. By disguising their recommendations as those of physicians, and allowing physicians to ‘claim the credit’, nurses were able to advocate for their version of appropriate patient care while also avoiding the negative consequences of being a nurse who failed to play the game. This more adaptive strategy allows nurses to influence patient care even as they lack the professional power to challenge medical hegemony directly.

While ‘playing the game’ may feel like an anachronistic relic from olden times, I found more recent evidence of a nurse using the very same tactic in order to achieve her goal:

“I’m looking for anything to be a little off so that I can notify the doctor of things that need to be ordered…suggest things to the doctor I think should be ordered in a way so that it’s their idea…How am I going to word this so I get what I want?” (nurse)(ellipses in original text) (p.9, Boblin-Cummings et al, 1999)

In the previous quote, the nurse was explicit about ‘playing the game’ to make it seem like her ideas were in fact the physician’s ideas so that she could get what she wanted. She was describing a successful tactic. Miller and colleagues (2008) also interpreted nursing behaviour in terms of ‘the game’. Similar to nursing in the previous millennium, the authors observed nurses conforming to medical cultural norms in order to have access to clinical decision making. A series of four quotes from the article illustrate examples of nurses trying to ‘play the game’, sometimes unsuccessfully. Indeed, nurses avoided conflict and used indirect means to try to advance their professional goal of influencing clinical decision making:

However, nurses at times appeared passive in articulating their knowledge to contribute to patient management. Nurses in the study spoke of the need to understand and ‘play the game’ of that forum if they are to have an active input into clinical management. Through such game playing, nurses had to conform to the norms and values of medicine – the dominant culture – in order to create
opportunities to contribute to clinical decision-making. This is entirely consistent with the solutions originally offered by Stein (1967), although in more recent work Stein et al. (1990) observed that younger nursing and medical staff were now cooperating more effectively without playing games. (p.340, Miller et al., 2008) 

The authors chose to end this paragraph by linking to Stein’s opinion about the end of game playing between physicians and nurses even while their own nurse participants reported they continued to have to ‘play the game’ as a condition of access to decision making power. From the perspective of nurses even in their own study, however, ‘the game’ is not over, as reflected by their data.

Miller et al. drew observations from three hospitals. In two of those hospitals, nurses were protesting constraints on their participation in interprofessional rounds by not attending rounds. Nurses were not attending because they felt they were accorded low professional respect at the meetings. Unfortunately, their protest was not seen as protest:

“Physicians attributed nurses’ absences to clinical duties and scheduling conflicts. In contrast, nursing managers identified the absences as a collective strategy of ‘fighting against the system’ given nurses’ lack of protected time.” (p338, Miller et al., 2008) 

Often in a hierarchy, the dominant power does not understand the position of the subordinate profession, sometimes because it does not need to (O’Daniel & Rosenstein, 2008). In this case, the protest of nurses against the structure of rounds in the two hospitals went unheeded, since the physicians did not notice that or know why the nurses were choosing not to attend. Nurses avoided conflict and avoided challenging medical omniscience by not communicating the reasons for their discontent. Yet efforts by the nurses to bring about change was ineffective due to their lower professional status and also because their (missing) contributions to interprofessional rounds were not much valued by physicians. Their protest action was a failed usurpationary strategy stemming from lack of professional power and options.

In the third hospital studied by Miller et al., interprofessional rounds were structured differently and a nurse liaison facilitated the meetings.

“A senior physician disclosed during interview that leadership of the [IPC] meetings was contentious since the nurse liaison role ‘fostered resentment by medical house staff’ who believed that ‘when nursing leads the discussion, medicine feels they are not in control’. At this study’s conclusion, a leadership
Physicians used closure strategies to demarcate nursing participation within a constrained frame controlled by physicians. Nurses were avoiding conflict and protecting medical omniscience in not directly challenging medical control of their participation in interprofessional rounds. Nursing strategies appear gendered in that they were passive; nurses ‘played the game’. Witz described how women use different strategies to advance the professional project because hierarchical structures intersect with gendered patriarchal expectations.

### 3.4.3 Gendered Professional Strategies Over Time

In all of the quotes in Subtheme 2a, *Physicians ascribe the role of ‘handmaiden’ to nurses*, physicians displayed an understanding of nursing work and nurses’ time as being ‘in service’ to medicine. This attitude is stark in articles published early in my data set (Keddy et al., 1986), no less subtle as spoken by physicians in Freeman et al. (2000), then discussion of nursing ‘service’ becomes more subtle as the writing becomes more contemporary (Burford et al., 2013; Miller et al., 2008). Yet the intention remains the same: nurses and their work serve physicians’ needs.

Over the entire time period covered by quotes in Subtheme 2b, *Nurses ‘play the game’ to access power in the health care hierarchy*, nurses used strategies of ‘playing the game’ outlined by Stein (1967) to try to influence processes such as clinical decision making and interprofessional rounds. In both articles published before the year 2000, Keddy et al. (1986) and Boblin-Cummings (1999), ‘playing the game’ was described overtly as a successful strategy for nurses. The nurses in Miller et al.’s (2008) article struggled to find successful strategies to find an avenue for their professional knowledge to influence physician patient care. As Stein noted, ‘playing the game’ is a gendered strategy for nurses. In each quote, nurses countered physician demarcationary and exclusionary strategies with gendered usurpationary strategies such as avoiding directly challenging physicians, conforming to the norms of medicine, and making their diagnostic advice consistent with more authoritative advice.
Chapter 4
Discussion and Conclusions

4 Gender is Central to Interprofessional Collaboration and Often Overlooked

For nurses, the growing focus on interprofessional collaboration in health care has represented an opportunity to gain recognition for their contributions to patient care. Interprofessional collaboration is potentially a site of usurpationary action by nurses and the nursing profession, as they stand to gain power and legitimacy through achieving status as a formal contributor in collaboration. Witz’s theory of occupational closure therefore provides an opportunity to consider how relations between nurses and physicians are affected by both professional and gender hierarchies. In this research, I asked how the writing in journal articles about interprofessional collaboration reflects professional struggles and hierarchies, how those struggles are gendered, and how those struggles have evolved over time. Both of the themes that I developed over the course of my research engage gender as a lens through which to consider interprofessional collaboration between nurses and physicians. In my interpretation of my data, I have applied a gender lens to the work of others, but the authors themselves often have not seen the gendered dimensions of interprofessional collaboration work. In my discussion, I use Witz’s occupational closure theory and critique Stein’s 1967 article ‘The Doctor Nurse Game’. I recast Stein’s characterization of nurses and their work, and I propose some reasons why gender may be routinely omitted from interprofessional collaboration research.

