Nursing Inquiry

Nursing Inquiry 2013; **20**(4): 280–292

Feature

Games, civil war and mutiny: metaphors of conflict for the nurse–doctor relationship in medical television programmes

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Accepted for publication 3 December 2012
DOI: 10.1111/nin.12023

WEAVER R. *Nursing Inquiry* 2013; **20**: 280–292

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Metaphors of medicine are common, such as war, which is evident in much of our language about health-care where patients and healthcare professionals fight disease, or the game, which is one way to frame the nurse–doctor professional relationship. This study analyses six pilot episodes of American (*Grey's Anatomy*, *Hawthorne*, *Mercy*, *Nurse Jackie*) and Australian (*All Saints*, *RAN*) medical television programmes premiering between 1998 and 2009 to assess one way that our contemporary culture understands and constructs professional relationships between nurses and doctors. Analysis shows that these popular television programmes frequently depict conflict, with games, civil war and mutiny between nurses and doctors over patient safety rather than professionals working collaboratively in teams to deliver health-care. Although the benefit of this televised conflict is the implication that nurses are knowledgeable, skilled professionals, the negative connotations include a dysfunctional and dangerous healthcare system, and also ongoing power struggles. Given that popular culture can sometimes influence the public's understanding of real-life nursing practice, it is important to explore what these metaphors of conflict are communicating about the nurse–doctor relationship.

Key words: communication, conflict, metaphor, nurse–physician relationships, nurse roles, power relations, television.

The professional relationship between members of health-care teams is important. The nurse–doctor relationship is interdependent (Fagin and Garelick 2004), relying on sharing knowledge and responsibility for patient care. For nurses and doctors and other health professionals to function effectively in delivering health-care, relationships must demonstrate respect, trust and competence (Pullon 2008). When these qualities are absent, conflict between nurses and doctors can lead to negative outcomes for patients (Larson 1999) and financial implications (Forte 1997) and can adversely affect nursing satisfaction and retention (Rosenstein 2002).

Expectations and beliefs about the roles of nurses and doctors can be influenced by the images of health-care available in popular culture (Kalisch and Kalisch 1987; Darbyshire and Gordon 2005; Gordon and Nelson 2005; Summers and Summers 2009; Cabaniss 2011). The public's knowledge of medical and social information can be affected by what they see on television (Davin 2003). More than this, media images can 'directly influence both a nurse's self-perception and the profession's ability to advance and evolve' (Burton and Misener 2007, 258). The image of nursing matters because it can affect how people understand the status of nursing in society, and because it can influence recruitment and retention within the profession: 'A positive nursing

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image is important to recruit the best and brightest student into nursing, establish trusting relationships with patients, promote positive morale within the profession and articulate a nurse's contribution to positive health outcomes' (Cabaniss 2011, 113). Television plays a key role in this, given its wide accessibility and audience, and although we cannot quantify the extent to which nursing images in popular culture affect the impressions or practices of people in and outside the profession, these popular images on television and elsewhere nonetheless play some role in how our society understands nursing.

Images of nurses and doctors across various media have received much attention over the years, with research suggesting that there are specific and enduring stereotypes that comprise the representations of nursing over time (Kalisch and Kalisch 1987; Bridges 1990). Despite the integral role of nurses in the healthcare system, the nursing role in popular culture has often been one of exclusion and absence (Ward and Summers 2008; Summers and Summers 2009) or submission and subservience (Keddy et al. 1986). Nurses are often seen in terms of their caring and compassion, while images of doctors tend to focus on their expertise and superior knowledge (Kalisch and Kalisch 1977; Aranda and Brown 2006). The occupations of doctors and nurses are traditionally gendered: doctors have typically been male, nurses female (Keddy et al. 1986; Sweet and Norman 1995). Although these gender roles do not now reflect current student and professional populations, these stereotypes remain along with their obvious implications for the power relationship (Falk-Rafael 1996; Warelow 1996), where traditionally doctors have been dominant and held power (Kalisch and Kalisch 1977; Keddy et al. 1986).

Images and stereotypes are often linked with metaphors and language. Metaphors are common in health-care, such as detection, exploration or a journey (Hodgkin 1985; Mitchell, Ferguson-Paré and Richards 2003; Reisfield and Wilson 2004). One common metaphor is military related, where health-care is a war against disease (Hodgkin 1985; Warren 1991; Michell et al. 2003; Penson et al. 2004; Reisfield and Wilson 2004). Beyond general metaphors, one specific to the nurse–doctor relationship is the game (Stein, Watts and Howell 1990; Sweet and Norman 1995), where nurses use subtlety to communicate their (sometimes conflicting) opinions and suggestions about treatment to doctors, which preserves the power relationship so that doctors can maintain the facade of authority over nurses with no threat of confrontation undermining this balance (Stein 1967). In the game, the 'cardinal rule was that open disagreement between the players had to be avoided at all costs. Thus, nurses needed to communicate their recommendations without appearing to make them' (Stein et al. 1990, 546). Over time, the game has shifted to more open communication (Hughes 1988; Stein et al. 1990; Sweet and Norman 1995) even if at times there remain vestiges of cloaked opinion (Svensson 1996). However, Stein et al. (1990, 549) raise the possibility that 'more open communication may degenerate into competitive struggles that undermine patients' confidence and threaten the quality of care'.

