
Women in European Universities
RESEARCH AND TRAINING NETWORK

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Doing dominance and doing deference: Doctors, nurses and gender[1]

'Doing gender' has become a useful and widespread concept in feminist theory and gender research.[2] It suggests active performance and subjectivity – bringing our attention to the ways in which gender relations are (constantly) created, maintained and contested in interaction and daily life. It lets us understand that gender and gender relations are not a static pre-given but moulded in ongoing actions where at least two partners need to be present. As an analytical tool, it lets us examine how others (willingly or unwillingly, consciously or unconsciously) do gender when interacting with us, but equally how we are accomplices (willingly or unwillingly, consciously or unconsciously) in the doing. But the active and continuous form implied in the 'ing' of the doing equally signals its transformative status, indicating that relations can be changed. The doing can and does change form (for better or worse).

Closely related to doing gender are the concepts of 'doing dominance' and 'doing deference'.[3] While power relations are inevitably on the agenda in the term doing gender, doing dominance and doing deference highlight more clearly the nature of unequal and oppressive relationships at work – where gender may be central but of course even other relations such as class and ethnicity. In this paper I would like to discuss more closely the ways in which doing dominance and doing deference can be understood in a hospital setting when examining the everyday working relations between doctors and nurses and in particular between women doctors and nurses. Gender, but even class, are placed centre-stage.

My introduction so far might suggest that doing gender, doing dominance and doing deference, focus solely on an *individual level*, that it is

[1] This paper is based on a speech held at the project's mid-term conference in Lund in October 2001.
[2] As far as I know West & Zimmerman (1987/1991) were among the first to introduce the term into the accepted conceptual vocabulary in their article with the same title – even if it was implicit in earlier feminist work. It is implied of course also in some of Goffman's work.
[3] Cassell (1996), for example, uses these terms in her study of women surgeons.

only individuals' actions that are of concern. It is, however, not that simple. Individuals' actions have to be understood within a wider societal setting where structures, symbols and discourses – that are all imbued with gender – are taken into account. There is a relentless and reflexive process of these other levels influencing individual action and individual action similarly constructing, maintaining but even altering these structures, symbols and discourses. The various levels are intertwined. In the vein of Dorothy Smith's (1987) work, it is important to explore the social relations individuals bring into being in and through their actual practices. Central in Smith's work is this notion of social relation that cannot be collapsed into people's goals, objectives, or intentions. As Smith argues:

> It [the notion of social relation] provides a procedure of analyzing local work practices – the locus of the experience of the subject – as articulated to and determined by the generalized and generalizing relations of economy and ruling apparatus. (Smith, 1997: 167)

In other words, everyday life and the practices we find there should not be our focus of attention in themselves as pure ethnographic description. Rather they are a starting point for unveiling what lies behind – for helping us uncover gender and class relations at work and to understand the complex interconnections.

The study

In the late nineties I carried out a qualitative study – involving shadowing doctors and nurses in their daily work, as well as a number of in-depth interviews – at the Departments of Surgery and Ophthalmology at a Swedish district general hospital.[4] Originally I was interested in trying to establish if women doctors received poorer service from and/or were less respected by nurses (who are still overwhelmingly female[5]) than their male counterparts.[6] Could it be that the shared gender among women doctors and nurses would

[4] Participant observation was carried out during a period of five months. 42 individuals were formally interviewed. In addition a focussed interview with a group of nurses was also carried out. Both men and women were shadowed and interviewed.

[5] Despite attempts to interest more men to enter nursing in Sweden, the percentage of men working as nurses still lay at 7.6 % on 1999-12-31 (http://www.vardforbundet.se/medlem/stat/hel_del.htm)

[6] Internationally and nationally there was some evidence that this was the case. See, for example, Heising, 1995, Lindgren (1992) Mackay (1993), Porter (1992), Pringle (1998), Risberg (1998).

account for a poorer relationship? It seemed an important question to ask given that women are rapidly increasing their numbers in the medical profession.[7]

As the research moved along, and I became more immersed in the field, the original research question was both broadened and re-evaluated. It seemed more relevant to enquire how the relationship between women doctors and nurses was possibly of a *different nature* (perhaps worse but perhaps equally better?) than was the case between male doctors and nurses. Other important changes were also apparent at the time, influencing my focus. One was nurses' strategies at professionalization (where own independent duties are emphasised) which meant that the word service – indicating nurses' handmaiden role – appeared antiquated. Another was the fact that the medical profession in Sweden has been subject to processes of deprofessionalization, proletarianization and disempowerment.[8] The above tendencies mean that the boundaries between nursing and medicine are thus being renegotiated.[9] At the same time, the two professions are importantly historically imbued with particular gender relations and build upon *certain* notions of femininity and masculinity – which while under fire at the present time, still equally leave their mark in an important fashion. My interest became thus directed at examining the relationship, with its inherent conflicts, between medicine and nursing more generally from a gender perspective while also keeping my specific interest in the working relations between women doctors and nurses in view.

