"Female nurses: Professional identity in question how female nurses perceive their professional identity through their relationships with physicians”

Dorit Weil Lotan*

**Abstract**: Background: Nurses and physicians are longtime complementary professions in the hospital setting, prominent in patient care. The hierarchic relationship between them, by gender and professional status, results in various conflicts. Over the years, the balance of power between the two has shifted: nursing has undergone great development in the professional aspects, while the number of female physicians has increased. The influence of these changes on the nurse’s professional identity and interactions with other medical professionals was studied.

Objective: The current study aims to understand how professional identity and the gender of physicians affect the relationship between female nurses and physicians.

**Design**: Female nurses underwent qualitative, semi-structured interviews and responded to hypothetical scenarios describing their interactions with male and female physicians.

**ABOUT THE AUTHOR**

Dr. Dorit Weil Lotan is a Certified Nurse (RN, MPH, PHD), and head of Resuscitation and Ambulatory Care in Hadassah Ein-Karem Hospital, in Jerusalem. For many years, she served as a Lecturer in Hebrew University Nursing School. Dr. Weil-Lotan's additional clinical positions included being Head Nurse in Internal Medicine and Division supervisor.

Throughout many years of working at a hospital, Dr. Weil-Lotan has been interested in the human factor in the clinical setting. Working together in efficient cooperation involves many psychological and sociological aspects. Dr. Weil-Lotan has dedicated the past decade studying these factors, emphasis on aspects of gender.

With support of the Hebrew University in Jerusalem Department of Psychology, she has conducted a comprehensive qualitative research doctorate, examining female-nurse’s perceptions of female-doctors, and how it affects cooperation in the clinical setting. The combination of clinical work and academic positions has benefit to Hadassah Hebrew University Medical center.

**PUBLIC INTEREST STATEMENT**

This study examines the relationship between female nurses and doctors from a gender perspective, in light of the substantial increase in the number of female medical doctors, in recent years. The study raises important questions regarding the way female doctors are perceived by female nurses.

We are witnessing a change in gender dominance in medical practice. Though some might expect women to support and encourage each other, the study’s findings suggest this is not always the case.

Analysis of Interviews conducted with 20 nurses working in medical department, indicated a strong prejudice towards female doctors. It seems that working with female-doctors challenges nurse’s self-perceptions and sense of professional identity. Possible contributing factors are discussed.

The study sheds light on a less attractive side of the feminist revolution, and how it affects the ability of female nurses and doctors to cooperate and provide the best medical care.
Setting and participants: Twenty female nurses with at least one year of experience from seven internal medicine departments in a major public hospital in central Israel participated in the study.

Methods: Semi-structured in-depth interviews were carried out, including descriptions of conflicts with physicians, and nurses’ responses to hypothetical scenarios with male and female physicians. Explicit and implicit statements as well as anecdotes were analyzed.

Results: Nurses tended to define their professional identity in relation to physicians, presenting a united front against the so-called “other,” a distinct “us versus them” divide. They appeared to perceive themselves as superior to physicians, competing with them over their professional importance and prestige. They utilized aggressive and manipulative strategies as means of resolving conflicts with physicians. This was more pronounced with female physicians, who received little to no respect from nurses, and were judged by gender stereotypes, and only gained recognition if they proved themselves worthy of it. Apparently, physicians, and female ones, in particular, shape the professional identity of the nurse through a struggle over influence, authority and public prestige. By so doing, nurses simultaneously undermine and preserve the existing nurse-physician hierarchy.

Conclusion: Nursing in hospitals is focused on the structuring professional identity, alongside competition with the female physician over influence, authority and public prestige, which simultaneously undermines and preserves the existing hierarchy. Thus, the nurses’ professional identity is influenced by their interaction with and gender of medical physicians.

Subjects: Behavioral Sciences; Communication Studies; Medicine, Dentistry, Nursing & Allied Health

Keywords: gender; conflict; professional identity; work environment

1. Introduction

The hierarchic relationship between nurses and physicians is affected by gender and professional status. The effects of these two factors cannot always be distinguished. Historically, medicine is perceived as a mostly male-dominated profession, whereas nursing is predominantly female (Braun, O’Sullivan, Dusch, Antrum, & Ascher, 2015). As such, it is associated with the display of care, devotion, compassion and emotional bonding, i.e., so-called feminine and maternal characteristics (Davies, 2003). The relationship between the two professions was therefore traditionally viewed as a male/female relationship, where the physician is the authoritarian, dominant male, a controlling husband, while the nurse is the submissive, obedient wife. Their relationship is supposedly flirtatious, with a clearly defined gender identity that requires the participation of both parties (Dingwall & McIntosh, 1978; Gamarnikow, 1978). The Doctor-Nurse Game, a term coined by Stein (1967), refers to the interaction between the two professions, adhering to a clear set of rules: nurses are expected, perhaps even required, to respect the physicians; they do not diagnose patients or expressly recommend treatment; and any overt disagreement by them is totally unacceptable (Keddy, Gillis, Jacobs, Burton, & Rogers, 1986).