It is just these 'competitive struggles' that I want to explore in this study, by analysing some contemporary metaphors around the nurse–doctor relationship. This study came from a larger project studying medical students' perceptions of medical television programmes (Weaver and Wilson 2011). While I was watching the programmes I was struck by how many featured serious conflict between nurses and doctors in the opening episodes. Scene after scene in these programmes showed a nurse disagreeing with a doctor regarding patient care. In most cases, the nurse was proved correct, but the scenes highlighted the conflict regardless of the different ways each nurse communicated disagreement. Given the previous research around metaphors of war and games in particular, I wanted to analyse these programmes in more detail to assess if those metaphors are still in use or if there are other ways of framing the relationship between nurses and doctors.

METHODS

The data for this research are from a convenience sample of medical television programme DVDs available for purchase (and, in one case, rental) in 2010. The analysis is based on Pilot episodes of six television programmes. The criterion of Pilot episodes allows a more in-depth textual analysis than would be possible if entire seasons were included, although this limits the findings for specific shows because it cannot reflect developments over the series. As the purpose of Pilot episodes is to quickly create a world that attracts viewers, it is worth studying the ideologies about particular roles evident in these episodes.

Although I watched other medical television programmes, I limited the programmes to those that featured a doctor–nurse conflict storyline related to patient safety. In this way, Pilot episodes of programmes that did not meet the inclusion criteria included *House*, *Nip/Tuck* and *Royal Pains* (none of which featured nurses to any noticeable extent), and *ER*, *Private Practice* and *Scrubs* (all of which only included brief dialogue revealing conflicts between doctors and nurses over minor issues such as shared facilities).

To develop a broader picture, I included major American medical television programmes from recent years as well as Australian examples for further comparison. Including this perspective is important to see whether these metaphors operate only in a particular culture or recur across other (similar) cultures despite different health systems.

Television is a text that can be 'read' in a similar way to other media such as literature. The data analysis approach was akin to close textual analysis of literary works, and included taking detailed notes of the television programmes with a focus on dialogue and all the visual and sound elements of television to explore the meanings and messages created by the combination of these features. I drew upon these notes when writing my analysis of the programmes. Fiske (1987/2011) distinguishes between three levels of codes that contribute to how we read television. The first is the social code of reality, which includes such aspects as costuming, speech and acting. The second is the code of representation, comprising technical elements such as the camera work, editing, lighting, music and sound, and conventional representational elements as in character, dialogue, setting and narrative. Fiske's third level of code relates to ideology, which may include issues of ethnicity, class and patriarchy. Thus, the first level of codes combines with the second to provide particular ideological messages: in this case, the costuming and dialogue of a nurse character and the music and camera work used for their scenes can influence how the programme positions that character in their status and role in the context of the show as a whole. My findings refer to these elements as they relate to my discussion.

As Fiske (1987/2011) notes, however, texts may be subject to multiple interpretations based on considerations such as different audiences. Accordingly, the following reading of these programmes may be one of many potential readings. I do not assert here that these metaphors of conflict are the only representations of the relationship in popular culture. In my analysis, moreover, I am focusing on only some of the interactions between nurses and physician characters, and so my discussion does not attempt to consider other ideologies or themes in these shows. These metaphors of conflict are just one way to characterise how nurses and doctors interact, but the recurrence across programmes makes it important to study. I have included references to real-life examples throughout, to ground my analysis in reality. Although I have organised my findings around three main metaphors: the game, civil war and mutiny, these are not intended to be precise categories, and there are common elements across all programmes. All the metaphors relate to conflict.

RESULTS

The game: Grey's Anatomy and *Nurse Jackie*

Grey's Anatomy began screening in the United States in 2005. *Grey's* is a doctor-centred drama that focuses on surgical interns at a hospital setting in Seattle, featuring a female intern, Meredith Grey, as the protagonist. The pilot episode featured some nursing staff in very minor roles. *Grey's* warrants analysis first because its focus on doctors offers a counterpoint to the nursing-centred shows and because it frames nurse–doctor relations as a game.

Grey's sets itself up by explicitly drawing on game metaphors with its opening scene voiceover from Meredith: 'The game. They say a person either has what it takes to play or they don't', a motif that is repeated at the end of the episode. *Grey's* use of 'game' refers to the sporting arena as a metaphor for surgery, but it is an unexpectedly resonant frame when one considers that this episode also depicts the nurse–doctor relationship in ways that recall the theory of the nurse–doctor 'game' of nurses unable to openly communicate their opinion (Stein et al. 1990).

This first episode of *Grey's* includes a scene when an older nurse questions a young intern, Alex, about the correct diagnosis of a patient. Alex's response is scathing: 'Well, I don't know, I'm only an intern. Here's an idea, why don't you go spend four years in med school and then you let me know if it's the right diagnosis.' The nurse later raises her concerns with Alex again by paging him, but Alex ignores the page, sighing and contemptuously dismissing the patient as 'old. She's freaking ancient. She's lucky she's still breathing […] Don't page me again.'

What is particularly interesting about this scene is the way the nurse (who is never named) communicates her disagreement. The nurse asks 'Are you sure that's the right diagnosis?' Her second attempt is then downgraded from question ('Are you sure…') to observation ('4B's still short of breath'/'The antibiotics should've worked by now'), which requires even more reading-between-the-lines from the doctor. This relatively passive approach – asking if a diagnosis is correct or making observations rather than suggesting it is wrong and why – aligns with the theory of the nurse–doctor game, and we can perhaps read Alex in Stein, Watts and Howell's (1990, 546) description of 'Physicians who were unskilled gamesmen and failed to recognize the nurses' subtle recommendations'.

