Nurse Education Today 48 (2017) 134–139

Contents lists available at ScienceDirect

Nurse Education Today

journal homepage: www.elsevier.com/nedt

Nursing students' awareness of inequity in healthcare — An intersectional perspective

Inger K Holmström [a,b,*], Elenor Kaminsky [a,b], Anna T Höglund [b], Marianne Carlsson [b,c]

[a] School of Health, Care, and Social Welfare, Mälardalen University, Box 883, SE-721 23 Västerås, Sweden
[b] Department of Public Health and Caring Sciences, Uppsala University, Box 564, SE-751 22 Uppsala, Sweden
[c] Faculty of Health and Occupational Studies, University of Gävle, SE-80176 Gävle, Sweden

ARTICLE INFO

Article history:
Received 15 April 2016
Received in revised form 6 October 2016
Accepted 18 October 2016
Available online xxxx

Keywords:
Intersectionality
Gender
Ethnicity
Age
Power
Telephone nursing
Equity in healthcare
Nursing students

ABSTRACT

Objective: The overall aim of the present study was to explore awareness of inequity in healthcare and the intersection between different structures of power among nursing students. Another aim was to delineate the knowledge and use of Swedish Healthcare Direct in this group.
Design: The study had a descriptive design with a quantitative approach.
Participants: The sample consisted of 157 nursing students from three universities in central Sweden.
Methods: The students filled out a study specific questionnaire in class. The questionnaire consisted of short descriptions of twelve fictive persons who differed in gender, age, and ethnicity, with questions about their life situation. The mean was calculated for each assessed fictive person for every item. In the next step, the assessments were ranked from the lowest probability to the highest probability. A 'Good life-index' consisting of quality of life, power over own life, and experience of discrimination, was also calculated. Free text comments were analysed qualitatively.
Results: People with Swedish names were assessed to have the highest probability of having a good life. Among those with Swedish names, the oldest woman was assessed as having the lowest probability of a good life. All students had knowledge about Swedish Healthcare Direct, but more female students had used the service compared to male students.
Conclusions: The results indicate that the nursing students had awareness of how power and gender, ethnicity and age, are related. Based on the free text comments, the questions and the intersectional perspective seemed to evoke some irritation which points to their sensitive nature. Therefore, the questionnaire could be used as a tool to start a discussion of equity in healthcare and in interventions where the aim is to raise awareness of inequality and intersectionality.

1. Introduction

Nursing students are the future healthcare workforce. Their perceptions and awareness of inequity and intersectional perspectives of health and healthcare are therefore important to study. One way to decrease the disparity of care for vulnerable and minority groups is awareness of such perspectives. Equal care and good health for all citizens are stipulated by the Swedish Health Care Act (1982:763) and the Patient Act (2014:821), and has for decades been the guiding principle for healthcare in Sweden. Behind these laws lay the UN Declaration of Human Rights and, especially, Article 12 in the International Convention on Economic, Social and Cultural Rights, which have been ratified by the Swedish government. Previous research has, however, found that equal care is not always achieved in a Swedish context. Women are less likely to get expensive medicines and are less prioritized in healthcare (Smirthwaite, 2014). Women, elderly and people with low income have also been reported to receive liver surgery due to colon cancer to a lower extent (Norén et al. 2016). There are also gender related patterns in people's health seeking behaviour. Women tend to seek healthcare more actively than men and they are also more eager to contact healthcare services on behalf of others (Höglund & Holmström, 2008; Kraemer, 2000).

1.1. Background

Principles of equal care are taught in Swedish nursing education. The programme is three years in duration, leads to a Bachelor's degree, and follow regulations from the Swedish government and the Swedish Higher Education Authority. The programme includes courses and training in communication and encountering patients. Specialist nursing educations, such as district nursing, include more advanced training in communication, for instance about telephone advice nursing, and/or motivational interviewing. However, most registered nurses (RNs)

* Corresponding author.
E-mail address: inger.holmstrom@mdh.se (I.K. Holmström).

http://dx.doi.org/10.1016/j.nedt.2016.10.009
0260-6917/

provide telephone advice, as patients' call both inpatient- and outpatient clinics regarding health related questions.