In the following discussion of each theme, I will draw out the gendered aspects embedded but not necessarily noted or discussed in my collection of articles. While I began my inquiry with an eye to considering power, hierarchy and gender broadly, I found that gender was the lynchpin that reinforces and locks in professional hierarchies, and I consequently focused my research to illustrate this finding. A gendered lens is essential to understanding struggles and failures in interprofessional collaboration in health care. In closing, I conclude that omitting gender from interprofessional collaboration research is an exclusionary strategy. This strategy protects medical hegemony by obscuring gendered power hierarchies, thus making them invisible to criticism and transformation.
4.1 Theme 1: The invisibility of gender

The degree to which authors write about gender is a measure of how relevant authors think gender is to interprofessional collaboration, which is also related to the discourse in which authors locate themselves. In the utilitarian discourse, interprofessional collaboration research aims to discover how collaboration can be implemented effectively to meet health system outcome goals such as improved patient outcomes (Haddara & Lingard, 2013). This discourse, which originates from a post-positivist research paradigm, emphasizes objectivity and attempts to control for context to drive generalizable results. As a result, the influence of context, such as from gendered work environments and hierarchical interactions, is reduced or ignored. In contrast, in the emancipatory discourse, research is focused on dismantling medical hierarchy or leveling the playing field for non-medical professions (Haddara & Lingard, 2013). This discourse is characterized by overt discussions of power. My own epistemological standpoint as a critical scholar predisposes me to want to look for and talk about power, and therefore my research aligns with the emancipatory discourse. However, I argue that authors from both discourses need to consider whether gender is influencing the outcomes of their research about collaboration, regardless of whether they want to improve collaboration or dismantle power hierarchies. In the following discussion, I note how even some authors who wrote about power and hierarchy failed to include gender in their analysis in ways that I believe affect the quality of their findings, and thus the potential impact of their work.

4.1.1 Degree 1: Gender as an analytical construct

Of the four articles (9% of the data set) where gender was considered in the analysis, only two (Burford et al., 2013; Keddy et al., 1986) used gender as an analytical lens for their results. Of these two, Keddy et al. (1986) chose to centre gender as a way of explaining their findings, while Burford et al. (2013) elected to discard gender as a relevant frame for their findings (“We saw no apparent relationship between informants’ gender and their experiences, either in terms of explicit references or implicitly gendered language. Questions of gender are therefore not considered separately in the analysis, although a single case where gender was referred to is described.” (p.396, Burford et al, 2013)). Even when gender is considered in the analysis, it can
become a slippery construct. Many authors start out discussing the importance of gender, then drop the thread even though gender seems demonstrably significant to their findings.

Devine (1978) conducted an analysis of a hospital system. She found that economic inequality resulted from low professional power because nursing work was less valued and because it was done by women. Writing in 1978, she noted that nurses could not access structures of power to instigate change in their work environment. Nurses wanted change, but did not know who in their organization to approach (Devine, 1978). Devine concluded that gendered hierarchical structures limit nurses’ autonomy. Though she did not set out to identify gendered work structures for nurses, she concluded that nurses were subordinate to both doctors and hospital rules, and the work nurses were allowed to perform was much less than their training had prepared them for. Nursing work was constrained by gendered hierarchical relations enacted through both physicians and patriarchal institutional rules. It is important to note that although Devine related limits on nursing work to gender, this was a minor finding in her paper and she did not centre gender in her analysis.

Keddy et al. interviewed nurses who practiced in the 1920’s and 30’s, seeking the point of view of a subordinated profession. They interpreted their findings through a framework (Stein, 1967) that had gendered relations at the heart of the interpretation. Keddy et al. brought a feminist interpretation to Stein’s initial idea, moving the interpretive frame from Stein’s ‘unmasking’ of a phenomenon to a critical revolutionary transformative frame (Hacking, 1999). Keddy et al.’s characterization of early nursing as ‘handmaidens’ to physicians and therefore as practitioners whose work was limited by organizational structures controlled by physicians is also supported by other nursing historians (Kitson, 2001; Peplau, 1966). Keddy et al. centred gender throughout their analysis, resulting in suggestions for systemic change that included a recognition of gender’s role in excluding nurses from power.

Dombeck wrote of how professionals learn the ‘personhood’ of their profession through educational and work culture. For Dombeck, clashing professional values affect interprofessional collaboration, and therefore professions need to learn about other professions’ cultures and undertake cultural sensitization activities to build effective interprofessional collaboration. Dombeck essentially argues that training, work institutions and gender socialize professionals into their roles, and collaboration is difficult because individuals do not realize how they and
others have been socialized into their professional values. Gender is very lightly addressed as part of socialization, but not explored or considered in her recommendations for improving collaboration. Gender appears to have slid from view by the end of her paper.

The article by Burford et al. deserves particular attention, as it is the only article published post-millenium to consider gender as an analytic frame, and is therefore the only modern articulated analysis of gender. Burford et al’s (2013) study concerned informal learning by new physicians from nurses. The authors feel their results challenge the contemporary relevance of Stein’s doctor-nurse game. Their informants openly acknowledged the expertise of nurses, from which the authors concluded that unequal professional power which required game-playing was absent from the study environment between new physicians and nurses. The authors conflated knowledge hierarchy with professional hierarchy, treating them as the same. The authors acknowledged that they only interviewed physicians and that:

> Although this partial perspective is still important as it shapes their attitudes and behaviour, it must be acknowledged that aspects such as structural power relationships cannot be fully discussed with only one viewpoint. (p. 399, Burford et al., 2013, *JIC*)

In essence, they recognized that their study design did not allow for an accurate assessment of power relations, and then concluded that there were minimal power relations between the nurses and new physicians.

Burford et al. also conclude, based on finding only one incident of gender in their data set, that their informants may not have been consciously aware of gender issues, as their new identity of physicians may have been more important than gender identity at the time of the study. This is directly contrary to findings from other research where the effect of gender on nurse-physician interactions was investigated. Davies (2003), Pringle, (1996) and Gjerberg & Kjølsrød (2001) found that gender is more salient for medical residents than all other levels of physicians because medical professional authoritative power is lowest compared to nurses at that time, and therefore gender accounts for the majority of hierarchical power difference over nurses (for men medical residents). Specifically, women medical residents experience diminished professional respect and cooperation from nurses compared to men residents, and the difference in the way nurses treat physicians by gender decreases as physicians advance in their careers (Davies, 2003; Wear & Keck-McNulty, 2004). In choosing to speculate about the influence of professional hierarchy
versus gender hierarchy for physicians without conducting a gender analysis, Burford et al. arrived at conclusions that are counter to more deeply investigated and therefore more deeply nuanced considerations in this area of research.

Burford et al. also looked for evidence of gender being a factor linguistically in their data, either directly or implied. However, the authors do not appear to have evaluated whether men and women participants had a different quality of experience not indicated by gendered language, such as conflicts over authority, or the experience of having a nurse acquiesce to requests for teaching. Other researchers have found gendered differences in how medical residents request nursing assistance (Davies, 2003; Wear & Keck-McNulty, 2004). Reports from women physicians and women nurses suggest that new men physicians command nurses, while new women physicians ask for assistance (Gjerberg & Kjølstrød, 2001; Pringle, 1996). In limiting their gender analysis to bias in language, Burford and colleagues missed an opportunity to explore other types of gendered interactions between new physicians and nurses.

Though gender was a subtheme of hierarchy in their analytic framework and this research was done by sociologists, whom we might hope are attuned to nuances in power and gender, Burford et al. repeatedly overlooked the potential for deeper analysis of gender influences. Perhaps this happened in part because we are trained to ignore and diminish women’s reports of gendered treatment (Jackson, Hutchinson, Luck, & Wilkes, 2013). Burford et al.’s dismissal of gender as irrelevant, and their faulty conclusions related to medical residents, nurses, and gender are sadly in keeping with the post-millennial silence on gender in interprofessional collaboration in my study.