Alex does, however, recognise that the nurse is questioning him, but his reaction is defensive. He does not reconsider his diagnosis or ask any questions of the nurse: he does not hear the real message behind the words, which is that

his diagnosis is wrong. Instead, he hears only someone he believes to be his inferior undermining his authority. This is not just a fictional scenario; Arford (2005, 75) suggests that real-life doctors who only hear questions or differences of opinion as 'a challenge to their status and power' are symptomatic of dysfunctional communication, and this seems to be the case in *Grey's*. As an example of nurse–doctor communication, this dialogue in *Grey's* is markedly different to the five other shows I discuss. As becomes clear, the other programmes depict very frank disputes between the nurses and doctors; some fairly civil, some hostile, but all show more initiative than this nurse. Of course, *Grey's* is a doctor-centred show; this may explain why the writers have chosen such a passive, game-like manner for the nurse to adopt in this first episode.

Alex's rejection of this nurse's knowledge is symptomatic of a greater malaise than his pride, however, for it becomes clear that nurses are not valued in this hospital, a point noted by others as well (Hallam 2009; Summers and Summers 2009). Twice Meredith is palpably disgusted by comparison with a nurse: first, when she says, 'What did you just say? Did you just call me a *nurse*?'; and second, when a patient tells her, 'I twisted my ankle […] and I didn't get stuck with someone this clueless. And that was like, a *nurse*.' The patient sits up to say the word *nurse* in an exaggerated whisper, with acting that makes it abundantly obvious that Meredith should be humiliated by this comparison. Doctors taking offence at being 'mistaken' for a nurse is not unique to *Grey's*, of course; in the first episode of *Scrubs*, Elliot responds in a similar way: 'I'm a doctor, okay? The stethoscope, the beeper – a doctor, got it?' Summers and Summers (2009, 69) similarly note the problems of representation in *Grey's*, and although they offer a rather more brief summary, they make the important point that 'The female physicians' reactions to the slurs [of being mistaken for a nurse] effectively endorse the assumptions that underlie them'.

The nurse's concerns are proved valid, but the person who ultimately corrects Alex and wins acclaim for her knowledge is Meredith, not the nurse who first, and repeatedly, raised the concerns. In this doctor-centred programme, it is perhaps no surprise that a doctor steps in to assert authority to resolve this dilemma of a bad doctor at risk of being shown up by a nurse. In these scenes and in others, nurses in this episode of *Grey's* are shown in distinctively powerless ways, able to communicate only by question and implication in a game.

In contrast to the focus on doctors in *Grey's*, three nurse-centred television programmes began screening in 2009 in the United States. The first of these I want to discuss is *Nurse Jackie*. In an obvious attempt to distance itself from stereotypical depictions of nurses as angels of mercy, *Nurse Jackie* is a dark comedy that depicts Jackie Peyton as its painkiller-addicted, adulterous lead character. Jackie is seen taking drugs, forging paperwork and lying to patients' families. Focusing on Jackie's bad back and difficult working conditions, *Nurse Jackie* removes some of the glamour that coats some other depictions of the nursing profession, yet also rehearses the same plots about nurse–doctor conflict over patient safety.

In the first scenes, the audience sees conflict mirroring *Grey's*, where an older nurse questions a younger doctor. *Nurse Jackie* does not use language specifically around the game, but the interaction between this nurse and doctor is highly suggestive of the modern game, where disagreement becomes more open and hostile. Here, we see the nurse, Jackie, deploying a much more assertive mode of communication than in *Grey's* ('Let's check for glucose, rule out CSF, all right? The guy needs a scan'). This doctor, Dr Cooper, responds with the same defensiveness as Alex: 'I know what I'm doing'. The next scene shows the patient dead as Jackie stands beside him. Jackie then calls Cooper a 'retard': 'That was my patient, I told you he was slipping and he was. If I tell you to order a scan you order a goddamn scan, 'cause if you don't do it I'll just go to the next doctor […] that kid died and it is all on you'. Cooper's response is to grab her breast and follow this up with apologetic excuses of involuntary actions when nervous. This drift into farce undermines Jackie's legitimate concerns, which is the pattern of the next scene when a supervisor berates Jackie for working too much and then asks her to work a double shift. These shifts produce the comedy, but they also produce competing discourses that undercut the significance of these issues. Jackie also blames herself for the death, but the doctor is implied to be more culpable because of his unwillingness to respect Jackie's knowledge.

Jackie later calls Cooper 'incompetent and dangerous. He killed a bike messenger today. […] What do you doctors have against healing people?' Her (doctor) friend replies: 'Healing, helping, fixing. Fantastic. That's why you're a nurse. When I was a little girl, I took a butter knife and opened up a dead bunny to see how it worked. That's why I'm a doctor.' This distinction implies the cure/care binary opposition, a notion that defines doctors by the ability to cure and nurses by the ability to care (Jecker and Self 1991), where medicine, science, logic and the rational are constructed as being in opposition to nursing, caring, emotions and intuition, although here it also extends to an opposition between intellectual endeavour and physical assistance. Jackie's manner with patients is caring, albeit discriminatory (as when she flushes a patient's severed ear in a toilet as

revenge for his attack on another patient) or unethical (as when she forges the dead patient's signature to allow organ donation).

As with *Grey's*, Jackie is vindicated in her disagreement with the doctor. Yet, the price of demonstrating this is the patient. The programmes appear unable to envisage a way of promoting nursing as a profession of skill and expertise without simultaneously denigrating doctors as hapless practitioners whose egos and inflated sense of hierarchy cause danger or death for patients. The implication that patients can become a casualty of the nurse–doctor game and conflict is not the stuff of fiction, however, for commentators have pointed out that poor communication and dysfunctional relationships between nurses and doctors can lead to negative patient outcomes (Larson 1999; Rosenstein and O'Daniel 2005; Saxton, Hines and Enriquez 2009). *Nurse Jackie*, as with all these other programmes, adds to the image of nurses and doctors in conflict where patients become the casualties.