It is not my intention to present the research findings as such from this study in this paper – although some empirical data will be presented.[10] Rather I wish to illustrate how the problematic of doing dominance and doing deference in hospital work can be approached with the help of yet another concept that has gained importance in feminist and social research in recent years, namely the body. (See for example, Bordo, 1995; Davis, 1997; Featherstone, Hepworth & Turner, 1991; Shilling, 1993 and Turner 1996.) I use the body analytically in a variety of ways. On the one hand, there are real bodies involved, situated in

[7] Women constitute just over 50% of students in current medical education in Sweden as well as in many other countries (see, for example, Crompton, et al, 1999) and are fast increasing their share as practising medical doctors. The top positions – including consultants – are still, however, overwhelmingly held by men. Consultants (Sw: överläkare) consisted of 75% men and 25% women in 1995 (Nordgren, 2000: 70). 39% of women doctors were at the junior doctor level in 1998, while the equivalent figure for men was 25% (Nordgren, 2000: 70).

[8] See Nordgren (2000) for an interesting analysis of these processes.

[9] A number of other elements also account for the changed relationship: work organisation on the ward and in the hospital (eg. primary nursing); the significance of 'welfare illness' (as opposed to infectious diseases) as the major medical panorama – which in turn requires a different form of care; down-sizing, rationalizations and market economy ideas and their implementation.

[10] The study is more extensively reported and discussed in Karen Davies, *Disturbing Gender. On the doctor–nurse relationship,* Lund: Department of Sociology, 2001.

space and place, evoking interactional patterns linked to gender and class relations. On the other hand, the body is used in a more metaphorical sense and refers to the bodies of medicine and nursing. Just as we can say a body of knowledge, the bodies of medicine and nursing imply that the professions embrace collective values, views, ways of working, knowledge bases, etc – which understandably affect how the two (collective and individual) bodies approach and understand each other. The various levels – embracing the body and gender relations – seep into each other, which will become apparent in the following pages.

It can perhaps be pointed out that the body is implicated in a further way in a qualitative study such as this. It is of course *my* body inscribed with its gender, race, age, and immigrant status, schooling in a Western tradition that privileges me as a knower. It is my body – on the ward, in the operating theatre – that is the standpoint from which the study is carried out.

The paper will be structured in the following way: 1) First the bodies of medicine and nursing will be examined from a gender relations perspective. In a sense, this section is an important background to the following two sections. 2) The fact that 'gender is inscribed on the body' and thus affects interactions between doctors and nurses will be addressed in the second section. 3) Finally, the question of situatedness – where the bodies (of doctors and nurses, men and women) find themselves in the daily run of things will be approached.

The bodies of medicine and nursing

> While medical training can be seen as a 'toughening up' process preparing students for the rigours of a doctor's life, nurse training is an object lesson in submission. In nurse training *others* get tough. The nurse is taught to follow rules, to be deferential to doctors, and the importance of routine is emphasised. (Mackay, 1993: 43–44)

This quotation comes from the beginning of the nineties and it can be argued that the description with regard to nurses is no longer totally correct. Change is underway. Yet traditional relations still hold sway to a large extent – relations that were initially premised upon doing dominance and doing deference.

Without doubt what has been considered the most important attribute of nursing from its inception to the present day is *caring* – the ability to nurture, to show comfort, concern, dedication, emotional contact and warmth, but even sacrifice. Caring is not of course only the prerogative of nursing – it is seen as an important element in many women's jobs (including the home) and is indeed often equated with a 'feminine attribute'. The point of feminist work has been to

show that this attribute is not natural in itself but part and parcel of a particular discourse. At the time nursing was being established, at least in Britain, as an independent occupation for middle-class women in the mid-nineteenth century, its related sister – caring – was being emphasised as a desirable and necessary quality in *all* women regardless of class – it was something to be striven for by women, a part of their education. In her book *Formations of Class and Gender* (1997) Beverley Skeggs links the inculcation of a caring attitude in the nineteenth century with the concepts of respectability and responsibility. Women were given responsibility for upholding the moral standing of the nation, they were in other words to civilise the nation, to be responsible for social order and were of course blamed if they did not succeed in their part of the colonial project. Skeggs shows how this attitude was linked to the concerns of hygiene, sexuality, the centrality of the family and women's place in it. But furthermore their education into a caring subject position was interlaced with socialisation into acceptance and enjoyment of this subjectivity. What is important in Skegg's work is that it shows how *a caring self* – a particular identity – is discursively constructed as a normative feminine ideal. In other words the construction of femininity and caring go hand in hand. The following quotation from 1905 clearly shows this in relation to nursing:

> Nursing is distinctly woman's work... Women are peculiarly fitted for the onerous task of patiently and skilfully caring for the patient in faithful obedience to the physician's orders. Ability of care for the helpless is woman's distinctive nature. Nursing is mothering. Grownup folks when very sick are all babies (*Hospital,* 8 July 1905, p. 237). (Quoted in Gamarnikow, 1978: 110)

A caring self and related (constructed) feminine attributes were not cast independently but in relation to (a certain type of) masculinity that prevailed at the time. Femininity meant dependency and subordination in relation to masculinity. Nursing was unequivocally created as subordinate to medicine. As a male doctor wrote at the end of the nineteenth century:

> My name and reputation as a man and surgeon depend on my ideas being carried out as I would have them carried out... The nurse is not employed as consultant, as critic, as arbiter, she is strictly an executive officer (*Hospital,* 31 July 1897, p. 164). (Quoted in Gamarnikow, 1978: 109)

Writing 'as *a man* and surgeon' clearly indicated the gendered relations involved. Gamarnikow (1978) saw a parallel in these turn of the century relations of the nurse-doctor-patient triad with the family structure. Ideologically, nurses could be seen as 'mothers' (doing the nurturing work), doctors as 'fathers' (making the decisions in a patriarchal manner) and patients as 'children' (where decisions

were made over their heads and little or no autonomy was encouraged). This patriarchal style did mean that: 'In return for being prepared to behave as handmaidens nurses could expect gratitude and protection, the approval and recognition of powerful men' (Pringle, 1998: 190).