4.1.2 Degree 2: Gender as an incidental or a participant characteristic

For the 13 articles classified as Degree 2 (30% of the data set), gender was not an analytic consideration. For eight of these papers, authors used gender simply to describe the participants of their research. These articles will not be further discussed. Two papers highlighted gender as an issue but then did not carry it through to analysis, and will be given particular consideration. A few papers mentioned gender inconsistently, and the nature of that inconsistency will be explored. Overall, the papers in this category presented results, conclusions, and recommendations that did not consider gender or patriarchy for interprofessional collaboration situations involving nurses.
Porter’s 1991 paper is particularly of interest because Porter addresses gender-based issues directly in many ways, yet leaves gender out of consideration in their analysis and conclusions. Porter highlighted gendered historical relations between nursing and medicine, cited Stein’s doctor-nurse game, and noted that nurses’ limited professional autonomy was directed by physicians. Having established that nurses lack professional autonomy, particularly over decision making, and that the origins of this hierarchy are historical and gendered, Porter then provides no analysis of gender. This omission is significant because the author parses nurse-physician interactions closely for signs of overt and covert communication around decision making. This means that power related to gender and gendered expectations of communication may have been a confounding factor in Porter’s analysis, particularly as there were men and women nurses and men and women physicians in the consulting exchanges. Porter concluded that nurses had made great progress in advancing from informal covert decision making to informal overt decision making. However, Porter’s conclusions are called into question because they did not consider gender. In Porter’s article, the history of nurse-physician relationships was cast as historically hierarchical and patriarchal, but its analysis of interactions between nurse and physician does not appear to consider patriarchal hierarchical effects.

Porter pointed to nurses’ failure to negotiate power for the profession as the reason nurses do not have equal decision-making power with physicians. In making this assertion, the author ultimately located problematic interactions as originating in the professional hierarchy, with no consideration for gender effects in that hierarchy. Bowman (1993) rejects blaming individual nurses for failing to advance nursing autonomy, and rejects ascribing responsibility to individuals set in a constrained environment, as Porter did. Instead Bowman highlights the organizational barriers nurses face in the struggle to gain autonomy. She argues that nurses often do not have positions of authority at the level where strategic decisions that involve nursing decisions are made. Porter makes no mention of organizational limits on expanding nursing autonomy. In addition, Witz (Witz, 1992) advises that patriarchy intersects with hierarchy to result in structures that affect professions differently according to gender. Porter also failed to consider that nurses may face continued gendered cultural and organizational constraints – structures which require participants to use gendered strategies to advance the professional project. In spite of many opportunities to investigate and address the effects of gender on interprofessional communication, Porter’s work is effectively silent on gender.
The article by Miller et al. (2008) was a qualitative study on emotional labour performed in surgery. I found it surprising that Miller et al. largely evaded gender in discussing emotion work. Emotion work is routinely characterized as gendered work done more often and more deftly by women (Erickson & Grove, 2008; James, 1989), even in the foundational work on emotional labour cited by Miller et al. (Hochschild, 1983). Even though Miller et al. cite Stein’s ‘The Doctor-Nurse Game’, which brought attention to how nurse-physician relations have been influenced by gender stereotype roles, they mention gender in their paper only once, making it notable by its absence.

In the three articles in Degree 2 that refer to gender inconsistently (Freeman, 2000; Kaasalainen et al., 2011; Reeves et al., 2009), the gender of only some participants is recorded, and the authors do not specify why the gender of those particular participants are worthy of note. I argue that inconsistently mentioning gender is not neutral in meaning, but rather the authors imply (perhaps unconsciously) that gender is significant only in the case of the indicated findings. For instance, Freeman et al. identified gender for a ‘male nurse’ who was assertive about sharing the nursing perspective when the nurse felt it was important. Presumably, his actions are notable in contrast to other nurses who are more passive, and who, in not being gendered, are implied to be women. In giving this example, Freeman fails to recognize that men nurses find it easier to have their perspective respected by physicians (Tellis-Nayak & Tellis-Nayak, 1984), and therefore this man nurse’s communication style may have been more confident because he was not subject to gendered expectations that he not challenge authority. Due to his gender, he was not expected to ‘play the game’ of being passive and avoiding conflict. Indeed, in the article the ‘male nurse’ is presented as a rare example of a nurse who did not avoid direct conflict (Freeman, 2000).

Furthermore, Freeman et al. reveal their own bias by designating that single nurse with gender, as ‘male nurse’, instead of just ‘nurse’. Why was this particular nurse’s gender notable, but not that of any other nurse? Perhaps the authors included the gender descriptor because, in that moment, the actor was more ‘male’ than ‘nurse’, as he was acting in a way that fit his gender more than his profession. Furthermore, this nurse’s marked gender is significant because he is described in a way that makes him an exemplar, a lesson for the other, more passive nurses. However, men nurses can experience professional support from men physicians in the form of less condescension and receiving more responsible tasks (Tellis-Nayak & Tellis-Nayak, 1984). Indeed, research has documented that men nurses experience advantage from being a minority in
nursing in the form of preferential hiring and promotion (Bowman, 1993; McMurry, 2011), a phenomenon that has been called the ‘glass escalator’ (Williams, 1992). However, Freeman does not overtly discuss gender in relation to this man nurse’s successful presentation. The influence of gender on power at work is rendered invisible as a result.

In the articles by Reeves et al. (2009) and Kaasalainen et al. (2011), gender was unevenly applied to participants. Some participants were described by their gender and some were not. Gender is thus constructed by these authors as being relevant or notable about some participants but not others (for Reeves et al., some men practitioners are assigned gender, while for Kaasalainen et al., patients but not care providers are identified by gender). The message about gender is obscure and implied—gender is sometimes notable. In both articles, the authors’ focus is on interprofessional interactions and they do not notice their own biases in how they present gender. The authors appear to simultaneously overlook gender while also indicating gender is important some of the time. Gender has, once again, elided scrutiny.

4.1.3 Degree 3: Invisible Gender

25 of 43 articles about interprofessional collaboration and nurses, which represents 58% of my data set, did not mention the words sex, gender, male, female, men, women, masculine, or feminine. This indicates that the majority of authors studying interprofessional collaboration consider gender irrelevant to collaboration.

One article particularly deserving of comment due to not discussing gender is by Coombs & Ersser (2004). A qualitative study that looked at hierarchical relations between nurses and physicians, the article provided a rich resource of quotes for the earlier sections of my analysis on medical hierarchy. Confusingly, the authors cite Stein’s ‘The Doctor-Nurse Game’, which brought attention to how nurse-physician relations have been influenced by gender stereotype roles yet omitted gender from their own analysis. Coombs & Ersser are adept at recognizing power and hierarchy effects in their work, yet they are completely silent on gender.

Why is the interprofessional collaboration literature largely silent on gender? I explore this question in more depth as a component of the Why Is Gender Missing? discussion in section 4.4.
4.1.4 Changes in the Degree of Writing About Gender Over Time

For Degree 1: *Gender as an analytical construct*, the trend seems to be that articles published before 2000 do identify gender as an important factor in their analysis, but the one post-2000 article did not. Authors of the one post-2000 article in the group, Burford et al. (2013), considered gender but concluded that a gender analysis was not necessary based on their data. While there are too few articles to make a confident statement, over time, recognition of gender as a significant analytic factor seems as though it is in decline.

In Degree 2: *Gender as an incidental or a participant characteristic*, gender was used as a descriptor for participants, identified and then left unanalyzed, or findings about gender were implied but not overtly stated. Most articles in this category were published in the year 2000 or after (10 of 13 articles), suggesting that authors publishing after the split in my data set did not perceive a need to discuss gender, or, in the cases where gender is mentioned inconsistently, gender slipped in almost unnoticed.