Civil war: Mercy and *Hawthorne*

If the game of *Grey's* becomes more open conflict in *Nurse Jackie*, other shows continue to extend this to a sense that nurses and doctors are at war with each other. The second metaphor, then, is civil war. Although the broad metaphor of war is very common in medicine, where healthcare professionals and patients fight a battle against disease, several of these programmes show conflict between the healthcare professionals themselves and depict a war between doctors and nurses. I call this a civil war because this conflict is essentially a battle between two forces wishing to take control of the same territory, which in this case is the healthcare setting. The metaphor of civil war also allows for the added sense that often one of the groups is attempting to win independence from a controlling group, and in these cases, it is the nurses who are trying to gain more autonomy.

The second nurse-focused programme that began in 2009 is *Mercy*, a drama that aired for one season only. The main character is Veronica, an army nurse recently returned from Iraq. *Mercy* and the other nursing programmes all highlight the undeserved lower status of nursing on the healthcare hierarchy, and present nurses as highly skilled, knowledgeable and confident professionals. The opening scenes of *Mercy* attempt to establish nursing as an exciting role along the lines of television emergency medicine doctors and highlight the extent to which nursing is underappreciated as a profession. We see this when Veronica witnesses a car crash and runs outside to perform heroic surgery. Viewers then learn of nursing's underappreciated role when Veronica is castigated in three separate ways following this event. A physician character, Dr Harris, outlines the hierarchy when he asks her: 'What the hell is going on here? Who ordered all this? […] On what authority? You're a *nurse*, okay? A *nurse*. I'll handle it.' Then, the patient's wife is horrified to learn that Veronica is, after all, a nurse rather than a doctor, shrieking: 'You're not a doctor? After all that, you're just some stupid nurse?' before threatening to sue. Finally, Dr Parks, who appears to function as supervisor to both nurses and doctors, questions Veronica about her failure to transfer the case to the doctor, and Veronica rails against Harris's 'stupid ego' as her defence.

It is clear from this one subplot that there is a hierarchy where doctors are seen as the controlling group and are ranged against nurses in a sustained and hostile conflict between the two groups in this episode. However, the way to promote nursing in *Mercy* again tends to be to denigrate doctors. In a scene shortly afterwards, one patient throws a bedpan at a nurse and complains 'You nurses, what are you good for anyway?', to which Veronica answers 'Well, we do try to keep the doctors from killing you.' And, indeed, doctors are sometimes incompetent on *Mercy*. A young doctor, Whittaker, flatters the nurses by bringing donuts as 'a little appreciation for the best nurses in the state' and then injures a nurse character by neglecting to say 'Clear' when using a defibrillator. Veronica points out his error and he watches rather forlornly as the competent nurses wheel the patient away. Another nurse, Sonia, asks, 'why do the nice ones always have to suck?', as if physician skill is directly proportional to arrogance. Sonia suggests reporting the incident to Harris, but Veronica claims that Harris will not listen to them and that they should instead 'just let the other nurses know to watch him'. This comment seems to encapsulate the dysfunctional representation of the nurse–doctor relationship in *Mercy*: doctors are hostile forces to both nurse and patient, and nurses must monitor doctors' behaviour rather than attempt to communicate with them.

It is worth comparing Veronica's communication with previous scenes in *Grey's* and *Nurse Jackie*. In a later scene, Veronica takes Whittaker aside to recommend an alternative treatment: 'You know, maybe we should be worried about a fat embolism. We could give him heparin. […] We used it on the front line. There are studies that show heparin can help.' Veronica's manner is confident and courteous as she suggests potential problems ('a fat embolism'), maintains a sense of collaboration ('we should') and offers rational and evidence-based suggestions ('We used it', 'There are studies'). She does temper her recommendations with qualifiers ('maybe', 'could') that may recall the language of the game, especially given that she offers statements rather than expli-

cit disagreement. Whittaker agrees to consider Veronica's concerns, but does not act on them, and the patient dies after developing an embolism. If respect is vital for successful nurse–doctor interactions in the real-world (Pullon 2008), *Mercy* (and all programmes discussed here) highlights the absence of this respect in fictional doctors' attitudes to nurses, although Veronica's own behaviour is unprofessional at times as well.

There are some positive sides to the nurse–doctor divide in this programme, however, where nurses are shown to be advocates for patients, particularly in end-of-life scenarios. In a scene with an elderly patient who is 'circling the drain' (a metaphor for approaching death, as described by the nurses), Veronica politely reminds the doctor, Sands, to explain the goals of surgery, recovery outlook and other options to the patient. Away from the patient, Veronica argues that the patient simply needs 'permission to give up' rather than yet another treatment. The show again heavily underlines its theme that nurses are under-valued, when Veronica tells Sands 'Hey, I'm just the nurse', when it has already been constructed that her knowledge and understanding of the patient is superior to the doctor's. At this point, the episode also invokes the binary opposition of cure/care, evident when Sands says: 'I treat the disease', to which Veronica replies: 'I treat the patient.' Their fictional conflict reflects real-world research that shows nurses and doctors may have competing values in end-of-life care. For instance, Oberle and Hughes's (2001, 711) study includes a nurse's comment that doctors have difficulty 'letting this patient die', a theme appearing in *Mercy*. Veronica's position is vindicated when the patient thanks her as 'the only person who's been honest'. Although aspects of *Mercy* also show unprofessionalism and abusive behaviours from nurses, the focus on nurses at war with doctors in this opening episode of *Mercy* does attempt to promote nursing skills and knowledge as equal (or superior) to that of doctors.