Such relationships, based on professional and gender hierarchy, are fertile ground for professional and personal conflicts affecting the quality and safety of patient care, patient and caretaker satisfaction, and institutional costs (Warner & Hutchinson, 1999; Zheng, Sim, & Koh, 2016). Physicians and nurses lend different significance to various professional goals, such as medical treatment versus patient care. As such, they may encounter numerous challenges through
collaboration (Tang, Zhou, Chan, & Liaw, 2018). Most conflicts between nurses and physicians occur within the scope of the general care routine, specific instructions, and preparation for patient care (Kelly, 2006; Leever et al., 2010). There is no single answer as to how nurses settle conflicts with physicians. Studies adopting Thomas and Kilmann (1974) model found that junior nurses tend to respond to conflict by avoidance, while more senior nurses opt for compromise (Kunaviktikul, 1994). Conversely, Prescott and Bowen (1985) report that nurses choose a controlling approach to problem-solving, and adopt strategies beyond the existing models, such as approaching superiors. This concept contradicts most findings and has yet to be validated. Conflicts are seen as negative, emotionally draining, reducing focus and causing unease and fear of confrontation, all of which the nurses wish to avoid (Churchman & Doherty, 2010; Tabak & Koparak, 2007; Wilson, 2004).

Since nursing is a primarily female-dominated profession, compromise and avoidance may be attributed to the female gender and the feminine ethos in fostering relationships (Valentine, 2001).

Over the past three decades, Western healthcare systems have been undergoing changes in progressive financial and structural aspects, as well as with respect to the role of nurses. Whereas in the past, physicians were the undisputed authority in patient care, contemporary nurses are taking on more independent roles in terms of healthcare tasks. These new roles define physicians as supervisors of caretaking and nurses as executers of these procedures (Brodsy & Van Dijk, 2008; LeTourneau, 2004). In another gender-related change, more female physicians have joined the workforce in Western Europe, the USA, and even in Israel (Jefferson, Bloor, & Spilsbury, 2015). The percentage of female medical doctors in the USA, which was 5.7% in 1990, reached 42% within a single decade. Today, there are more female than male physicians (Wear & Keck-Mcnulty, 2004). Few studies have explored this gender shift and its influence on the relationships between nurses and physicians (Jogulu & Vijayasingham, 2015; Rothstein & Hannum, 2007; Wear & Keck-Mcnulty, 2004; Zelek & Phillips, 2003).

A nurse’s professional identity is influenced by numerous factors other than interaction with physicians. Professional identity is defined as part of self-perception: “Who or what am I as a professional?” It depends on characteristics, beliefs, values, motivations and experiences whereby an individual defines his or her professional role (Ibarra, 1999). Professional identity is comprised of several factors: professional uniqueness, i.e., how the profession is distinguished from others; continuity, or the link between the nature of the profession in the past, present and future; commitment to defining factors of the profession; and identification with the goals, colleagues and the organization (Caricati et al., 2015). Professional identity is influenced by self-perception and

---

**Box 1. “Us versus Them”**

| “Them”—Physicians | “Us”—Nurses |
|--------------------|-------------|
| Wrong              | Correct     |
| Absent             | Present     |
| Passive            | Active      |
| Need supervision   | Mature adults|
| Unsure of themselves | Sure of themselves |
| Ego-centered       | Patient-centered |

**Box 2. Battlefield vernacular**

| Front | Commander | Front Line | War |
|-------|-----------|------------|-----|
| Battle | Soldier   | Distance   | Junior |
| Victory | Defeat   | Interception |     |
public image, as well as by education and professional training and the work environment, both social and professional (Björkström, Athlin, & Johansson, 2008). A positive and flexible professional identity is highly critical for the nurses’ optimal performance, affecting both their colleagues and those under their care (Björkström et al., 2008).

2. The study

2.1. Aim and definitions
The aim of this study is to describe how professional identity and gender structure affects female nurses’ relationship with physicians.

2.2. Design
A qualitative study was based on twenty in-depth interviews (approximately 90 minutes in duration) with female nurses.

2.3. Participants
The sample consisted of twenty nurse interviewees with at least one year of experience from seven internal medicine departments at a major public hospital in central Israel. Most of the participants (65%) were married, and 85% were native Israelis. Most (80%) had a Bachelors’ degree. Nursing experience was varied: 20% of participants with 1–3 years of experience, and 25% with 3–5 years, 35% with 5–10 years, and 20% with over 10 years. Experience within the same department was also varied: 45% of the participants worked in their department for 1–3 years, 20% for 3–5 years, 15% for 5–10 years, and 20% for 10 years or longer (see Table 1).