Celia Davies (1995, 1996) has persuasively argued that the foundational underpinnings of a profession – where medicine's status is of course firmly assured – are inextricably bound up with a certain masculinist ideal, what could be called, I would argue, 'hegemonic masculinity' in Connell's (1995) terms.[11] The qualities that are associated with this form of masculinity, which Connell shows are historically constructed, can be described in the following terms: rationality, hierarchical authority, objectivity, decisiveness, physical and mental strength, competitiveness and individualism.[12] Drawing on Rosalyn Bologh's work (1990) and relating back to Weber's ideas about bureaucracy, Davies (1995) shows how the construction of public man (or the 'manly man' in Weber's terms) is infused with a discourse of hegemonic masculinity:

> He is /.../ restrained. His belief in a cause disciplines him to self-control, and to a careful weighing of courses of action in pursuit of the cause. He must use his intellect and arrive at an independent judgement /.../; he must apply rational criteria to his decision-making. He must not allow his vision to be clouded by sentiment, and in this regard must welcome and foster the distance from others that this entails. (Davies, 1995: 33)

Indeed compare this to the description of the qualities and inscribed body of the doctor – which the medical student needs to learn:

> In medicine, the inscribed body of the physician, both male and female, is marked as decisive, objective, rational, and above all, composed. The performances incised on medical students' bodies are from head to toe, including a forthright gaze, handshake, and stride, along with countless other nuanced ways of moving throughout the halls of medicine. Doctors *control* interviews, procedures,

[11] I am aware that the concept of masculinity has been criticised (see for example, Hearn, 1996), but I still feel that hegemonic masculinity is of relevance to the discussion here. Crompton, et al (1999) are sceptical as to whether a profession can be defined as 'masculine', arguing that traits such as expertise, impartiality and impersonality may be necessary to the practice of the profession and are not as such masculine. What I am trying to argue here is not that medicine is masculine *per se,* but that it was historically constructed in relation to *one* form of masculinity and furthermore in relation to nursing – where practitioners were seen as subservient and where a *certain* form of femininity was constructed.

[12] Acker (1990: 153) writes 'Currently, hegemonic masculinity is typified by the image of the strong, technically competent, authoritative leader who is sexually potent and attractive, has a family, and has his emotions under control'.

> practices. Of course the doctor's body may touch or exhibit other caring gestures, facial expressions, or tender tones, but it is a body *in control* of itself. (Wear, 1997: 105–106, emphasis in the original)

The construction of (these forms of) masculinity and femininity, of medicine and nursing, exhibit quite different qualities and of course it is here that we can find one of the reasons why women doctors may find their position problematic – they have to find space in an area that has already been defined by masculinist ideals and where values and behaviour, that women doctors may feel are a part of their own constructed femininity, are questioned. Or as Joan Acker (1990) puts it:

> Women's bodies cannot be adapted to hegemonic masculinity; to function at the top of male hierarchies requires that women render irrelevant everything that makes them women. (Acker, 1990: 153)

Hegemonic masculinity is always given privileged status. Hegemonic masculinity also involves homosociability – the preference for similarity, to work and play together with other men, to appoint others cast in their own image.[13] Risberg (1998) argues that homosociability means that men at workplaces, despite internal antagonisms and different positions in the hierarchy, behave unitedly in front of women and in so doing maintain their position of power. In her latest book Lindgren (1999) suggests however, that homosociability – at least within surgery – is in crisis. One reason given is the introduction of new technology. Homosociability implies a hierarchical order where senior men receive respect from younger men who in turn receive tutelage from the older. New forms of surgical operations using computers and digital pictures – 'Nintendo surgery' – are easily and skilfully learned by the younger generation, whereas the older may have difficulties. The senior artisan can no longer train the junior doctor. The traditional hierarchical order is turned around and the previous holy alliance between men is put to the test.

Quotations that I used earlier from Gamarnikow (1978) in relation to nurses and hegemonic masculinity were from the turn of the last century. 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. Let me though cite the opinion of J.R.

[13] Hegemonic masculinity also involves homophobia. Connell (1995) shows how homosexuals constitute a different form of masculinity, one which is considered substantially subordinate to hegemonic masculinity.

See Lindgren (1999) for a more comprehensive discussion of homosociability in relation to surgeons/surgery.

Benson, a leading British surgeon, who in 1992 wrote the following in the *Lancet* (quoted in Pringle, 1998: 69). It can be seen as an example of how hegemonic masculinity ensures its position and dominance by rejecting notions of gendered social constructions and by calling upon a discourse of biological difference (and where psychological differences are imputed as naturally given).