The medical drama *Hawthorne* also premiered in 2009 and features registered nurse Christina Hawthorne, Chief Nursing Officer at Richmond Trinity Hospital in Virginia. *Hawthorne* begins in similarly dramatic fashion to *Mercy*, showing the lead nurse in a heroic scene as she runs to save a suicidal patient. Christina threatens and abandons the patient, rescues him then attempts to honour his DNR order and is finally led away wrestling with security officers, shouting: 'You can't do that! I'm a *nurse*!' Despite this melodramatic start, *Hawthorne* offers some indications of a multilayered image of nursing, particularly in its depiction of Christina as nurse manager. Christina is shown in a leadership position, facilitating meetings, defending her nurses against the encroachments of hostile doctors and raising concerns at committee meetings.

The major battle of *Hawthorne*'s civil war occurs between a nurse, Ray, and a physician, Dr Marshall. Concerned about a patient's dosage levels, Ray pages the doctor (away golfing) and his lines showcase his dilemma at having to question a hostile combatant: 'I'm a nurse, so I can't give a diagnosis […] Nurse questions dosage […] Nurse wants doctor to clarify […] Or is nurse just being a bitter know-it-all who wants to catch the doctor in a mistake.' Viewers then hear Ray answer Marshall's call, struggle to say a word as the doctor presumably talks over him, and finally says, flatly: 'Yes doctor. Understood.' When Ray hangs up, he recites the doctor's message for his colleague's (and viewers') benefit: 'You nurses have got to stop calling me for every little thing. If I wrote it, I meant it. […] Who do you think you are, questioning my orders.' And finally, Ray sums up his understanding of the nurse–doctor relationship: 'And I follow doctor's orders. That's what nurses do.' The repetition of 'orders' is worth highlighting; such language implies deference on the part of nurses (Falk-Rafael 1996) where they are subordinates answering to the commands of their superior officers in a military hierarchy (Summers and Summers 2009). In *Hawthorne*, this message of unwilling obedience is laboriously repeated when Ray pauses before changing the dosage to sigh to the sleeping patient 'I'm a nurse'. Shortly after, the patient has a seizure because of the dosage error, codes and is transferred to intensive care.

The conflict continues when Marshall returns to the hospital and observes sarcastically to Ray: 'Interesting, giving me pointers on patient care. Remind me where you went to medical school?' Statements such as these perpetuate the myth that doctors alone are the sole experts on patient care and that medical school is the sole repository for health knowledge. Marshall's blame of Ray continues in a committee meeting, where she repeats Ray's line about the subservient role of nurses: 'nurses don't know how to follow doctors' orders'. Christina defends Ray, and Marshall leaves in anger, protesting 'I will not be lectured to by a nurse'.

As Svensson (1996, 389) points out, in real-life situations nurses can find themselves walking a line between 'the risks of […] appearing to be stupid or of irritating the doctor' and failing their duty to their patient by acting against their own convictions. In the fictional world of *Hawthorne*, Ray knew the doctor was wrong but defends his actions because he was adhering to 'hospital protocol to the letter to protect my patient'. Christina criticises his actions but does not canvass his other options, however, simply recommending the rather nebulous concept of following one's 'instincts'. This philosophy warrants attention because it again reminds

us of the cure/care binary opposition I noted earlier in respect to *Nurse Jackie*. This dialogue in *Hawthorne* implies that nurses rely on instinct (feelings, emotions, intuition), and doctors rely on knowledge (learning, mind, logic), which recalls Cixous's (2008) critique of hierarchical and gendered binary oppositions of male/female as head/heart, intelligible/palpable, logos/pathos. In *Hawthorne* (and the other shows here), these are all too easily recognised as medicine/nursing, with cure/care, mind/emotions, logic/intuition ('instincts'). Ray is a male nurse, but nursing is still often viewed as a feminine role: as Falk-Rafael (1996), the idea that women are irrational is linked to the belief that caring does not involve expertise or knowledge. This offers little support for the image of nursing as a valuable role in healthcare delivery alongside doctors. After all, students do not undertake university and nursing education to become highly trained professionals in feelings and instinct. Yet Gordon and Nelson (2006) suggest that in some cases nurses themselves reinforce the traditional ideas of virtue and caring rather than asserting their knowledge.

Christina explicitly frames the nurse–doctor relationship as an outright conflict when she warns Ray that 'Marshall just put a bullseye on your back and my entire nursing staff' and then proceeds to claim she is not on his 'side', but the side of the patient. This comment thus extends the conflict to suggest that it is a war not simply between nurses and doctors, but between patients and healthcare professionals. The patients constitute a third 'side' in this war; against them are aligned incompetent and hostile healthcare forces that consist of nurses and doctors at war with each other too. Parallels between real and fictional worlds of health-care are clear when we consider *Hawthorne's* fictional scenario against real-life comments from a participant in Rosenstein and O'Daniel's (2005, 24–25) study: 'Dr. X (a female physician) has chosen to be argumentative, demeaning and rude, not just to nurses but to (physician) colleagues […] unfortunately, patient care and morale have suffered. Nurses are afraid (and) intimidated to talk to Dr. X and delay that for as long as possible'. This particular real-life scenario is repeated across countless fictional medical television programmes, and *Hawthorne*'s use of it reinforces the nurse–doctor civil war.

Mutiny: All Saints and *RAN*

Moving beyond American television, my final two examples are drawn from Australia as a point of comparison. Both programmes showed conflict between nurses and doctors in very similar ways to *Mercy* and *Hawthorne*, but rather than simply disagreeing, in these cases, the nurse characters actually attempt to defy the doctors. Given the scenes use military language and also highlight the incompetence of individual doctors in charge of a patient, the rebellion of the nurses against those individuals is perhaps best captured in the metaphor of mutiny.