Degree 3: *Invisible Gender* is the largest category of articles, containing 58% of the data set, which indicates that the majority of authors writing about interprofessional collaboration between nurses and physicians do not consider gender relevant to their topic. Of the 25 articles of Degree 3 where gender made no appearance in the articles, 7 were published before the year 2000, and 18 during or after 2000.

Overall, gender was not a common consideration in literature about interprofessional collaboration and nursing in the journals I selected. Few authors mentioned the patriarchal hierarchical history of nurses and physicians, and even fewer authors considered gender in their analysis. Research and writing concerning gender in interprofessional collaboration between nurses and physicians is a vast and echoing blank space, particularly post millennium. Gender was slightly more likely to be mentioned in some form before the year 2000 than after. In my discussion on Why Is Gender Missing? below, I will speculate on how the broader cultural context may have contributed to this shift.
4.2 Theme 2: Interprofessional Hierarchies in Nursing Work are Reinforced by Gendered Strategies

4.2.1 Theme 2a. Physicians ascribe the role of ‘handmaiden’ to nurses

The term ‘handmaiden’ as applied to nurses originated with Florence Nightingale (Nightingale, 1859). A handmaiden is defined as “1. a personal maid or female servant; 2. something whose essential function is to serve or assist” (Merriam-Webster, 2018). The term handmaiden itself denotes service by a woman, and is therefore in its very name a gendered service role (it is difficult to imagine calling a man carpenter’s assistant a ‘handmaiden’, or even a man nurse a ‘handmaiden’). Gender is often an invisible presence in patriarchal systems where women are assumed to be in a service role, and this is true in writing about nurses and interprofessional collaboration. Nursing work arose from an extension of women’s work in the home and women’s altruistic duty to care. Accordingly, as an altruistic duty, neither economic reward nor autonomy were considered necessary (Ogren, 2001; Susan Reverby, 2001). Patriarchy and institutional systems combine to locate nurses in a subservient role related to gender of the nurses and the type of work they do. Nurses’ service is assumed, and that form of women’s work is directed by physicians. The expectation of nurse-as-handmaiden appears to be an assumed privilege resulting from the combination of physicians’ historical gender and higher professional power.

The articles coded in subtheme 2a were mostly sharing the perspective of physicians. These physicians ascribed the role of ‘handmaiden’ to nurses in the way that they valued nursing and through their expectations of nursing. Physicians evaluated nurses on how proficiently they followed orders (as opposed to skill in caring for the patient), or praised nurses for their teamwork based on their knowledge of exactly what a physician wanted. Meanwhile, nurses did ‘the boring bit’ (Freeman et al., 2000), or waited while residents used the computers at the nursing station for both professional and personal work. Working nurses on the floor were cast as objects from which to acquire skills needed by new physicians. The nurse is praised for serving or assisting the physician, and is not seen as having work responsibilities or tasks that are independent of the needs of a physician. Hierarchy is apparent in each of these acts by physicians towards nurses, where physicians direct or use nurses in order to accomplish the tasks physicians value.
The fact that physicians assume nurses will serve them has also been observed by researchers outside of my data set. (Tellis-Nayak & Tellis-Nayak, 1984) described the hierarchical service expectation physicians had towards nurses in their ethnographic hospital study. One nurse described the unspoken service that nurses were expected to perform around patient charts. Physicians would walk towards the charts and mention a patient name and expect the nurse to provide the chart. “The nurse takes the servant position of fetching and retrieving charts for the doctor” (p.1067), even if the chart was being used by a nurse in that moment. The authors observed that physicians symbolically enforced their superior hierarchical position by devaluing nurses’ time, invading their work and personal space, and expecting nurses to stop their work to meet the request of the physician. The authors questioned how much of the status difference between nurses and physicians was a factor of gender and how much a factor of professional asymmetry, and conclude that it is an additive effect that consolidates nurses as subordinate (Tellis-Nayak & Tellis-Nayak, 1984).

While total control over nursing work by physicians appears to have lessened from the early days of nursing to current times, quotes from the year 2000 and later show that physicians still feel they direct nursing work and disregard the importance of nursing work in comparison to their own work needs, which reinforces medicine as hierarchically dominant over nursing. In this, my findings align with the findings of Paradis et al (2017), in that physicians are generally explicitly or implicitly seen as leaders of interprofessional teams. When physicians see nurses as assistants and their work is viewed as ‘in service’ to physicians, collaborative relationships based on mutual respect, trust and knowledge of professional roles are out of reach, and collaborative relationships with equal power or flattened hierarchies are a striking impossibility.

4.2.2 Theme 2b. Nurses ‘play the game’ to access power in the professional hierarchy

Most of the quotes in subtheme 2b are from nurses, reflecting their experience of collaboration. I found that nurses also used gendered strategies to navigate the professional hierarchy and advance their professional project. While use of the phrase ‘play the game’ in this theme title was inspired by Stein’s work (1967), the idea is by no means original to him, as this nursing advice from 1898 illustrates:

Never assert your opinions and wishes, but defer to his, and you will find that in the end you generally have your own way. It is always easier to lead than to drive.
This is a truly feminine piece of counsel, and I beg you to lay it in your heart.

Stein wrote ‘The Doctor-Nurse Game’ in 1967, at a time when using the pronoun ‘he’ to refer to all doctors and ‘she’ to refer to all nurses was a stylistic norm. ‘The Doctor-Nurse Game’ lacks empirical evidence and a theoretical framework; nonetheless, Stein’s paper had broad appeal among medicine and nursing which afforded the paper a kind of resonance and cultural veracity, and turned it into a watershed paper (as of May 2018, the paper had been cited more than 800 times on Google Scholar). Authors continue to consider Stein’s ‘The Doctor-Nurse Game’ relevant, and to cite it (Burford et al., 2013; Reeves, Nelson, & Zwarenstein, 2008; Willis & Parish, 1997).

Stein’s framework of nurse physician interaction was based on gendered, stereotypical roles for each profession (Stein, 1969), where nurses had knowledge that was important for patient care but no formal structures of communication existed to allow that knowledge to be communicated. Stein proposed that nurses were paradoxically required to make recommendations about patient care based on their observations and knowledge of the patient while also appearing passive, as though the recommendation was initiated by the physician. He described how nurses couch their recommendations in terms of patient observations instead of as advice to physicians in order to protect the physician’s feelings of omniscience and yet still table their care recommendations. In the same vein, physicians would request recommendations without seeming to ask, so as not to indicate their need for information. Preserving medical omnipotence required active cooperation from the nurses. Stein ascribed these communication patterns to the respective styles of educational training for each profession, gender-stereotyped roles of dominance and passivity, and the total responsibility held by the physician to make care decisions.

‘Playing the game’ has taken on a broader interpretation since Stein first published. The term now encompasses the broad strategies by which physician status is maintained by nurses and physicians as nurses seek to communicate about patient care or otherwise achieve their professional goals. In my set of articles, nurses used a variety of tactics to try to balance preserving the impression of medical omniscience and achieving their professional goals.