> We live in a world where a policy of sexual equality, especially at work, prevails. However, in reality the sexes differ not only biologically, but also in less tangible, more subtle ways in respect of psychological make-up...
>
> Apart from the long and unpredictable hours of work that inevitably involve sleep deprivation, surgeons also sometimes have to operate (often on long and difficult cases) when very fatigued. In my experience, female house surgeons are not as tolerant of sleep deprivation and more prone to succumb to exhaustion than their male counterparts...
>
> Some aspects of surgery – for example, procedures for emergency thoraco-abdominal trauma – demand a certain attitude of mind and level of confidence, with a minimum of diffidence and hesitation and absence of any impression of panic. Such qualities may be to some extent gender dependent in favour of the male psychological constitution. (Benson, 1992: 1361)

Doing masculinity can be understood as performance or 'masquerading'. Pringle (1998) points out that masquerading suggests acting and duplicity and implies that something may well be hidden in the masquerade – that if we take the veil away we will discover something else. She suggests that all versions of masculinity – including the surgeon's – are to some extent masquerades, 'which may stem from a sense of lack or fragmentation and lay claim to an omnipotence which is impossible for anyone' (Pringle, 1998: 81). If masculinity is performance, if it is socially constructed rather than biologically given, there is of course no reason why women shouldn't succeed in mastering the performance. On the other hand, it is perhaps the masculinist project with its props, roles and accoutrements – and insistence on hierarchy – that is rejected. And while doing masculinity is perhaps masquerading and therefore 'play', it becomes 'deadly reality' in its consequences, namely it ensures 'doing gender'/'doing dominance'and therewith disadvantages and hurts women.

Analysing medicine and nursing in terms of projects of masculinity and femininity helps us understand the tensions and problematics involved in present day relations. Nursing ardently struggles to attain professional recognition, yet caring with its emphasis on closeness and emotional aspects is not part of the masculinist definition of a profession. This is then, as Celia Davies (1995) argues, the professional predicament of nursing. Specialisation, mastery and impersonality – the hallmarks of a profession – sit uneasily with what nurses see as central to their occupation that emphasises holistic care.

There is furthermore an additional problem. The idea(l) of a profession rests importantly upon the notion of autonomy. Yet professional autonomy is dependent on the hidden work of others. The work would be impossible without the recording, filing, service duties, preparatory and follow-up work of (primarily female) others. 'It is only through this activity that the work can take on its active, agentic and distant and controlling character. Autonomy therefore, turns out to require considerable additional work without which it cannot be sustained' (Davies 1996: 670). Thus Davies argues that a further predicament for nursing in aspiring to professional status is that its own work is part of a gendered division of labour that helps support and preserve the medical profession.

However, it is not only nursing and the masculinist vision of a profession that jar badly. I would argue that even medicine is in a process of redefining what a profession means and questions its masculinist base. In recent years a debate has arisen around the inhumane aspects of medicine, suggesting that there are shortcomings in everyday relations with patients.[14] Compassion, respect for the individual's dignity and integrity – *seeing* the individual patient, caritas and self-knowledge are all important aspects on the agenda. Thus it would seem that even within medicine, the traditional notion of profession is being both questioned and reformulated. Are curing and caring to be once again united?[15] It is often at this intersection of caring and curing that the possible (and assumed) contribution of women doctors is raised – frequently in relation to a more essentialist gendered understanding. But as Pringle (1998) argues:

> More interesting than any absolute truths about the differences between men and women is the discursive production of difference and the subjectivities that get constructed in relation to these meanings. Therefore the issue is not whether women doctors are truly more caring than men but what can now be done with such claims. Can they be used to fracture the associations between medicine and masculine authority, to open the ground for a rethinking of what we want medicine to be? (Pringle, 1998: 221)

Pringle sees masculine authority woven into the medical profession as illustrating what she calls 'medical modernity'. As we shift into late or postmodern times, we could argue that *one* way of doing things, one way of being a doctor or nurse becomes obsolete and that the narrow constructions of masculinity and femininity that have been a part of medicine and nursing become historical figurations. It is also interesting to note that, as Celia Davies (1996) points out, what can be called the 'new managerialism' – while assuredly

[14] The establishment of a professor's chair in humanistic medicine at the Karolinska institute, Stockholm suggests, I would argue, the importance of a differing discourse.
[15] See Fisher (1995) for a much wider discussion around the issue of curing and caring.

problematic in many ways – has provoked more overt gender talk and starts to question and to some extent unmask the values associated with hegemonic masculinity.

I have tried to show in this section that doing dominance and doing deference have undoubtedly been part and parcel of how medicine and nursing were historically constructed in relation to each other. These relations are at the present time in flux – yet they still importantly influence how the two collective bodies understand the other and work with the other. Space does not allow me in this paper to explore in more detail how this was expressed in my study – see, however, Davies (2001).

Gender is inscribed on the body

I would now like to move our analysis to another level and argue why the inscription of gender on the body is central in understanding the working relations between women doctors and nurses – and between male doctors and nurses.

We may well imagine that sex/gender is not important when interacting with other individuals – that other qualities are more salient – but we are *always* aware whether the person we are talking to, or interacting with in some other sense, is male or female.[16] Our senses automatically register this information whether we wish to or not. It is almost impossible to continue an interaction if we can't work out the sex/gender of the other individual. As Cecilia Ridgeway (1997) has argued:

> Thus, although we may be able to imagine an ungendered institutional script whereby 'the student talks to the teacher,' we cannot interact with any actual student except as a male or female student. The sex categorisation of self and others, even in institutionally scripted settings, is a fundamental process that injects a variety of gender effects onto the activities and institutional contexts that people enact. (Ridgeway, 1997: 220)

[16] Chatting on the internet is perhaps an interesting exception. Using nicknames, altering identity, makes it possible to be genderless or change gender. In this sense, it is perhaps possible to argue – in postmodern terms – that identity is not fixed. At the same time, communication on the net is not face to face – does this make the centrality of gender less important – the body as such is not present ? Are embodied face to face contacts always characterised by the need to determine the gender of the other?