After approval from Ethics Committee, head nurses in internal medicine departments were asked to recommend 3–4 nurses with at least one year experience willing to give

| Marital status       | Married | Marital status       |
|----------------------|---------|----------------------|
| 65%                  |         | 65%                  |
| 30%                  | Single  | Marital status       |
| 5%                   | Divorced|                      |
| 85%                  | Israel  | Country of Birth     |
| 15%                  | Former Soviet Union | Nationality        |
| 80%                  | Jewish  |                      |
| 20%                  | Muslim  |                      |
| 50%                  | Secular | Religious Affiliation|
| 10%                  | Traditional |                |
| 40%                  | Religious |                |
| 5%                   | None    | Academic Education   |
| 80%                  | BA      |                      |
| 15%                  | MA      |                      |
| 20%                  | 1–3 years | Professional Experience |
| 25%                  | 3–5 years |                      |
| 35%                  | 5–10 years |                      |
| 20%                  | 10-and over |                |
| 45%                  | 1–3 years | Department seniority |
| 20%                  | 3–5 years |                      |
| 15%                  | 5–10 years |                      |
| 20%                  | 10 and over |                |
60-90 minutes to the study, relating to their daily work experiences. The interviews were conducted between October 2014 and May 2015, nurses were presented with two scenarios of conflictual interactions, one with a male and the other with a female practitioner, to determine whether the physician’s gender affected their responses recorded with participant permission, and transcribed by a third party. Each interview lasted approximately 90 minutes.

2.4. Data analysis

All interviews were recorded and transcribed by a certified professional. Analysis of the findings was conducted in three stages: open coding, in which findings were categorized; mapping analysis, which attempted to detect links between the categories; and the focal stage, in which the categories were rearranged as a narrative focused on one main category with subcategories.

Throughout the interviews, participants responded to specific questions, as well as spontaneously shared stories in order to emphasize or stress an idea. Their vivid descriptions prompted a narrative short story analysis, in addition to the categorical analysis, employing a method intended to identify their end point, the goal of the story, by identifying selection mechanisms. Spector-Mersel (2011) presents six selection mechanisms defining what they chose to divulge or to withhold: inclusion, sharpening, omission, silencing, flattening, and appropriate meaning attribution. In her view, these mechanisms are not coincidental, but rather serve the narrative end point.

2.5. Ethical considerations

Each participant signed an informed consent form guaranteeing full anonymity and granting the right to refuse to answer questions, or leave at any point. The recordings and transcriptions were saved as password-protected files. The reporting was anonymous, disclosing only profession, sex and years of experience. The names reported in this paper have been changed.

3. Results

3.1. Power struggles with physicians over status and prestige

Nurses reported professional status and prestige as the dominant factors in power struggles with physicians. Interestingly, their discourse simultaneously undermines and perpetuates the existing hierarchy.

3.1.1. Undermining the hierarchy

The main theme arising from the nurses’ interviews is of two rival teams fighting over status, prestige, importance and authority. Their stories are laced with military and “us versus them” terminology reinforcing the idea of opposing extremes. The nurses’ narratives support their peers, while belittling the physicians’ role. They undermine the existing hierarchy with phrases such as “the gaps between the professions has been minimized,” “nursing is just as important as medicine,” and “the myth of medical doctors is far from reality.”

3.1.2. Minimized gaps

Nurses describe their profession as one which has developed to the point of minimizing the gaps between them and medical doctors. While cure and care were once mutually exclusive, nowadays, nurses also have great knowledge of cure.

Orit: The nurse is expected to follow doctors’ orders ... Lately I find myself managing myself rather than being managed by a doctor, primarily in more complex patient care ... Sometimes I view the interns in our department as inexperienced, or insecure, and then they need the nurse by their side ... I pretty much exclusively oversee patient treatment.

Ravit:
Nurses are just as important as doctors! They used to be two separate professions, but nurses are more academically educated now and most have seniority in the department over the interns ... That is why the doctors need us.

Ilanit: The nurse manages the patients’ treatment, because she knows them better than the doctor!

3.1.3. Nursing is just as important
Nurses describe their daily work through recurring events in which their presence prevents a bitter outcome. They explicitly state that their role in the system is critical, and they often shield the patient from the physician.

Alexandra: Doctors require nurses’ supervision ... They need nurses’ guidance and supervision in taking care of patients and overseeing medical treatment.

Liel: ... Often you even save [the patients] ... Doctors can also “miss,” and you’re the one who takes care of them, more than the doctors. Most of the time you get to a point in your career where you tell the doctor, “I gave them this and that, write it down, I ordered this and that, sign it,” you know, manage their treatment.

Ravit: ... Sometimes we’re the doctors’ watchdogs ... especially in evening and night shifts.

3.1.4. Doctors: myth versus reality
Maria: Outsiders don’t really know that doctors don’t always know the correct dosage or what to do in specific situations. We are often their behind-the-scenes advisors. People think that doctors are all-powerful ... like gods. in reality, this is far from the truth ...

Inbar: ... People think that successful treatment is attributed to the doctors, but sometimes even though the operation is successful, the patient may die without the right treatment from the nurse.

Orly: Contrary to what people think, I often find myself having to protect the patient from getting harmful treatment ... With some interns, I feel completely responsible for the patient, [and] am “all eyes” on any decision or order they give ...

Liel: ... Some doctors ... think they’re gods in the department, but actually you have to tell them what to write, do, bring, sign ... You need to know everything because sometimes there’s a doctor, but sadly, you’re alone, mostly in public medicine ... and when something goes wrong, you’re scared, because what you’ve got isn’t really a doctor.

Halima: Although medical doctors get all the prestige, I think nurses are the ones that you truly cannot do without. The elderly patient in internal care especially needs the nurses ... if we had authority, I’m certain that some departments could run without doctors ... I can prescribe antibiotics just as well. I have the knowledge and the experience ...