All Saints was a long-running Australian medical drama, which screened from 1998 to 2009. Set in a hospital ward, *All Saints* initially featured nurse unit manager Terri Sullivan as the protagonist surrounded by fellow nurses as well as other medical staff such as doctors and paramedics. Later seasons of *All Saints* moved the setting to the emergency department, began to focus more on the doctors, and finally added the subtitle *Medical Response Unit*. Because of its enduring popularity on Australian television, with high ratings and twelve seasons, and its setting in a different healthcare system, *All Saints* offers a useful counterpoint to American programmes.

The first episode of *All Saints* ('Body and Soul') opens with a scene showcasing general conflict between nurses Terri and Stephanie and an intern, Damien, over an elderly patient with breathing difficulties. The two nurses are in increasingly agitated conflict with the doctor, with Stephanie suggesting twice that the patient has pulmonary oedema and what to prescribe, Terri explaining why the patient cannot breathe, and Damien attempting to assert his authority ('I'll be the judge of that, thanks'). Later, a nurse is berated for completing paperwork: 'Doctors are supposed to do that […] Yeah, well you just do your job and I'll do mine, okay?' Shortly after, the show makes a distinction between 'good' and 'bad' doctors by introducing Dr Luke Forlano, whose entrance provokes one nurse to say: 'Right on cue. We need our faith restored in doctors', although Luke's solution is to manage the situation for them, while they eat cake in the tea room. Damien further rails against nurses when he tells Terri: 'Get your nurses off my back. I don't need them telling me what to do.' Terri points out that Stephanie is an experienced clinical nurse specialist, to which he returns a string of assertions that pick up most of the themes in these shows: 'well I'm a doctor and I don't need her help to diagnose […] I'm sick of not getting any respect […] I didn't slave my guts out for years to be treated this way […] and nurses are experts in the field are they?' And finally Damien quits, blaming the nurses as he leaves.

Beyond this general sense of conflict, another plot specifically shows a nurse's defiance of a doctor's orders. Similar to *Mercy*'s plotline of end-of-life care, Terri disagrees with the patient's assigned doctor, Dr Williams, over the treatment of an elderly patient who is dying. Williams' dialogue draws on the war metaphor as he says 'It's always worth fighting for […] We must keep fighting'; Terri insists the patient be

given the right to make her own decisions about treatment and frames it as a choice of 'dignity'. The patient herself wishes to die, and unbeknownst to Dr Williams, Terri enlists another doctor, a psychologist, to encourage the patient to stand up for her rights and in so doing defy Dr Williams' orders. In a scene that we could read as the crew of a ship conspiring together to overthrow the captain, Terri and the other doctor organise for the patient to tell Williams that she is refusing treatment, leaving Williams alone and without authority. When Williams insists on continuing treatment, Terri ignores this to instead follow the patient's wishes by allowing her to die. This familiar scenario again reflects real-life competing goals in patient care in end-of-life situations (Oberle and Hughes 2001), and also recalls Warren's (1991) point that the war metaphor can mean that the physician is intent on winning the battle against the disease but the patient may be more concerned with other goals, such as avoiding 'indignity or pain' (Warren 1991, 41). *All Saints* also depicts skilful doctors and productive relationships, but it reinforces the notion that nurses and doctors can be ranged against each other in a conflict over patient care, to the point of acts of defiance.

My last programme for analysis is *RAN: Remote Area Nurse*, a six-episode series airing in Australia in 2006. Unlike the previous five programmes, all set in hospitals, this nurse-centred drama focuses on Helen Tremaine, a white nurse working with Australian Indigenous groups in a remote island in the Torres Strait. Earlier research points out the dominance of the hospital rather than community and health centres as the setting for medical television programmes (Garland 1984), and this is the case in these programmes as well. This means that *RAN*'s non-hospital setting may inspire different plots rather than conflict because of nurse–doctor hierarchy, particularly given that the series is primarily concerned with island life and Helen's attempts to be accepted by the locals.

Helen is a nurse in the island's clinic working alongside local health worker Paul with the occasional monthly visit from Dr John Bourke. Bourke's first appearance in Episode One demonstrates his patronising attitude to Helen and perhaps health-care on the island in general, drawing on a Jack and Jill nursery rhyme reference when he says: 'Well, if you've got the vinegar and brown paper ready, Helen, let's go and mend a few broken crowns'. Despite this implication that her work is trivial, Helen's responsibilities are wide ranging and she exercises some degree of authority and autonomy, treating a variety of health problems.

Yet, this limited autonomy is at the heart of the nurse–doctor conflict in this episode, when Bourke berates Helen for failing to obey health regulations when she allows a pregnant woman to follow 'island way' by remaining on the island to have her child. Helen actively attempts to hide the patient from Bourke in a clear act of rebellion against his authority: thus, unlike most of the other nurse characters described in this study, Helen not only disagrees with the doctor but defies his authority in a mutinous act that leads to a confrontation. Unlike many of the other fictional doctors discussed previously, Bourke gives Helen the opportunity to explain her actions before he intervenes. Yet, when Helen attempts to use her patient knowledge to disagree ('Look, can you just trust me on this please, I think I know what's best in this situation'), Bourke's response is to invoke their relative power relationship ('Since when does a registered nurse outrank a qualified physician?') – note the language of military hierarchy (*outrank*). Helen's opinion seems grounded in her knowledge of her patient, but she expects the doctor to simply 'trust' her decisions. Svensson (1996, 385) points out that real-life nurses hold a special position in wards because they hold different knowledge about patients and their unique situation than doctors; doctors are 'dependent on the nurse's knowledge'. This is true in non-ward settings too, and particularly so in the isolated (fictional) nursing context of *RAN*, where Helen is almost independent, or at least until the doctor visits. Yet, despite the potential for nurses' patient knowledge to be greater, in many cases doctors still hold responsibility for making decisions in patient care and treatment (Fagin and Garelick 2004), and again art reflects life on *RAN*.