In a similar vein it can be argued that a nurse never just interacts with a doctor or vice-versa, it is always a female or male nurse[17], female or male doctor.

Drawing together empirical findings and theory from social psychology/social cognition, Ridgeway (1997: 220–221) delineates how interactional processes infused with gender, work. Our perceiving of others is always hierarchical. It begins with an initial classification that works on an automatic basis and is prompted by a very small number of primary social categories, which in time take the form of a more detailed typing depending on the circumstances. In Western society, sex is one of these primary social categories – indeed as I suggested earlier 'we automatically and unconsciously sex-categorize any specific other to whom we must relate', to use Ridgeway's words (p 220). But it is not only in the initial meeting that this sex-categorisation takes place:

> Yet sex categorisation continues because the actual process of *enacting* an institutional script with a *concrete* other evokes habitual person perception, and with it the culture's superschemas that define the basic attributes necessary to make sense of any person. (Ridgeway, 1997: 220)

Cultural super-schemes evolve hand in hand with gender stereotypes, which describe what behaviours can be expected from a person of a given category. Subsequent detailed typing may fade the original (stereo)typing – whereby other identities take larger command.[18] However, they may also increase in their tenacity and steering of behaviour. Ridgeway continues:

> In work settings institutional identities are likely reside in the foreground for actors. Evidence indicates, however, that even when other identities are the most powerful determinants of behavior in a situation, cultural gender stereotypes become *effectively salient* (ie. sufficiently salient to measurably modify actors' expectations and behavior) under at least two conditions: when the interactants differ in sex category, and when gender is relevant to the purposes or the social context of the interaction. (Ridgeway, 1997: 221, emphasis in the original)

[17] While male nurses were included in my study, their numbers were far too small to draw out a more detailed gender analysis.

[18] Tilly (1998) discusses the treatment of women in men's jobs, such as concrete truck driver and rapid-transit conductor. Initially, he argues, it is difficult to be accepted for the job they do since they are seen as *women.* But with time recognition for their work can be achieved as well as less harassment. 'With experience, the relationship shifts from predominantly man/woman to predominantly worker/worker. Accumulated local knowledge actually produces a change of script' (p 98).

Gender stereotyping in our society usually works to the advantage of men, suggesting that they are more competent in a field and imbuing them with higher status. In the medical world, default stereotyping can include attitudes such as male doctors are better clinicians, better in the operating theatre, better in positions of authority, better at dealing with conflicts, etc.

Reskin (2000) draws attention to the fact that although some employment discrimination (while I am not interested in employment discrimination as such here, the arguments are transferable to an understanding of how we treat people in different ways in work settings) results from people pursuing their group-based interests or prejudices, much discrimination is the result of normal cognitive processes which are divorced from an individual's motives as such. In other words, beliefs or actions may occur automatically regardless of what we may more consciously think. Categorisation is a non-conscious process. Reskin (2000:3) reports on a study carried out by Bodenhausen et al (1998) where subjects in an experimental study were asked to avoid sexist statements in a sentence-completion task. Findings showed that subjects were able to succeed in this request if enough time was available to complete the task, but if they felt time pressure their constructed statements were even more sexist than those who were not instructed to avoid making sexist statements. This may well have ramifications, I would argue, for how men and women work in a hospital setting when stress and lack of time certainly hold sway at the present time.

Nurses will argue, when asked, that the sex/gender of the doctor plays no role when working together – that it is primarily a question of personality. Both male and female doctors can be easy or difficult to work with. Supported by Ridgeway's and Reskin's contentions, I would argue that nurses might like to think this (and indeed in our times of overt equality talk it would be politically incorrect to state otherwise), but that in reality it is hard to escape the fact that gender stereotyping is implicated in social interaction – whether we/they like it or not.[19]

On the one hand, then, we have unconscious gender stereotyping emerging its head – influencing attitudes. On the other hand, the situation is complicated by the gender-class divide – by the realities of doing dominance and doing deference. Traditionally, medicine has meant doing dominance. Whereas traditionally in society at large, being a woman has meant doing deference. Women doctors thus straddle between the two, finding themselves in some kind of no man's land. The following nurse sums up the situation:

[19] In ensuing discussion, the nurses would in fact often provide evidence of responding to a woman doctor differently or of a woman doctor behaving differently towards them.

> If a female doctor shows herself to be the slightest superior, then it's much more difficult for her. One gets slightly confused – I mean she's a woman, like us, but she's a doctor and has higher status than us and still she comes here and doesn't know anything and I've worked here for twenty years... it's probably unconscious... it's harder for a young female doctor than a young male doctor.

Women doctors' 'doing dominance' is thus problematic in the nurses' eyes.[20] Or as another nurse put it:

> The male doctor is usually more authoritarian. He plays his ball game regardless. And if he says to me, 'Go and take that patient's blood pressure', then I go and do it. I don't stop and think about it, whereas with a woman I might have thought that she could go and do it herself. I've got less patience with regard to an authoritarian attitude if it's a woman. If I say, 'Do it yourself', the men don't do it. They've been pampered for too long. The women give in more easily – a bit embarrassing really – they think, 'OK, I'll do it myself'.