Keddy et al., in discussing interviews with nurses who practiced in the early 1920’s and 30’s, describe the limits placed on nurses’ contributions to patient care. Nurses’ intelligence was ‘not
useful’ unless it shored up physicians’ feelings of authority or improved their self-concept. As part of their work, nurses were responsible for the boosting, or at least not damaging, the egos of physicians. Keddy et al. portray physicians as dependent on nursing knowledge, while also claiming credit for nurses’ ideas. In Keddy et al.’s study, physicians need information about the patient from nurses, and also try to erase or conceal their dependence on nurses in the public sphere by requiring nurses to ‘play the game’ – disguising patient knowledge and promoting an all-knowing image for the physicians. A nurse in one article (Boblin-Cummings, Baumann, & Deber, 1999) was explicit in describing how she planned to present her own needs as physician needs in order to get what she wanted. For her, ‘the game’ was a necessary tactic to achieve her professional goal.

If ‘playing the game’ is a gendered strategy, it is easy to assume that nurses play the game because they are women, socialized to use feminized forms of communication. However, (Bavelas, 1982) discovered that people use indirect communication when they are in an interpersonal situation in which all messages will be received with negative consequences. (Tellis-Nayak & Tellis-Nayak, 1984) observed that nurses used indirect cues and circumlocution when they witnessed a physician error in order that physicians did not feel a lack of status, again illustrating how indirect communication is a strategic response to imposed hierarchy. In this vein, I suggest that patriarchal structures make indirect communication a logical and successful strategy, which is then dismissed as nurses ‘being passive’. Indeed, nurses’ ‘playing the game’ can be recast as an effective usurpationary resistance using gendered strategies to access power. Nurses avoid conflict and present their professional opinions in a way that is pleasing to physicians in order to access professional power such as contributing to patient care decisions.

As illustrated in the example from Tellis-Nayak & Tellis-Nayak, when nurses ‘play the game’ to contribute to patient care, nursing expert knowledge is diminished or lost. Keddy et al. explain how ‘the game’ leaves important information out of patient care planning. ‘The game’ limits nurses’ contributions, but more than that, represents a gendered strategic action to join clinical decision making.

4.2.3 Gendered Strategies in Nursing Work Over Time

In early publications, physicians spoke overtly of nurses being ‘in service’ to medicine, while in later publications, physicians are somewhat more subtle about their expectations for nurses’
‘service’. Still, the intention is consistent across time. From the physicians’ point of view, nurses and nursing work serve the needs of physicians.

(Pillitteri & Ackerman, 1993) highlight the consistency of physician attitudes towards nurses over time in their comparison of the journals of two medical students. They compared the journal of a man first year resident of 1888 to the journal of a man first year resident of 1990, to explore evidence of change in nurse-physician relations over the 102-year span of time. The authors found that the two residents had surprisingly similar negative responses to nurse assertiveness, one saying it was ‘uncalled for’ and the other resident describing it as ‘not tolerable’. The authors conclude that while the medicine the two men practiced was very different, their attitudes towards nurses were more similar than expected. While the journals represent personal attitudes of two individuals working over 100 years apart, the findings are remarkably similar to both early and later findings in my data set – that nurses’ opinions are not welcomed by physicians. Physicians position nurses as subordinate health care practitioners under their direction as an exclusionary professionalization strategy to maintain medical hegemony.

Both authors and nurses from across the entire timeframe of my data set characterized nurses as ‘playing the game’. This strategy is recognized as a deliberate tactic by nurses to achieve their professional work goals in the face of constraints on contributing their professional opinions, and this usurpationary strategy is common and widespread, demonstrating that nurses across time and work environments struggle to effectively participate in interprofessional collaboration. The fact that this finding is robust and unchanging throughout time suggests that nurses continue to require gendered strategies such as ‘playing the game’ to navigate professional relationships with physicians, despite many changes to the health care system over time, and despite the increased call for collaboration to improve health care and patient outcomes.

4.3 The Doctor-Nurse Game, Critiqued

When Stein’s description of ‘the game’ (1967) is viewed through Witz’s dual closure theory, nurses’ communication strategies are recast: “gendered actors…have differential access to the tactical means of achieving their aims in a patriarchal society” (p. 677(Witz, 1990). Seen through Witz’s theory, gender can be interpreted as one of the driving factors for nurses who elect to protect medical hegemony by ‘playing the game.’ In order to even have an opportunity to
communicate their knowledge of patients, nurses used gendered, stereotyped communication strategies.

What happens to nurses who do not ‘play the game’? Stein suggested ‘the game’ of indirect communication was maintained because direct-speaking nurses were punished by the dominant profession, who disparaged any nurse who was outspoken:

““The nurse who does see herself as a consultant but refuses to follow the rules of the game in making her recommendations, has hell to pay. The outspoken nurse is labeled a ‘bitch’ by the surgeon. The psychiatrist describes her as unconsciously suffering from penis envy and her behavior is the acting out of her hostility towards men” (p 700, Stein 1967).

Nurses who spoke out or spoke up faced denigration not about their actions, but about their gender, to remind them of their ‘place’ in the gendered work environment. In contrast, Stein reports that physicians who did not play the game found that small helpful tasks that smoothed their work process went undone. The consequences of breaking the rules for physicians were work inconveniences, while the consequences of breaking the rules for nurses were hostile sexualized verbal abuse. Physicians experienced workflow problems, while nurses experienced personalized discrediting gendered attacks. Sexualized verbal abuse for nurses is a common method of intimidating nurses and enforcing socialized gender roles (Jackson et al., 2013). Gendered differences in the consequences of breaking the rules of ‘the game’ represent a medical demarcational strategy in response to nurses’ attempts to usurp the medical power to make care recommendations.

However, Stein (1967) did not question the motivation for both professions to protect medical omniscience, and failed to consider larger institutional factors that reinforce ‘the game’, or that benefit the status quo for medicine. Instead, he attributed the reason for the game to ‘transactional neurosis’:

“The major disadvantage of a doctor nurse-like game is its inhibitory effect on open dialogue which is stifling and anti-intellectual. The game is basically a transactional neurosis, and both professions would enhance themselves by taking steps to change the attitudes which breed the game.” (p.703, Stein, 1967).

There is a long history of defining women’s protests about discriminatory treatment as mental illness (Showalter, 1997). Writing in 1967, Stein assigns equal responsibility to both professions for ending the game. Stein also made the point that the doctor-nurse game was perpetuated by
societal sex stereotypical roles of passive women and dominant men, and thus this pattern of communication would be both professionally and socially reinforced and difficult to shift. Interpreted through Witz’s closure strategies, gender was used to contain nurses in a submissive role, “a related but distinct sphere of competence” (p. 45, Witz, 1992) under the control of medicine.

In casting the doctor-nurse game as a colluding communication strategy to protect medical omniscience, Stein deflected attention away from the elements of physician-nurse interactions that result from patriarchal structures that enforce gendered strategies to acquire power. Witz (1992) argues that job segregation by sex is a result of the combined effects of capitalism and patriarchy, where the dominant profession – in this case, medicine – uses legalist and credentialist strategies to control and subordinate the work of adjacent professions. As a result, members of the subordinate profession must use gendered strategies to try to navigate and shift patriarchal structures.

In 1990, Stein and colleagues revisited ‘The Doctor-Nurse Game’. Writing with two other physicians, he recapped the historical paradox nurses faced in being duty-bound to contribute suggestions about patient care while knowing that making a recommendation to a physician would be insulting and unwelcome. Stein et al. opined that the game had changed since 1967, and the traditional hierarchical relationship between medicine and nursing had shifted to a more equal one.