3.1.5. Neglecting to mention collaboration
Only one nurse mentioned inter-professional collaboration. The fact that this subject was left untouched by all the other participants can be viewed as a significant finding in the current study. Perhaps this neglect of collaboration is related to undermining the hierarchy. It is therefore recognized as lacking. This topic, like many others including identity and the like, was not brought up by the researcher; nevertheless, while others were touched upon by interviewees, collaboration was not.

3.1.6. Competing as a means for conflict solution
Participants were presented with hypothetical scenarios in addition to the semi-structured interviews and analyzed according to Thomas and Kilmann’s five conflict-handling modes (see Figure1). All participating nurses utilized competing as a response to at least one of the proposed scenarios. Their tactics included bypassing authority and documentation in patient charts. In some instances, nurses excluded the physician by doing as they deemed fit and informing the attending physician...
after the fact, or by turning to a higher authority. Nurses are well aware that such acts threaten physicians, and use them as a form of power display.

3.1.7. Perpetuation of hierarchy
3.1.7.1. Craving the physicians’ appreciation and respect. The nurses were asked to describe a satisfying situation in their professional career. Out of twenty stories, fifteen reported satisfaction at recognizing something the physicians had overlooked, which was enhanced by gaining the appreciation of the physicians involved.

Liel: ... The patient lost consciousness. The attending physician (... terribly smart and upstanding) began making calls and scheduling an urgent head CT and other tests ... I said doctor, hold on ... let me check his sugar levels, he’s diabetic. It turns out the patient went hypo ... I prepared a glucose push, he administered it, and within minutes the patient came to. So he thanked me, said that if he had waited with the glucose and opted for the CT, the patient would have simply died there and then, and no one would have known why.

Ravit: I had this patient ... I was about to discharge him and noticed his hand was bloated ... The pressure to discharge was coming from all directions—the ER, head nurse, the patient’s daughter ... but I said wait, this doesn’t feel right ... I went to the doctor and told him ... meanwhile the department head arrived and saw the discharge letter on the counter and asked “why didn’t you discharge him?” I turned pale and was afraid that maybe I made a mistake in not discharging him, and wasted this time when there are patients in the hall ... So I told him, “Listen, I wanted the doctor to have a look at this because it didn’t look right ... ” So I told him my diagnosis and he said, “O.K., Ravit’s diagnosis is correct.” My heart was pounding with excitement ... It is satisfying to know that if he had gone home, we can’t be certain he would have made it back to the ER for treatment ... I know there’s a good chance I saved his hand. In such a difficult moment, when I didn’t have any time, ... I saved his hand. I carry this satisfaction around. It happened ... a year ago maybe, but I remember it .... The head of the department saw it and complimented me in front of everyone.

These accounts reveal that nurses see themselves as diagnosticians, often superior to esteemed physicians, and pride themselves on performing well under pressure. More importantly, their stories expose their desire for the physicians’ appreciation and public commendation.

3.1.8. Perpetuating the Doctor-Nurse game
The current study found that the nurses still comply with the rules of the Doctor-Nurse game, a term coined by Stein in the late 1960s. They are expected to be bold, show initiative and provide significant recommendations, while appearing passive; their suggestions must appear as though they were initiated by the doctor (Stein, 1967).

Ravit: I had to give this patient Ventolin [Salbutamol], and for some reason I also took a look at his potassium levels. I noticed they were at the lower end of the spectrum, maybe below. I came up to the doctor with a seemingly idiotic question, “Tell me when potassium levels are low, is
it problematic to give Ventolin?” even though I knew the answer. So he said, “Yes it is, why?” and surprisingly, the order was cancelled [laughter]. There are tons of cases like this, but I don’t mind. I don’t mind seeming stupid … at first they thought it was just my lack of knowledge … later they realized I’m not just asking questions, they should listen to me.

Liran: I would tell her [the physician] something and then play dumb and say “maybe we could push ten units” or something like that, … something along the lines of the correct answer, and what’s really required, and wait for her to say it as though she came up with it …

Liel: I had this patient in her 60s with shortness of breath and fever, overall not feeling well … ER diagnosed pneumonia … During one of my shifts I noticed she wasn’t getting better despite the antibiotics, I told the attending [physician] that maybe we should start Clexan [blood thinners], I tried to hint that the patient might have pulmonary embolism … The doctor didn’t really respond, and the senior was just making his rounds, and I hear him tell the attending [physician] that it might be a pulmonary embolism … and maybe we should start her on Clexan just in case … The senior suggested a protocol PE CT, and by the end of the shift they actually had a PE diagnosis and started on the right treatment, she was discharged about ten days later in an overall good state.

The reward for a game well played is an efficient doctor-nurse team. The physician can utilize the nurse as a valuable advisor, and the nurse gains self-esteem and professional satisfaction. Penalties for failure at the game, however, may be severe. The physician, an unskilled player, makes powerful and sometimes vengeful enemies of nurses (Stein, 1967). As nurse L put it: doctors are scared [laughter], we often have more power than they do. You know what happens when they get on our nerves and are on call? They’d get a call every ten minutes, even if there’s nothing we actually need …

3.1.9. Manipulation as a means for problem solving

Figure 1 (see above) presents Thomas and Kilmann’s five conflict-handling modes, to which manipulation was added in this study, as a sixth mode, since it occurred in over half of the interviews. The nurse coaxes the physician to agree with her, without his realizing the manipulation. One nurse called it care-maneuvering, downplaying the aggression of the manipulation. Unlike aggression as a means of problem solving, described as a characteristic of subverting the inter-profession hierarchy, manipulation, in this case, can be viewed as a means for maintaining the hierarchy.