My data would suggest that it's not only a question of nurses having problems with the women doctors doing dominance, the female doctors, themselves, may be uncomfortable with this mode of behaviour. Pingel & Robertson (1998) give further support for this in their study. As one woman doctor said:

> I find it difficult to ask for help with things I could do myself – yesterday I hesitated in asking an assistant nurse to clean the floor when an incontinent woman wet herself – I mean it's preposterous to imagine that I should clean the floor and be late for my out-patients – and yet all the same it's hard asking another woman for help with the dirty work. (My translation) (Pingel & Robertson, 1998: 26)

Gender stereotyping can however become less salient with time. My material seemed to indicate that women doctors encountered most problems as newcomers, whether it be as a newcomer to a department[21], in the emergency room or in the operating theatre. When they had shown their competence and knowledge and that they were 'OK people', then the nurses were often more enthusiastic about working together with them than the male doctors.[22] However, if the women doctors continued to have what were considered

[20] The question of women doctors and authority is more thoroughly addressed in Davies (2001).
[21] Junior doctors have to frequently move department and ward as a part of their training.
[22] Sexuality could, of course, also affect the relationship – so that (female) nurses are/were more likely to help a male doctor (this of course presupposes heterosexuality). Space does not allow me to develop this more comprehensively in this paper.

authority problems (being too bossy, too hard) then the nurses tended to treat them more harshly than their male counterparts (regardless of the doctor's position in the hierarchy).

One important reason why the nurses could, however, prefer working with a female doctor was the latter's amelioration of doing dominance; the nurses felt that they were given more space in their joint encounters with a patient. They appreciated the type of mutual communication[23] that could emerge with a woman doctor. Many of the female doctors supported the contention that they 'included' the nurses:

> The round is important because that's when we [the doctor and the nurse], *together,* put the picture together. Some of my male colleagues get at me for this attitude. They say, 'You're the one deciding'. OK, maybe it's a female dilemma; it's hard to be totally authoritative. Of course we're not always in agreement. But I can often learn an awful lot from the nurses who are experienced. It is a *dialogue* – that we *together* decide what is best for the patient. But this requires that we really make the decisions together, because if one of us starts thumping our fist on the table and doesn't bother to listen to the reactions of the other who's going to be carrying out what's been decided, then I've noticed it just doesn't work. (Female junior surgeon)

While doing dominance and doing deference was an issue of relevance between women doctors and nurses – in terms of reducing its saliency, it was also an issue *within* the medical academy itself. The doctors' narratives made it clear that those lower down in the hierarchy, regardless of gender, were subservient to those higher up. But in addition, there was evidence in my study, as well as in the general literature in the area, showing that women within medicine encounter particular difficulties and differential treatment.[24] Some of the women doctors in my study[25] voiced, for example, the following opinions:

[23] I am aware that this could be interpreted in terms of binary oppositions: women are good at communication and men are not. This is not what I am trying to argue – at least not on an essentialist level. If the women took time to communicate, it was primarily because – I would argue – they saw the need to create a viable working relationship with the nurses if they were to be able to do their jobs properly and engage the nurses' cooperation. See Davies (2001) for a description of the type of work women doctors put into 'winning the nurses over'.

[24] See, for example, Crompton, et al (1999), Hultcrantz, (1998) Lorber (1984), Perhson (1997), Pringle (1998), Riska & Wegar (1993) och von Vultée & Arnetz (1997).

[25] In addition to women doctors working at the two departments studied, I interviewed a considerable number of other women doctors working at other departments and hospitals. Older women were less likely to be critical as were the women at the two departments actually studied. The latter may be linked to the fact that it is was harder to be critical of colleagues, knowing that I was regularly at their workplace and more or less knew everybody. Of course it may also mirror the fact that hierarchical and gender relations were of another nature at the departments studied (due to leadership, type of speciality, etc).

> We have to take our starting-point in men as the norm – we have to adapt ourselves to their rules. We're only allowed in as guests. (Woman orthopaedic surgeon)

> They [the male doctors] want tough boys for this job because they were tough boys themselves. (Woman surgeon)

> My clinic is like a military camp where the top rooster gets unbelievable respect. (Woman physician)

Female doctors working in departments where the number of fellow women doctors are few frequently experience a sense of outsiderness; that male doctors – particularly their seniors – do dominance towards them.[26] Some of these women related how they would purposefully form alliances with the nurses so as to offset the masculine environment they felt forced to be a part of and which was destructive to their own identity as women and doctors.

Situatedness: the body in space and place

Social and feminist geographers (see for example the authors in Rendell, et al, 2000 and Duncan, 1996) have brought our attention to the ways in which space and place are instrumental in social relations.

> The appropriation and use of space are political acts. The kinds of spaces we have, don't have, or are denied access to can empower us or render us powerless. Spaces can enhance or restrict, nurture or impoverish. (Weisman, 2000: 4)

Once again the body becomes central here since the appropriation and use of space is directly linked to where the bodies (of doctors and nurses, of men and women) locate themselves and/or are located in the daily run of things. Situatedness is also closely linked to doing dominance and doing deference. In this final section, I would like to illustrate how these relations can actually be enacted, first in relation to women doctors within the medical hierarchy and second with regard to the (shifting) boundaries between doctors and nurses.

[26] There was a strong feeling that young male doctors today are very different from the older generation in terms of values and attitudes.