The authors painted an optimistic picture of change driven by nursing’s move towards professional autonomy. Nursing education shifted to university-level instruction, which socialized nurses differently than in the past (Stein et al., 1990). Nurses were being taught to be aversive to physician influence and consider themselves professional equals. Academic nursing leaders now claimed expansive and humanistic aspects of health care for nursing knowledge, in contrast to medicine’s narrow focus on illness. In the later article, Stein et al. (1990) announced the end of ‘the game’, as nurses had unilaterally decided not to play anymore. Stein is not alone in considering that ‘the game’ is over. Several authors seem to agree (Burford et al., 2013; Radcliffe, 2000). Yet in Stein et al.’s 1990 article, the authors also referred to the new nursing attitude as “stubborn rebel” (p 548, Stein et al., 1990); a rather patronizing term with which to describe an entire profession of which none of the three authors is a member. The authors also
suggested that some physicians long for a return to the established hierarchy. Both of these statements are clues within Stein’s own article that suggest ‘the game’ was not over in 1990, a claim supported by other authors (Holyoake, 2011; Manias & Street, 2001; Pillitteri & Ackerman, 1993; Reeves et al., 2008; Sirota, 2007; Willis & Parish, 1997) and my own research. Both authors and nurses from across the entire timeframe of my data set characterized nurses as ‘playing the game,’ which means that ‘the game’ is still not over past 2000 and as late as 2014, even as it might have evolved.

Stein et al. appear to be acknowledging nursing’s strategic advance of their professional project, in acknowledging that advanced credentials for nursing contributed to the end of ‘the game’. Requiring advanced credentials is an inclusionary strategy designed to gain professional power and authority in the arena of knowledge in order to gain legitimacy with physicians, based on how certified knowledge is valued within medically dominated health care.

Stein also suggests that interprofessional collaboration between physicians and nurses contributed to the transformation of nursing, because “[s]uch models of collaborative practice contravene the hierarchical structure of the doctor-nurse game” (p.547, Stein 1990). Stein’s idealized notion of collaboration assumes that collaborators leave their professional hierarchical standing out of their collaborative endeavours, something they had clearly not done when he first wrote about the game. More likely, interprofessional collaboration is an arena of power dynamics, since professionals with different training, knowledge and experiences of hierarchy come together to make decisions. Viewed through occupational closure theory, Stein et al. incorrectly assume that ‘the game’ – the need for nursing to avoid conflict, be indirect, and promote medical omniscience – has ended. In contrast to Stein’s assumptions, my research suggests that patriarchal structures of power are reproduced within collaborative spaces as physicians and nurses still play the game through gendered and hierarchical structures.

4.4 Why is Gender Missing?

Omitting gender from analyses of power in interprofessional collaboration is not uncommon in health care literature, as my analysis has shown. In 1992, Witz described how women’s professional projects were generally unrecognized and ignored by sociologists because the very idea of a ‘profession’ was gendered, which rendered women’s professionalization processes
invisible. In the same way, discussions of gender’s importance to interprofessional collaboration are routinely dismissed or made invisible.

Though medicine is no longer monolithically composed of men, the field of medicine still has a gendered masculine orientation of authoritative professional behaviours. Being a physician has meant ‘doing dominance’, while being a woman has meant ‘doing deference’, and thus women physicians experience discord (Davies, 2003). Gender roles and professional roles intersect, and woman physicians and woman nurses still act in gendered ways towards each other, though those relations are also threaded through with power and hierarchical differences from their professions. Women physicians ‘doing dominance’ is problematic for nurses, but not when men physicians ‘do dominance’ (Davies 2003). The role of gender in professional hierarchies has become more complex as the gender composition of medicine has changed, but gender is still a formative factor in interprofessional collaboration, whether it is acknowledged or not.

Says Davies (2003),

When looking back in history, we somehow expect a clear clash between hegemonic masculinity and the situation of women to rear its head, but we assume (or at least hope) that hegemonic masculinity may have disappeared—or at least weakened its hold—in the present day. (p.726 Davies 2003)

Davies comments that analyzing nursing and medicine in terms of ‘doing deference’ and ‘doing dominance’, or as projects of femininity or masculinity will reveal tensions based on gender in everyday relations. Without a lens connecting gender and power, gender tends to be overlooked, and the level of the profession remains the dominant analytic concept.

Several authors suggest gender is no longer an issue because medicine has become more equally balanced by gender (Baggs & Schmitt, 1988; San Martín-Rodriguez, Beaulieu, D’Amour, & Ferrada-Videla, 2005; Stein et al., 1990). Authors of a review on interprofessional collaboration in primary care ventured an opinion about gender and the future of collaboration: “The current feminization of the medical profession may present an opportunity to empower all team members, as women are more often inclined to a shared leadership” (p. 724, Supper, 2015) thereby implicitly acknowledging that men dominating leadership is a problem, but one that women should solve.
Assuming that gendered problems in collaboration can be solved by medicine becoming more gender-balanced is naïve and problematic for three key reasons. First, because it makes invisible the gendered workforce of nursing, which continues to be a profession of almost all women (92% in Canada). Second, this statement assumes that patriarchal structures can be solved by adding women. Women, like men, have also been raised in a patriarchal society and can also impose gendered expectations on others. Despite a more equal gender balance, medicine is still struggling with gender discrimination (Bell et al., 2014). Third, one implication of the statement is that interactions between nurses (assumed to be women) and women physicians are not gendered interactions but neutral interactions. In all of these, the central importance of gender as a factor in interprofessional relationships is sidelined or hidden.

Gender influences were easier to see when medicine was almost entirely constituted by men and nursing was almost entirely constituted by women. However, when the argument is made that gender is no longer relevant between nurses and physicians because medicine is no longer exclusively for men, that argument has at its heart the assumption that gendered interactions only occur between men and women. The idea that gendered behaviour is only enacted between genders is problematic in that it obscures ways in which within-gender interactions across power differentials can disrupt or enforce gender roles. Furthermore, arguing that gender no longer influences nurse-physician relations because medicine has become more gender balanced is another form of medical hegemony, since the implication is that the problem is solved for medicine, and therefore no longer needs to be discussed, even as the remarkable prevalence of women in nursing provides evidence that nursing is still a gendered profession.

Several studies have examined the role of gender as an influencing factor in the relationships between nurses and physicians. Gjerberg & Kjølsrød (2001) explored gendered interactions between family physicians and nurses in Norway. In their work, women physicians in Norway reported that they received less assistance and less respect from nurses compared to their men colleagues. This effect decreased with increasing age of the physician, likely due to older women physicians’ rising professional status within the hospital as they got older (Gjerberg & Kjølsrød, 2001). Pringle, (1996) found nearly identical relations between woman physicians and woman nurses in England and Australia. Gender and professional status appeared to be affecting men and women physicians differently. Similar to Gjerberg and Kjølsrød’s findings, Wear & Keck-McNulty (2004) found that nurses in Australia and the UK offered more complete nursing
services to men residents while expecting woman residents to find needed equipment on their own and to tidy work sites after themselves. Furthermore, Wear & Keck-McNulty found that men and women residents also treated women nurses in gendered ways. Men residents commanded nurses, while woman residents asked nurses for assistance. Devine (1978) found that medical residents have low status compared to other physicians in hospitals. Perhaps because the hierarchical power differential is lowest between medical residents and nurses, power from gender is most visible between new physicians and nurses.