3.2. Nurse and physician interaction: gender before professionalism

3.2.1. The nurse as a woman

The study directly approached the matter of nurse-physician interaction. The nurses were asked to describe the ideal male and then female physicians. All the participants claimed that they expected the very same characteristics and capabilities from both genders. However, half of the nurses added that they expected female physicians to exhibit feminine qualities as well.

Nahila: I expect female doctors to be more attentive, to be aware of the patients’ surroundings and notice whether the patient ate and drank or not.

Limor: With a more open heart … same as a male doctor, but maybe more able to express her emotions. Like a woman …

Orit: Like a male doctor, but with the heart and soul of a nurse, a woman.

The nurses expect female physicians to exhibit more care. They align with the cultural–social notion of care as a feminine quality and expect female physicians to be softer, more attentive and more empathic. Participants used distinct gender stereotypes when describing their interactions with female physicians, naming so-called feminine qualities such as loudness, hesitation, confusion and stress.
we have a female intern, whenever we work together I get stressed because of how stressed she is. During CPR, it’s vital that whoever is in charge of the procedure will be calm, with her it’s terrible. She yells and stresses, it makes it hard for the staff … We had to perform CPR on a young patient who suddenly crashed. I was treating him and urgently called her over while pumping the ambu. The moment she walked in she started screaming, everything was restless, probably because of her stress. She is inattentive. She can’t help it … she lacks self-esteem and that’s why she yells. When she’s on call, we’re far from happy …

Tamar: … it’s not a stereotype, they’re always more hysterical and hesitant …

So-called feminine qualities such as moodiness in female physicians were mentioned by six nurses, contributing to the gender stereotyping and criticism of female physicians.

Alexandra: Other nurses prefer working with male doctors … that’s what I think. Male doctors are used to getting orders from females, and don’t argue. Women are more opinionated and moody.

Meira: Male doctors don’t yell as much. Women are moodier. If a male doctor is aggressive, at least he’ll always be aggressive … a female doctor can be your best friend one second and completely different the next … Maybe it’s because women are more uptight.

3.2.2. Female physicians as “non-male”
Masculine characteristics include assertiveness, courage, leadership skills, quick decision-making, confidence, independence and a strong personality. These are part of a list described by Sandra Bem (1974) and mentioned by the nurses as characteristics which female physicians lack. Female doctors suffer from the double-edged-sword of social expectations. They are expected to prove themselves as much as their male colleagues, yet maintain a good work/home balance. Traditional gender roles place them as inferior to male doctors, thus forcing them to prove their worth over and over again, creating a conflicting duality of feminine and masculine traits.

Liel: We performed a long CPR on a patient … he had been dead for a while … she didn’t have the guts to call the time of death …

Inbar: All in all, I avoid confrontation and try to get along with everyone … I asked the doctor to come over and recommended intubation. She vehemently resisted … We stood around the patient’s bed, another experienced nurse and I, thinking if we don’t intubate, the patient will die … The doctor hesitated and was very confused until finally I called the on-call and let her talk to him and of course we intubated … The problem with our profession and hospitals in general is that you have to make decisions ad-hoc, there’s no time to hesitate.

Hesitation and lack of confidence was a recurring theme in most stories describing female physicians, overtly and subversively.

Liel: In general, a male doctor is easier for a nurse to work with and can be counted on. Some female doctors can’t make decisions …

Limor: I feel more confident working with a male doctor, and will resist less. Male doctors are more authoritative and exude confidence. Men are surer of themselves, they don’t hesitate, they’re more calculated. Patients also feel more confident with male doctors than female doctors …

Muneer: With new female doctors you can feel a lack of confidence … it’s not that their care is not good, but they hesitate, maybe this or maybe that … a female doctor always needs someone to tell her “you’re right, go on” …

Sivan: I feel better working with male doctors … they are more decisive and assertive [than female doctors] and I like that. I don’t like hesitation … especially when it’s an emergency. I want to feel confident. It’s easier to work with male doctors because you really have someone to count on.
Ronit: I can say that I had more confrontations with female than male doctors. I don’t know if it’s a coincidence or not, but we have female doctors who specifically confront the nurses more than male doctors. I don’t know if it’s because the nurses value the male doctor’s opinion more, or because he is more attentive to the nurses ... but with female doctors, we have more confrontations.

Some nurses spoke about male and female physicians in terms of male/female roles from a personal-life perspective:

Orit: It’s easier to get along with men. It complements the perspective, makes it holistic one. The nurse is in charge of the emotional aspect [of] reading the patient, and the doctor takes on the practical aspect [of] decision making.

Liel: Something about ... the dynamics of men and women ... overall, a male doctor is easier for nurses to work with.