Despite Helen's attempted act of mutiny against the doctor, in this case, the doctor is triumphant, removing the pregnant woman from the island by force. Summers and Summers (2009, 115) describe this as a 'sense that he [the doctor] was the ultimate health authority', but this is not simply 'sense' but fact. Helen and Bourke both explicitly frame their relationship in terms of a battle between opposing forces: 'Congratulations, you've won'/'It's purely a victory for common sense […]'/'And putting me on report? '/'I can only call it how I see it.' Here, too, cure/care is evident, where Helen functions as the healthcare professional who values the patient, and the doctor values the rules. Moreover, Helen's plea for 'trust' is countered with Bourke's call for 'common sense', returning us yet again to the framing of doctors/nurses as rational/intuitive. There is also the implied power relationship of this exchange: the doctor is in a position to facilitate the punishment of Helen, who has no power to counteract his orders except by subversion and deception. Helen may be removed from the typical hierarchy of medical programmes set in hospitals, but she cannot escape the nurse–doctor conflict in this episode at least.

DISCUSSION

It is clear that these programmes describe a pervasive metaphor of understanding health-care as the site of conflict. Rather than fighting disease in bodies, this battleground comprises the corridors and rooms of hospitals and health facilities. The combatants are not healthcare professionals and disease but doctors and nurses. Each scene begins with a nurse disagreeing with a doctor's instructions in patient care, and although each nurse takes a different approach to communicating this disagreement, all scenes involve conflict. I have theorised these conflicts variously as a game, civil war and mutiny, not only because the programmes often use military language but also because these categories capture some of the nuances of how this conflict is portrayed, whether the battle is fought in subtle or explicit ways and between individuals or groups.

These metaphors around conflict encapsulate many of the harmful messages about nurse–doctor interactions in popular culture. Conflict centres the nurses and doctors as the main figures in health-care rather than patients, by concretizing the doctors and nurses as active participants in battle, while patients represent the passive object under dispute. Patients and their bodies cannot be treated as the site of power struggles as if they are powerless, yet few of these episodes contained scenes where patients were involved in decisions about their care. With real-world research suggesting greater patient participation in health-care can improve outcomes (Speedling and Rose 1985; Fraenkel and McGraw 2007), the lack of patient involvement in decision-making shown in these fictional programmes is a concern.

It might be argued that at least these programmes (mostly) highlight nurses in positive ways. The increased visibility of nurses on medical television is a distinct departure from many earlier ideas about the role of nursing as subservient and silent. Yet in some ways, the nurses on these programmes are drawn in familiar stereotypes: handmaidens (Hallam 1998; Summers and Summers 2009) in *Grey's*; nurses who 'eat their young' (Baltimore 2006) such as new graduate nurses (*Mercy*, *Nurse Jackie*); and naughty nurses (Summers and Summers 2009) such as Candy (*Hawthorne*) and in some ways Sonia (*Mercy*), who stroll around corridors coyly smiling at their admirers. Although the battleaxe stereotype (Darbyshire and Gordon 2005; Summers and Summers 2009) is not evident in the main characters (with the possible exception of Von in *All Saints*), there are nonetheless examples of unprofessional and abusive behaviour from nurses in these programmes. The problem with stereotypes, as Kalisch and Kalisch (1986) point out, is that media depictions can legitimise such portrayals and affect nurses' self-image. To these familiar images, we might add a new one, based on this analysis of the television programmes: not an angel of mercy (Kalisch and Kalisch 1987; Gordon and Nelson 2005; Summers and Summers 2009) but an avenging angel, a harbinger of vengeance for patients whose lives are ended or endangered by incompetent doctors. This avenging angel stereotype demonstrates that in most of the fictional conflict analysed here, the nurses are portrayed positively in terms of knowledge and skills as well as caring, even if their power is lacking.

Does any of this matter? After all, we are dealing here with fiction and not reality. Yet as I note throughout my analysis, the themes and scenarios on these television programmes do mirror some real situations in nursing practice. As I mentioned earlier, what we see in popular culture can affect our beliefs about nursing practice and even, as some suggest, our behaviours (Kalisch and Kalisch 1987; Davin 2003; Darbyshire and Gordon 2005; Gordon and Nelson 2005; Summers and Summers 2009; Cabaniss 2011). In no way does this mean that television will always influence nurses or doctors in real-life, for it is just one possible source of information and persuasion for audiences, and audiences can and do treat television critically (Davin 2003). Yet just because we cannot measure the impact does not mean there is no impact. Moreover, the persistence of the nurse–doctor conflict on television tells us something about how we as a society perceive these roles, and its reflection in some examples of real practice does mean we ought to pay attention to this trope.

In one way, the television nurse–doctor conflict is entirely expected. Arford (2005) notes that organisational cultures are responsible for influencing the nurse–doctor relationship in the way the two groups communicate with each other. If we apply this point to the medium under discussion here – television, not an organisation – it is clear that television dictates conflict and drama for story arcs to maintain viewer interest. Thus, television's commitment to presenting realistic images of nursing is limited because the ultimate goal is always conflict as a means to tell a dramatic story and maintain viewer interest.