In another study by Zelek & Phillips (2003), the authors explored the power differential of both gender and profession. The authors asked nurses to respond to scenarios featuring either a man or woman physician. They found when the nurse and physician were the same gender, the nurses’ perception of professional power inequality diminished, and nurses both found women physicians easier to communicate with and resented women physician’s use of medical authority. The authors concluded that nurses felt more comfortable approaching and communicating with women physicians when the power differential of gender was eliminated, and therefore nurses’ perceptions of professional power inequality decreased. Observing in a Swedish hospital, Davies (2003) also observed women nurses who resented an authoritarian attitude from women physicians and accepted it from men physicians. However, nurses also appreciated the more mutual and inclusive communication style that woman physicians used (Davies 2003). In all of these studies, researchers, nurses and physicians alike are aware of gendered interactions. This is in marked contrast to the articles in my data set, where gender’s influence on interprofessional interactions is largely dismissed or ignored in spite of the ongoing, overwhelming evidence of its importance.

Though hegemonic masculinity ensures its position of dominance by rejecting gender as a relevant factor, gender is still relevant to both the professionalization of nursing and medicine, and to individual interactions (Davies, 2003). The vast silence on gender in interprofessional collaboration in my dataset indicates a blank space that needs to be explored. Why is gender persistently not recognized as relevant to health care work, health care professions, and health care research?
4.5 Occupational Closure Theory

Witz’s text, *Patriarchy and the Profession*, was written to provide a new view of how gender influences professional projects because she felt that approaches to sociology of the professions reproduced masculine constructions of professions. Witz developed occupational closure theory to provide a framework to consider how gendered actors and gendered structures affect the strategies and actions available to professions to advance their professional project. Witz’s theory of occupational closure allows me to interpret individuals’ actions as part of a larger strategic goal to access power in interprofessional collaborative relationships. Individual actions are reinterpreted in terms of advancing professional interests and also the theory brings into view that systemic hegemonic limits and barriers are often cast as individual failings. Encouraging nurses to take individual responsibility for professionalization “discounts the severity of gender-related institutional and organizational barriers to professionalization” (p. 286, Bowman, 1993). Wicks also indicates a need to “re-cast many of the so-called individual characteristics, behaviours and emotions of nurses into a perspective that takes into account the social construction of conditions” (p. 132, Wicks, 1995). In this frame, nursing resistance in particular ceases to be merely an individual action or act of ‘rebellion’, as Stein characterized it, and comes into view as a response to organizational structure (Wicks, 1995).

When nurses are not assertive, or not acting autonomously, these behaviours are described as personal failure, and not ascribed to the system in which they work. Bowman lists several structural limits to the nursing professional project: “centralized bureaucratic structural arrangements; the favoured promotion of male nurses and non-nurses over women to positions of authority, power and control; the near absence of a nursing voice in major decision-making bodies; compressed salary scales that serve to devalue expertise and discourage the retention of skilled practitioners” (Bowman, 1993). As Witz explains, gender intersects with patriarchal systems to create constrained autonomy for nurses, and the gendered aspect of that professional limitation is often hidden from sight.

An example of the structural limits on nursing agency comes from the collaboration in the three hospitals described by Miller et al., (2008). Miller et al. unintentionally provide an opportunity to consider how professions who have different levels of power and authority can influence hospital systems. In the care environments of Miller et al.’s study, when physicians were unhappy with
constraints on their contributions at interprofessional rounds, they had sufficient access to power to bring about a leadership review of a meeting structure of which they were resentful because they were ‘not in control’. In contrast, resentful nurses in the same study had so little power to influence interprofessional rounds that physicians did not even know there was a problem. Nurses and physicians have differential access to institutional power structures to effect change when they had complaints about collaborative processes. As Miller et al. proposed:

“It is possible that there exists no suitable dissent mechanism for nurses beyond absenting from interprofessional rounds.” (p. 340, Miller et al., 2008)

In other words, nurses had no ability to protest how their contributions were being limited in a purportedly collaborative space, and turned to the gendered tactics of ‘playing the game’ by avoiding conflict and protecting medical hegemony as their only avenue of protest, though those tactics did not result in any systemic change in that setting. Wicks (1995) proposes that emphasizing structural oppression by patriarchal systems can emphasize nursing passivity and contribute to researchers reinforcing their ‘inevitable’ dominance by medicine. She argues that focusing on nurses’ passivity obscures how nurses resist medical dominance.

Joining interprofessional collaboration has the potential to be a usurpationary move for nurses, since nurses stand to gain power through a formal process that validates and encourages their contribution to patient care. However, because of historical and present-day hierarchies, gendered professional roles, and hierarchical and gendered expectations, nurses use gendered usurpationary strategies such as avoiding conflict and presenting their opinions in a way that is pleasing to physicians in order to access professional power such as contributing to patient care decisions. In other words, nurses ‘play the game’ in collaborative settings in order to contribute professionally, and Stein’s ‘playing the game’ when interpreted through occupational closure strategy is actually a gendered act that uses apparently stereotyped forms of communication. Nurses ‘play the game’ because their knowledge base has less currency than the medical knowledge base (Willis & Parish, 1997). ‘Playing the game’ can also be characterized as a form of resistance to medical dominance (Willis & Parish, 1997).

In my research, I found that physicians used gendered strategies to demarcate nursing as subjugated and ‘in service’ to medicine. Nurses used gendered usurpationary strategies such as ‘playing the game’ to respond to exclusionary and demarcationary strategies employed by
physicians to limit nursing participation in interprofessional collaboration. Witz’s theory linking patriarchy and professional projects has led me to identify a void in writing about gender in interprofessional collaboration, at least in the journals I selected for consideration. Witz critiqued the absence of gender in writing about the professions, and I offer the same critique of writing about interprofessional collaboration. Writing about gender in interprofessional collaboration is scarce in my sample, and only one paper contained an in-depth analysis of gender. Gender and patriarchy affect nurses’ ability to participate and be seen as legitimate knowledge holders in interprofessional collaboration, and current and historical research habits allow gender effects to slide past unrecognized, as I demonstrated in Theme 1, *The invisibility of gender*.

Interprofessional collaboration requires respect, trust and knowledge-sharing between professionals, and is an arena where nurses may gain power as they gain legitimacy as a contributor to health care planning for patients. Witz’s occupational closure theory predicts that physicians will use exclusionary and demarcationary strategies rooted in patriarchal power to maintain exclusive control, in this case, in the collaborative space, and my Theme 2a, *physicians ascribe the role of ‘handmaiden’ to nurses*, confirms this prediction and shows how physicians attempt to limit the nursing role through gendered expectations of service.

Occupational closure theory also predicts that nurses will use gendered usurpationary strategies to gain professional power. My Theme 2b, *nurses ‘play the game’ to access power through physicians* confirms that nurses avoid conflict and use indirect communication to try to achieve their care goals for patients. The strategies nurses use to access power in collaboration with physicians are weak strategies because they have an inferior status in the professional hierarchy, a status that is reinforced through gendered power relations that are entwined with professional hierarchies.

While interprofessional collaboration is a health care necessity and an ideal, both historical and contemporary collaborative care are spaces where medical hegemony is enacted, and nurses struggle to contribute to collaborative care decisions. Physicians enact professional hierarchy by expecting nurses to be handmaidens to physicians, and nurses use gendered strategies in the form of ‘playing the game’ to try to influence patient care while appearing to protect medicine’s superior position in the hierarchy. As collaboration as a care ideal becomes more entrenched in health care, nurses stand to gain power and authority over patient care if their contributions are
genuinely invited and valued in collaborative spaces. However, gendered strategies by physicians and nurses reinforce patriarchal expectations of nursing work and interprofessional collaboration continues to be a site of gendered medical hegemony. This hegemony is further protected when gender is omitted from interprofessional collaboration research and publications. Rejecting gender as a relevant factor in interprofessional collaboration protects patriarchal medical dominance.