Particularly within certain specialities, being accepted as a woman doctor is a hard fought battle.[27] Interestingly the female body is used at times as a reason for their exclusion, or at least for questioning their suitability in spaces that historically have been constructed as masculine, such as orthopaedic surgery and general surgery. It is the size and strength of the female body that is brought into question. It is not a body, it is argued, that can meet the demands of certain operations. Stamina may be lacking. It is not a body that commands authority and respect from staff assisting operations. Admittedly these were not opinions openly raised by the majority of the respondents in my study – I would imagine that equality debate in recent years has inhibited what can be seen as open discriminatory talk. But the fact that it was mentioned spontaneously by a number of women doctors is evidence of its persistence notwithstanding.

A female orthopaedic surgeon showed the inconsistencies in the arguments sometimes put forward. Her example to be outlined below clearly highlighted how the female body is socially constructed rather than simply biologically determined; how senior male colleagues do gender and do dominance in the process. Orthopaedics is a speciality where the number of women doctors is especially low – in fact this is where, along with thorax surgery, we find the least number of women in Sweden; the figure for 2001-01-01 was 8%.[28] It could be argued that the reason lies in not enough women choosing this speciality. However, interestingly, many of the women preregistration house officers told me that they found the speciality exciting and said that they could seriously consider making this their choice of speciality. Orthopaedics involves both younger and older patients, requires concrete skills and is felt to be rewarding since patients frequently improve after operations and treatment. Suffering – which is so much a part of many specialities – is less evident here. For these reasons, the speciality is attractive. But is the speciality interested in keeping women?

The woman orthopaedic surgeon I spoke to described how women seldom stayed long – they disappeared into other specialities. Subtle forms of exclusion appeared to be at work. An example was given to show how the body is used to question women's suitability. Recently a woman house officer had started and was required to carry out an emergency operation on a hip fracture. Second on-call was contacted. The operation does require some strength, it was argued by my interviewee, but this is not what is most important; it is rather a question of technique. The senior doctor called in though, commented

[27] Within ophthalmology, a high percentage of women are to be found (just over 50%) as well as working hours that are similar to office hours. The situation for women doctors seemed somewhat easier here.

[28] Läkarfakta, 2001, Sveriges läkarförbund (Physician statistics, 2001, Swedish Medical Association).

afterwards upon the woman doctor's purported frailness. This caused my interviewee to react in the following way:

> They start straight away by measuring her physical strength. And yet we've had guys here that are much more 'delicate'. So I said to him, 'Have you thought about when we competed in the Vasa race[29] the other day – here all the male doctors take part in this competition – that she beat them by two hours, that she was much faster than any of the male doctors here – and you go around here and call her weak!'.

Body size was also commented upon by the women surgeons I followed into the changing rooms before operating. Claiming space was not automatic in their rather small bodies it was argued. Showing their (extra) worth and competence were necessary if they were to be taken seriously in the operating theatre. And indeed operating equipment did not always seem designed with a slighter body and hands in mind. The women surgeons often had to stand on footstools to reach a patient comfortably.

It was not only in the operating theatre that the women surgeons felt at a disadvantage. Their 'wrong bodies' elicited wrong reactions from patients as well.

> I don't know how many times – especially in the first years of course – when I've seen patients on the round twice a day, of which 75% by myself, I've admitted them, operated on them, discharged them, written prescriptions for them, signed their taxi receipts and sick leave forms, explained things to them and then asked if there is anything else they've wondered about and they say, 'When is the doctor coming?' (Female ward surgeon)

While smallness was the theme usually commented upon, one woman doctor on another clinic, who was rather large, mentioned her size as disadvantageous. She took too much space; something she felt contributed to her badly functioning relations with the nurses.

Regardless of whether comments about body size were openly aired or not on the clinic by male doctors or nurses, the women doctors were very conscious of their bodies – their fitting or not fitting into expected norms. They had internalised various cultural super-schemes (Ridgeway, 1996) with regard to space-place-body. They were very much aware that they were seen as being the wrong bodies in the wrong places. 'Body' could be made less salient with time if their expert and experiential knowledge came to the fore. Cassell (1996: 43)

[29] The Vasa race (Vasaloppet) is a yearly, international, long-distance skiing competition – the distance to be covered being 85.8 km.

suggests that there is a double rebuttal that needs to be revoked, as summarised by one woman: "Either you're not a woman, you're a bear, a dog, or a lesbian; or you're not a surgeon, you're no good." The latter is challenged, as many of my respondents argued, by showing that they are good at their jobs – and not just good, better than average. With regard to being a woman, Cassell's respondents spoke of the importance of wearing lipstick so that it would not be assumed that one was a lesbian. 'One woman described how, as a medical student on a surgical rotation, when called to the emergency room in the middle of the night to attend to a gunshot wound, the older female resident would remind the two of them, "Oh, we have to put lipstick on!"' (Cassell, 1996: 44).[30]

Let us now leave the situation of female doctors and apply our gaze to the meeting of the two professional bodies once again. A re-negotiation of certain spatial boundaries and rituals – perhaps not widespread as yet – would appear to me to be evident of current changes in the organisation of hospital work and in a levelling of status differences. The situatedness of bodies is highly relevant here.