Yet, we have also seen that these shows can, nonetheless, reflect real-life issues. And in this way, the emphasis on conflict is dysfunctional. Although these fictional shows imply that nurse–doctor conflict can save lives, real-life research has shown that such hostility can have negative consequences for patients (Larson 1999; Rosenstein and O'Daniel 2005; Saxton et al. 2009). The price for showing nursing as an important and skilful profession seems to be the denigration of the image of doctors, as well as adverse outcomes for patients. That a patient may become collateral damage in

nurse–doctor conflict is never an acceptable prospect. The discouraging implication of conflict is that patients cannot trust their healthcare providers to protect them, and it introduces an element of instability and anxiety into the health-care process that does not benefit patients. Moreover, this hostility extends further within the professions: beyond the nurse–doctor conflict, these programmes also often depict nurse–nurse or doctor–doctor battles, reflecting some real-life experiences (Jackson, Clare and Mannix 2002; McKenna et al. 2003; Baltimore 2006). The on-screen rehearsal of such negative and dysfunctional relationships can normalise them and in doing so may adversely affect recruitment into the profession. Yet, it is also worth noting that in some ways health education and practice have already reinforced these conflicts by drawing on familiar divisions between a medical model and a nursing model of health-care (Reed and Watson 1994; Engebretson 1997).

Although there are many negative aspects of these metaphors, there are also positive features. As Czechmeister (1994, 1227) notes, metaphors are 'two-edged swords' that may become 'negative forces, creating confusion, stereotype and stigma' or may have beneficial aspects, such as revealing how patients perceive the world, allowing emotions to be expressed and understanding the image of nursing in society. Beyond these points, the purpose of nurse–doctor conflict storylines outlined in this study is in most cases an attempt to elevate the status of nurses and recognise their knowledge, skills and vital contribution to patient care. This is evident in that the outcomes almost always vindicate nurses over doctors; a scenario repeated so often across the programmes that it may provoke viewers to adjust their expectations and beliefs about the role of nursing in health-care. Moreover, although television at times portrays nurses as akin to 'props' (Jackson 2009, 2250), the greater presence of nurses in five of these shows gives nursing a voice that is not simply limited to that of obedience. The five nursing programmes discussed here may suggest nurses remain subservient to doctors in power, but they are generally superior to doctors in their knowledge, skills and commitment to patient care.

A second positive aspect of these programmes is that they often show the nurses in positions of leadership. Christina is chief nursing officer (*Hawthorne*), Terri is nurse unit manager (*All Saints*), Helen is chiefly responsible for the health facility (*RAN*), and Veronica (*Mercy*) and Jackie (*Nurse Jackie*) both seem to occupy informal positions of leadership as they mentor younger nurses. Although nurse leaders on television have been portrayed negatively in the past (Kalisch, Kalisch and Clinton 1982), for the most part, these fictional nurse leaders (particularly Christina and Terri) are represented in positive ways that highlight their technical skills, leadership and management abilities, even if their power is unequal to the doctors. Showcasing a range of roles from graduate nurse to nurse manager gives viewers positive implications of career prospects of nursing within the programmes. Conversely, the programmes imply very limited opportunities in terms of location to practise nursing; the focus on hospitals in current programmes reflects earlier television shows (Garland 1984) and does not take into account the fact that nurses operate in a variety of settings.

These fictional conflicts also may have benefits in drawing attention to the real-life challenges facing healthcare professionals when working together to deliver health-care. Changes in the nurse–doctor relationship over time have resulted in more open communication in many cases (Stein et al. 1990; Sweet and Norman 1995; Svensson 1996), yet evidence shows that there is also conflict between the two groups (Rosenstein and O'Daniel 2005; Saxton et al. 2009). As noted earlier, successful interprofessional collaboration requires mutual respect and trust (Pullon 2008). Yet, these ideals may not be reflected in current practice, where elements such as communication, hierarchies, role-modelling, valuing other roles and interdisciplinary learning can influence the effectiveness of interprofessional collaboration in health-care (Kvarnström 2008; Conn et al. 2009; Gaboury et al. 2009; Rice et al. 2010).

Although some suggest medical programmes may cause more harm than good in the educational setting (Ward and Summers 2008), others note that the arts can offer valuable ways for nursing students to engage with the popular language of health-care (Czechmeister 1994). It is certainly possible that the scenes I have identified (and many others) may be useful resources for teaching both groups about the importance of communication and to develop techniques to avoid the dysfunctional situations imagined in these six programmes. As nursing students and nurses continue to become more informed and advocate in greater ways for a more realistic image of nursing, in time medical programmes may also become more nuanced and less prone to cliché and stereotype. It is also possible that the increased focus on empathy, narrative competence and reflection in medical curricula (Coulehan 2005; Hojat et al. 2009; Wald and Reis 2010) may further contribute to changing the images of nursing and medical practice.

CONCLUSION

The metaphors around nurse–doctor conflict reject traditional stereotypes of nurses as handmaidens who only obey doctors' orders without question. In these programmes,

nurses are shown to be skilful, knowledgeable healthcare professionals whose decisions to intervene in patient care and diagnosis are usually vindicated. We should be wary of reading these television shows as truly empowering, however, for although these shows do on the one hand provide nursing characters with a voice, at the same time, they very often present stereotypical images of nurse–doctor relationships that weaken any attempt to destabilise the power relationship. It is important to explore these fictional images because of their potential to normalise such conflict for both patients and professionals in the real-world, as well as the implications such negative images may have for attracting new students to nursing. Yet, these programmes can provoke continued dialogue about how to transform conflict into collaboration.

ACKNOWLEDGEMENTS

I would like to acknowledge funding received from the University of Western Sydney Research Seed Grant Scheme that made it possible to undertake this project. Thank you to Dr Kimberley McMahon-Coleman for reading and commenting on an earlier version of this study, and to the anonymous reviewers for their feedback.

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