Halima: it’s easier to work with men ... women with women, it’s harder ... men are flirtatious.

4. Female doctors as too masculine, or not feminine enough

Ilanit: Some female doctors act like real bitches, trying to prove they’re important and always right ... I don’t like that! You can talk to a person on the same level and get the same result.

Alexandra: We had this doctor, every time she would try to tell us what to do without giving any explanation. That’s not how we work. I want to know why an order was given or not [given]. I won’t work like a robot ...

Tamar: Female doctors get into this male model, copying their behavior. They’re less attentive than male doctors ... the opposite of what usually happens outside ...

5. Discussion

5.1. Professional axis

This study found nurses to be concerned with constructing their professional identity in the shadow of the “other”—the physician. According to Tajfel and Turner (1986), social identity is formed through encounters with the other. This other poses an alternative to the individual’s definition of self and forms the foundation of the dynamic process whereby the individual constructs all aspects of his or her identity. The convergence of physicians and nurses and their dialogue, whether real or imagined, is a manifestation of this encounter. The current study revealed repeated attempts by the nurse participants to define their identity through the nurse-physician dialogue. In describing their professional role, nurses put up physicians as a point of comparison, unable to define themselves and their roles without them. On the one hand, nurses present a united front against the “other,” visible through the (Box 1) “us versus them” divide. Nurses are united in discourse, depicting themselves as superior to physicians, fighting with them over professional prestige, criticizing and belittling them. On the other hand, the physician’s presence, status, role and authority pose an attractive, prestigious and vastly authoritative and humane alternative to the nurses’ identity.

Paradoxically, the physician unknowingly plays a dual role in both forming and disturbing the professional identity of the nurses. This study found the nurses to perceive their profession as overshadowed by the “other,” yet they simultaneously try to overturn the professional hierarchy between them and the physicians. This is manifested in their wish to disassociate themselves from the “other” and establish their profession as independent and distinguished in its own right, with equally influential capabilities. The preservation process, however, perpetuates nursing as an overshadowed profession. This fluctuation indicates the unease experienced by nurses with regard to their professional identity.
Interviewees repeatedly compared physicians and nurses in terms of importance, capabilities, status and professional prestige. They found their profession to be as important and lifesaving as that of the physician colleagues, going as far as viewing themselves as the patients’ defenders. They were resentful of the public perception of physicians as all-powerful gods, claiming that these notions are far removed from reality, while the public is unaware of the role of nursing. Critical discourse primarily refers to young physicians who are perceived as unprofessional, uncaring, lacking sufficient knowledge, hesitant and dependent on the nurses. Nevertheless, nurses, much like the public at large, continue to view senior physicians as all powerful.

Since physicians are the recipients of everything the nurses strive for, nurses appear to be envious of them. This paper coins the term Stethoscope Envy for the nurses’ wish that they had the status, prestige and scope of authority and autonomy of physicians, primarily with regard to decision-making.

The nursing and medical professions fight over influence, authority and public prestige, simultaneously overturning and perpetuating the existing hierarchy. They act as rivals in competition with one another. The nurses’ stories are laced with battlefield Box 2 metaphors, emphasizing their discourse as the complete separation between the two groups. This seems odd at a time when the medical system is brandishing the idea of medical collaborations, particularly between nurses and physicians. The literature of the past decade is primarily concerned with the importance of such collaborations as influencing quality, satisfaction and professional persistence, particularly among nurses (Gordon et al., 2011; Martin, Ummenhofer, Manser, & Spirig, 2010; Zwarenstein, Goldman, & Reeves, 2009). Surprisingly, barring one nurse, all the participants in the current study neglected to mention collaboration, which is a theme that is clearly lacking.

The professional hierarchy, together with the nurses’ specialization, forms a fertile ground for conflict. Their tales of friction are the nurses’ attempt to have their voices heard. The patients’ benefit is at the forefront of discourse, yet a much more complicated process concerning the role of the nurse in the spotlight is taking place behind the scenes. Nurses are trying to be heard, demanding to be headliners rather than co-stars.

From a personal-organizational standpoint, conflict management tools may be more significant than the conflict itself. Contrary to previous studies employing the TKI (Thomas-Kilmann) model to present nurses’ conflict management mechanisms as compromising on or avoiding issues (Kunaviktikul, 1994), all the nurses in the current study utilized aggressive methods as a response to at least one of the scenarios, using tactics that go beyond those described in the literature. These included appealing to higher authorities, other physicians, or senior nurses; refusal to carry out orders; and documenting the discussion with physicians based on the patients’ chart. In some cases, nurses disregarded the physician, did as they deemed fit and informed the physician after the fact, or otherwise turned to a higher authority. In addition to the TKI model, our study presents another tactic, termed manipulation. Nurses employing this tactic still considered the interest for which they fought as aggressive, yet managed to get agreement of the physicians, who do not realize they are being manipulated. One nurse described this as care-maneuvering, casting it in a friendlier, less aggressive light.