4.6 Recommendations for Future Research

As a result of my research, I have several recommendations for researchers of interprofessional collaboration. First, researchers should consider that power differentials between professions is potentially gendered, and thus both hierarchy and gender should be considered in interprofessional collaboration research. This recommendation applies to researchers working in both the utilitarian and emancipatory discourses identified by Haddara and Lingard (2013). Researchers familiar with the utilitarian discourse of interprofessional collaboration should attentive to factors about the setting such as institutional policies and cultures that may be affecting the success and efficacy of collaboration between nurses and physicians. Specifically, they should consider if hierarchy and gender are influencing the process of collaboration, and make recommendations that specifically target institutional change, instead of proposing continuing education for individual practitioners as a solution to problems of interprofessional collaboration. Researchers in the emancipatory discourse should be alert to gendered aspects of power hierarchies. Future authors, regardless of their discursive orientation, should attend to the importance of gender in interprofessional collaboration.

Second, interprofessional collaboration research should move beyond an emphasis on interview data. Authors of several review articles noted a lack of observational data and also that interview data was over-represented (Morgan et al., 2015; Paradis et al., 2014; Tang et al., 2013).

Observational studies of interprofessional collaboration would provide an alternative data source to interviews, and would allow researchers the opportunity to observe power dynamics related to hierarchy and gender and to identify individual and systemic limits on interprofessional collaboration. Though feedback sessions were not described in any research in my data set, Long, Forsyth, Iedema, & Carroll (2006) found that clinicians were able to recognize and begin to act to change behaviours rooted in the medical hegemony when they were shown video clips
of medical dominance at team meetings during feedback sessions. Researchers hoping to implement effective collaboration should consider video feedback as a way of demonstrating how professional and gender hierarchies hamper true collaboration.

Finally, researchers should reflect on their own biases and experiences with medical hegemony and gender to better inform their writing in interprofessional collaboration. Specific attention to language that implies professional hierarchy such as that described by Paradis & Whitehead (2015) or implies gender hierarchy will improve current understanding about interprofessional collaboration.

4.7 Conclusions

Interprofessional collaboration is a locus of tension between nursing and medicine’s professional projects as nurses and physicians act to advance or maintain professional power during interprofessional collaboration. I have suggested that for nurses, promoting and participating in interprofessional collaboration is a significant usurpationary activity because it provides a platform where nursing knowledge could be welcomed and valued as part of good patient care. For physicians, interprofessional collaboration represents a threat to their hegemonic control over health care, and therefore is a situation where exclusionary and demarcationary strategies are evident.

I have argued that physicians use gendered strategies to ascribe nurses to a limited role of ‘service’ to medicine. Meanwhile, nurses use gendered usurpationary strategies to resist and counter medical hegemony in interprofessional collaboration. Nurses ‘play the game’ as a way of being able to contribute to clinical decision making during interprofessional collaboration, and the power they gain has the potential to advance their professional project towards professional respect and clinical autonomy. The very characteristics that are ascribed to nurses as personal failure—those of being passive, indirect, and avoiding conflict with physicians—are actually an adaptive response to working within a repressive system. While absolute control over nursing work by physicians has diminished over time, physicians continue to expect nurses to work in service to medicine, and nurses have developed counterstrategies to contribute to patient care, occupational strategies that are remarkably consistent over time.
My data set was chosen to select articles that informed the ‘conversation’ about interprofessional collaboration in Canada and abroad. Hacking (1999) wrote that the social space influences what is studied, known and valued, and these values shift over time. In my data set, the social construction of gender has shifted from being occasionally present in research before the year 2000, to being almost absent from analyses of interprofessional collaboration between nurses and physicians. Gender has slid from view in this field, despite a long history of gendered domination and control of nursing by medicine. I proposed that authors of the reviewed articles may perceive gender dynamics to be less salient or critical because medicine has become more gender-balanced in recent years, but I then presented research that suggests that both women and men physicians have gendered interactions with nurses, and that nurses also treat men and women physicians differently. Gender effects are evident in research about interprofessional collaboration, even when it is not acknowledged by authors.

Instead, I suggest that gender is suppressed because medical hegemony is reinforced through gendered strategies. When gender is rejected as a construct relevant to nursing work, patriarchal medical hegemony remains dominant and unable to be effectively challenged and changed. Denying the importance of gender also invalidates conversations that might challenge the status quo. When one form of dominant power (gender) is made invisible, collaboration becomes an arena where medical hegemony is recreated even as the goal is purportedly to value diverse professional opinions. Failure of collaboration can then be ascribed to individual nurses who represent passive gendered stereotypes of their profession, while actual sharing of goals, values, decision making and power—elements of effective collaboration—are rendered out of reach. Interprofessional collaboration involving nurses and physicians faces an unnamed struggle because gender is not recognized or explored in most research as an avenue of potential professional hegemony impinging on effective collaboration.
References


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https://doi.org/10.1097/ACM.0000000000002233


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https://doi.org/10.3109/13561820.2013.867839


## Appendix A

Initial Coding Framework

*Initial Theoretical Coding Framework for Directed Content Analysis*

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<th>Name of code</th>
<th>Working definition</th>
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<tr>
<td>Inclusion strategy</td>
<td>Strategies used by a subordinate group to allow the subordinate group to have the same authority and power as the dominant group; to enter the dominant group</td>
</tr>
<tr>
<td>Exclusion strategy</td>
<td>Strategies to prevent subordinate groups from entering an exclusive professional space, such as prescribing or discharging</td>
</tr>
<tr>
<td>Demarcationary strategy</td>
<td>Strategies to delineate professional jurisdictions when a subordinate group is entering or sharing a professional space</td>
</tr>
<tr>
<td>Dual closure strategy</td>
<td>Strategies used by a subordinate group to simultaneously claim new jurisdictional territory while excluding other groups from current and new territory.</td>
</tr>
<tr>
<td>Usurpationary strategy</td>
<td>Acting to gain or exert control over a skill or environment that is currently managed by a more dominant group</td>
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<tr>
<td>Structural obstacles</td>
<td>Such as policies, informal policies, paperwork requirements, certification requirements that limit a profession’s participation in collaboration</td>
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<td>Professional hierarchies</td>
<td>Not having discharge care suggestions acknowledged</td>
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<td>Professional socialization</td>
<td>Training causes individuals from different professions to identify different priorities or solutions for IPC/ causes problems for IPC</td>
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<td>Accountability</td>
<td>Accountability for documentation, care, implementing care plans, medical decisions, affects collaboration</td>
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<td>Autonomy</td>
<td>Autonomy over skills or space is a conflict or solution for IPC</td>
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<tr>
<td>Claims for/control over resources</td>
<td>Conflict/proposed solutions over resources such as equipment, meeting times, supervisory advice</td>
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<td>Conflict in IPC</td>
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<td>Tactics to advance nursing power or autonomy and improve collaboration/tactics which are at the expense of collaboration</td>
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Appendix B

Final Coding Framework

*MAXQDA Final Coding Framework*

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