The morning round can be taken as an example. Traditionally, space and place have unequivocally spelled out status and position. The long train of individuals trooping into the patient's room is not a haphazard formation. The consultant takes the lead, the lowest person in the hierarchy comes in last. Indeed, one problem I experienced in my fieldwork was to know where in this formation my own presence would be normatively correct; that I did not overstep a boundary. I will discuss below another type of morning round to show how the situatedness of bodies in space can provide a certain sense of empowerment for the traditionally subordinate group; that doing deference can be ameliorated. The round, described above, is still in full force, at least on some of the wards I studied. But it should perhaps be pointed out that it is a far cry from an earlier regime where patients 'stood (sat) to attention' when the consultant came in, where doctors did not talk directly to the patient but only communicated via the staff nurse and where even the paper baskets were emptied in advance so as not to offend the consultant!

On one of the surgical sections I studied, a different form of morning round had been introduced. Doctors (consultants, the ward surgeon, house officers and preregistration house officers) congregated in a room on the ward in the morning and seated themselves around a round table. Primary nurses – who

[30] In her study of women surgeons, Cassell (1996) reports that she found little evidence in her interviews of direct sexism or misogyny and reflects whether this is due to the fact that it is easier for a woman surgeon to cope with her situation by 'forgetting' such events. It was rather in informal talks when she related 'shocking stories' that women surgeons would admit that they had experienced similar events. My own material is not overflowing with misogynic stories either. Yet there is often a sub-text around such issues. Regardless, one such story is one story too many.

were responsible for three or four patients – came in separately but in succession and also seated themselves at the table. Patients – their condition, their problems, their follow-up treatment – were then discussed. The nurse initiated discussion by first presenting a latest summary and appraisal of the patient. After the 'conference', doctors, unaccompanied by nurses, visited each patient.

Nurses were overwhelmingly positive about the new routine, doctors were more wary in their comments: 'It takes too much time, we need to get off to the operating theatre'. 'You need an old-fashioned round, so that the nurses can learn.' In particular, the house officers felt they had difficulty in grasping the situation of all the patients. Some of the consultants drew out its advantages though: 'We spend more time on discussing the patient from various angles, including the social and what will happen to the patient when he/she leaves the hospital, in addition to talking about various investigations and lab results. We can sit down and more discuss in peace and quiet'.

Interestingly, the nurses felt that they had won time with this form of round, especially as they did not accompany the doctors later into the patient (unless it was felt that there was a special reason to do so). Earlier time would be wasted waiting in the corridor for the doctor to get to their patient. Now the doctors might have to wait if the nurse could not drop everything on the spur of the moment when it was time to discuss her patients.

As I understood it, it had been the nurses that had pushed for the new order of things. The nurse manager gave the following reasons for its implementation:

> It's an attempt to minimise the number of people that are in the patient's room. What's the point of a whole flock? In part it's a question of confidentiality – when you're standing there in the corridor... And then the doctors, they get irritated when the cleaning trolley arrives or when the food trolley is on its way out. They themselves don't see that they stand there and take up a lot of space [in the corridor] during quite a long period of time. When the new electronic case records system was introduced, it became obvious that the old routine wasn't feasible any longer. I tried to argue that sooner or later they need to sit down somewhere when all the medication and case records are on the computer. We can't do a traditional round with a portable computer and everyone trying to peer into it. You have to be able to sit down at a larger screen.

Nurses in my study emphasised their advocacy role as well as their concern for the patient and this type of round, one could say, facilitates this. The following citation from a nurse working on another ward where a traditional round still held sway explains further why an advocacy role is difficult with the traditional routine:

> We just rush in and out. No meeting either before or after. I don't like this system. I'd like to see some sort of briefing before we go into the patient, I'd like to be able to say to the doctor, 'This is how it's been for Mrs Persson this morning...'. Unfortunately the doctors discuss treatment strategies in front of the patient. The patient just sits there like a big question mark... And then it becomes extra work for me. I have to 'clean up' after the doctors on this type of round.

The nurses on the new round indeed argued that the method allowed them to 'charge themselves' beforehand, it allowed them to prepare their arguments. My own observations – and comparing these to 'presentations' or information-exchange on the traditional round – noted well-structured and well-argued presentations.

Improving patient care then was an argument used by both doctors and nurses in justifying a new form of round. Surprisingly, establishing more egalitarian ways of working between the two professions was not taken up by my respondents. And yet it seemed to me that this was one of the (unintended?) outcomes and an important one at that. Space and situatedness were utilised in the traditional round to ensure medical authority; it was a way of doing dominance. The culturally determined spatial rules, admittedly unwritten but none the less widely understood, saw to it that each person knew their place in the hierarchy (including doctors within the medical hierarchy). Sitting around a table, by contrast, places bodies on an equal footing and provides the opportunity for real discussion.[31] Sitting down diminishes the importance of size (and dominance/deference) – that may be of relevance in relation to male doctors.

[31] I am of course aware that spatial arrangements may not be sufficient to engender equal talk.

A closing note

While some empirical findings from my study have been presented in this paper, my main aim has been to suggest how the concept of the body can be used when examining doing dominance and doing deference. Utilising the body in a number of ways, as suggested here, provides us with analytical access to the very complicated and multi-layered relations at work at the crossroad of gender, profession, hierarchy and bureaucracy. It also helps us see where gender relations can be contested and change introduced. Although I have examined these questions particularly in relation to the two main categories involved in hospital work – doctors and nurses, I assume that the framework is relevant for other workplaces where different professions or occupations interact and where doing dominance and doing deference is part of the nature of the gendered organisation.

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