Interestingly, despite describing the importance of their profession and simultaneously belittling doctors, all nurses spoke of the value of the physicians’ appreciation. This finding was covertly expressed in nurses’ descriptions of satisfying situations. Fifteen of the twenty stories mentioned satisfaction at identifying something the physician failed to see, which triggered appreciation from the physicians involved. Similarly, tales of conflict, whether directly asked for or posed as scenarios, reveal that nurses expect to be recognized and appreciated by physicians for being correct in their intuitions or diagnoses. Herein lies the paradox: on the one hand, nurses struggles with a professional identity by comparing themselves to the physicians; while, on the other hand,
their need for recognition and appreciation is based on the physicians’ superior position, thereby perpetuating the existing hierarchy.

Analysis of the findings shows that the nurses are well aware of the existing physician-nurse hierarchy, simultaneously rejecting it by aspiring for complete equality in medical decision making, while also maintaining it. Rejection is manifested through the themes of “minimized professional gaps,” “nursing is just as important as medicine,” and “the myth of medical doctors is far from reality,” laced with copious use of “us versus them” (Box 1) terminology. Perpetuation of hierarchy includes the striving for the physicians’ recognition and playing the Doctor-Nurse game. This may be primarily due to tradition, habits and convenience.

5.2. Gender Axis

5.2.1. Interaction with male and female physicians differs
When it comes to female physicians, the nurses introduce gender stereotypes to the discourse, in addition to competition, comparison and aggression thus far described in nurse-physician interactions. The current study exposes nurses as “doing gender,” in the terms of West and Zimmerman (1987), thereby contributing to gender-based discrimination. They raise themes of “the nurse as a woman,” “female physicians as ‘non-male’,” and “female doctors as too masculine or not feminine enough.” Nurses prefer working with male physicians, yet refrain from admitting it, except when discussing the preferences of other nurses. They state various reasons for this inclination, stereotypical and judgmental in nature. Male physicians are depicted through masculine qualities, such as confidence, assertiveness and high tolerance, whereas their female counterparts are described using negative judgmental phrases and the lack of desirable masculine qualities. According to this study, the nurses view such characteristics as positive and beneficial, even essential to the profession, while their absence is a disadvantage.

Considering Kohlberg (1966) and Gilligan’s (1982) theories on nurses’ interactions with female physicians, the sampled nurses seemed to employ Kohlberg’s approach in measuring the physician’s profession on a masculine scale, thus limiting the female physician’s public perception as professionals.

Of a total 30 stories shared by interviewees, 11 of them mention a female physician as the antagonist. They emphasize a different aspect of the nurse-physician conflict than with male doctors: depictions of conflicts with male physicians are discussed in terms of reason for conflict—e.g., non-traditional medication, sending patients unaccompanied, etc.—whereas depictions of conflicts with female physicians revolve around the physician’s behavior, particularly stereotypical judgment relating to personality. All stories pertaining to gratifying interactions and nurses’ desire for the physicians’ appreciation and recognition referred to male physicians. This is fascinating in itself: Do nurses desire appreciation and recognition from all physicians, or only from males? The nurses were found to be more excited about or flattered to receive attention from male physicians, and even more so from those in senior positions.

Another point of reference is related to the nurses’ encounters with the female physicians, Stein’s Doctor-Nurse game, in which gender plays a significant role in atmosphere, flirting and manipulation (Stein, 1967). Perhaps the game cannot be played when a female physician is involved. Since nurses apparently place gender before occupation, they would be less inclined to participate and take on the rules of the game. It would appear that the power struggles described on the professional axis are enhanced in the presence of female physicians. In interactions with male physicians, nurses maintain a balance between preserving and undermining the relationship, whereas the female ones primarily evoke the undermining reaction.

5.2.2. The gender of the “other” affects the nurses’ professional identity construct
The current study makes a significant contribution to the literature by providing a new interpretation of the nurses’ discourse concerning female physicians as a contributing factor to the undermining of their own professional identity due to their gender. Literature concerning physician-nurse relations has covered subjects such as cooperation, power struggle, gender, etc., but previous studies have not
proposed the very introduction of women into professional medicine as possibly linked to the undermining of the nurses’ professional identity.

This study presents the other side of the feminist revolution. Thus far, women’s entry into the women’s entry into occupations traditionally viewed as masculine has been perceived as extremely positive—at least from the women’s perspective. The current study exposes a gender shift which undermines the identity of women working under those women who attained equal opportunity. Based on this study, it can be concluded that the professional identity of nurses both affects and is affected by their interaction with physicians and their gender.

6. Merits and limitations
The current study has several methodological limitations. First, the participants were chosen by head nurses, and perhaps were more willing to share their experiences, but which may not represent the opinions of all nurses. The second limitation is related to the scope of the study. Although the sample consisted of nurses in seven departments, they were all employees at the same hospital, which might influence their organizational culture and discourse. Their views might not necessarily represent those of all the nurses throughout Israel. Moreover, the study explored relations in the hospital, yet it would be interesting to compare interactions within the community at large. The method itself poses a third limitation: perhaps observations should be used in addition to interviews, thereby expanding our understanding of the nurses’ perspectives in describing the links between their experience and action. Lastly, perhaps the location in which the study was performed is another limitation—cultural differences could very well have an impact on participant experiences, particularly given the complex and varied religious and national orientation of the Israeli public.

7. Conclusion
This study contributes to existing literature by demonstrating how nursing as a profession is in a state of unease with regard to its identity. Professional identity is affected by two axes: gender and profession. Nurses’ identity is constructed through comparison and the overshadowing of one factor by the other. According to this study, while the “other’s” scope had not changed, the “other’s” gender is now more focused on female physicians. This fact further disturbs the nurses’ identity, as witnessed through increased expressions of judgment and criticism toward female physicians.

As far as nurses are concerned, the professional axis changed the more they felt that the gaps between them and the physicians had minimized. Nurses were found to utilize aggression and manipulation as strategies for solving their conflicts with physicians. Given the critical importance of professional identity for the proper functioning of nursing professionals and their relationship with physicians, nurses should be aware of this factor, and stress their significant contribution to patient care within the hospital, in an attempt to escape the physicians’ shadow.

Björkström, M. E., Athlin, E. E., & Johansson, I. S. (2008). Nurses’ development of professional self—From being a nursing student in a baccalaureate programme to an experienced nurse. Journal of Clinical Nursing, 17 (10), 1380–1391. doi:10.1111/j.1365-2702.2007.02014.x

Braun, H. J., O’Sullivan, P. S., Dusch, M. N., Antrum, S., & Ascher, N. L. (2015). Improving interprofessional collaboration: Evaluation of implicit attitudes in the surgeon–Nurse relationship. International Journal of Surgery, 13, 175–179. doi:10.1016/j.ijsu.2014.11.032

Brodsky, E., & Van Dijk, D. (2008). Advanced and specialist nursing practice: Attitudes of nurses and physicians in Israel. Journal of Nursing Scholarship, 40(2), 187–194. doi:10.1111/j.1547-5069.2008.00225.x

Caricati, L., Guberti, M., Borgognoni, P., Prandi, C., Spaggiari, I., Vezzani, E., & Iemmi, M. (2015). The role of professional and team commitment in nurse–Physician collaboration: A dual identity model.

References
Bern, S. L. (1974). The measurement of psychological androgyny. Journal of Consulting and Clinical Psychology, 42(2), 155–162.
Nurses' views on challenging physicians' practice in an acute hospital. Nursing Standard, 24, 42–47. doi:10.7748/nst2010.06.24.42.42.c7830

Davies, K. (2003). The body and doing gender: The relations between physicians and nurses in hospital work. Sociology of Health and Illness, 25(7), 720–742.

Dingwall, R., & McIntosh, J. (1978). Readings in the sociology of nursing. Edinburgh: Churchill Livingstone.

Gamarnikow, E. (1978). Sexual division of labour: The case of nursing. In Feminism and materialism: Women and modes of production (pp. 96–123).

Gilligan, C. (1982). In a different voice. Boston: Harvard University Press.

Gordon, M. B., Melvin, P., Graham, D., Fifer, E., Chiang, V. W., Sectish, T. C., & Landrigan, C. P. (2011). Unit-based core teams and the frequency and quality of physician-nurse communications. Archives of Pediatrics and Adolescent Medicine, 165(5), 424–428. doi:10.1001/archpediatrics.2011.54

Ibarro, H. (1999). Provisional selves: Experimenting with image and identity in professional adaptation. Administrative Science Quarterly, 44(4), 764–791. doi:10.2307/2667055

Jefferson, L., Bloor, K., & Spilsbury, K. (2015). Exploring gender differences in the working lives of UK hospital consultants. Journal of the Royal Society of Medicine, 108(5), 186–191. doi:10.1177/0140013X15608749

Jogulu, U., & Vijayasingham, L. (2011). Conflict management does not have to create conflict. Journal of Nursing Management, 26(1), 11–18. doi:10.1111/jonm.12503

Thomas, K. W., & Kilmann, R. H. (1974). The Thomas-Kilmann conflict model instrument. Texusd, NY: Xicom.

Valentine, P. B. (2001). A gender perspective on conflict management strategies of nurses. Journal of Nursing Scholarship, 33, 69–74.

Warner, P. M., & Hutchinson, C. (1999). Heart failure management. Journal of Nursing Administration, 29, 28–37. doi:10.1097/00000511-199907000-00010

Wear, D., & Keck-Mcnulty, C. (2004). Attitudes of female nurses and female residents toward each other: A qualitative study in one US teaching hospital. Academic Medicine, 79(4), 291–301. doi:10.1097/00001888-200404000-00004

West, C., & Zimmerman, D. H. (1987). Doing gender. Gender and Society, 1(2), 125–151.

Wilson, J. L. (2004). Conflict management does not have to create conflict. Account Today, 9(20), 1–3.

Zelek, B., & Phillips, S. P. (2003). Gender and power: Nurses and physicians in Canada. International Journal for Equity in Health, 2(1), 1–5.

Zheng, R. M., Sim, Y. F., & Koh, G. C. H. (2016). Attitudes towards interprofessional collaboration among primary care physicians and nurses in Singapore. Journal of Interprofessional Care, 30(4), 505–511. doi:10.3109/13561820.2015.1105993

Zwarenstein, M., Goldman, J., & Reeves, S. (2009). Interprofessional collaboration: Effects of practice-based interventions on professional practice and healthcare outcomes. The Cochrane Database of Systematic Reviews, CD000072.