In addition to gender related issues, Swedish nursing students have expressed ambiguous perceptions regarding working with older people. About half of a group of 224 students expressed that nursing the elderly was boring, stressful and depressing (Carlsson, 2013). Students have also reported that heteronormativity governed their education (Röndahl, 2011). The present study has focus on nursing students' awareness regarding equal care in relation to Swedish Healthcare Direct (SHD). The service, which started 2003 with inspiration from UK's NHS Direct, is Sweden's national telephone nursing service. From 2013, it covers all county councils and regions in Sweden, and is staffed by about 1500 telephone nurses. All nurses are RNs and hold a variety of specialist educations (Kaminsky, 2013).

During 2014, the public made 5.5 million calls to SHD (Swedish Healthcare Direct, 2014) making the service one of Sweden's largest healthcare providers. Swedish citizens are recommended to make SHD their first contact with healthcare. The telephone nurses assess caller symptoms and decide whether to provide self-care advice, refer the caller to other healthcare providers, or send an ambulance. The telephone nurses thus have dual roles as care providers and as gatekeepers for the healthcare sector (Holmström & Dall'Alba, 2002). Given the gate keeping role, it is of utmost importance that assessment and referral of calls are correct, equal, and unbiased for all callers regardless of age, gender and ethnicity, as it will influence further access to care and ultimately, outcomes on health.

Studies of inequalities in health are important. Apart from studying how gender, age and socioeconomic differences can influence health equity, also ethnicity is of importance, since Sweden today is a multicultural society. Presently, over 17% of its citizens are born abroad (migrationsinfo.se). However, studies of inequalities in care have often focused on one category of difference at a time. Against this, one can argue that intersectionality is an important theoretical concept that can enrich health research in different ways, such as identification of inequalities and the development of intervention strategies (Bauer, 2014). Theories on intersectionality are used to analyse how socio-cultural hierarchies and power interact and construct inclusion or exclusion according to gender, ethnicity, age, sexuality, and so on (Collins, 2000). The term 'intersectionality' was first launched by Kimberle Crenshaw. She emphasized that gender interacted – or intersected – with factors such as ethnicity, age, and sexuality (Crenshaw, 1995). This theoretical position was further developed by Patricia Hill Collins, who argued that cultural patterns of oppression are bound together based on the different factors mentioned (Collins, 2000). These categories are regarded as discursively constructed, not necessarily as given. The idea is not additional, and the different categories are not regarded as hierarchically ordered in relation to each other. Rather, the focus is on the interaction between different power structures that also feature in healthcare.

Previous studies have indicated inequalities in SHD. Telephone nurses found it easier to talk to female callers, who were regarded as easier to persuade to 'wait and see' (Höglund & Holmström 2008). When fathers called, they twice as often as mothers received a doctors' appointment for their child, while mothers instead were given self-care advice. This could not be explained by differences in the severity of the children's symptoms (Kaminsky et al. 2010). The same pattern was also found when analysing outcomes of calls made by adult callers for themselves (Hakimnia et al. 2015). In addition, elderly callers used the SHD service to a lesser extent than expected, given their proportion in the population (Hakimnia et al. 2014). The service also seemed difficult to use for patients with low language proficiency (Hakimnia et al. 2015).

To summarise; based on the UN Declaration of Human Rights, the Swedish Health Care Act (1982:763) and the Patient Act (2014:821) stipulate that healthcare should be distributed on equal terms for all citizens. Contrary to this, earlier studies revealed that inequalities exist within use and outcome of calls to SHD (Höglund & Holmström 2008; Kaminsky et al. 2010; Hakimnia et al. 2014, 2015) Perceptions and awareness of inequity and intersectional perspectives are likely to affect the nurse-patient encounter. Since nursing students are the future nursing workforce it is important to study their awareness of inequity in health care with special focus on SHD.

1.2. Aim

The overall aim of the present study was to explore awareness of inequity in healthcare and the intersection between different structures of power among nursing students. Another aim was to delineate knowledge and use of SHD in this group.

1.3. Research Questions

The first research question concerned whether or not it was possible to assess a fictive person's life situation when only gender, age, and ethnicity of the person were known.

The second research question concerned the assessment of a 'good life'. How is the assessed probability of experiencing a good life in Sweden related to the intersection between gender, age, and ethnicity of a fictive person?

The third research question concerned to what extent SHD was known among nursing students, and to what extent they had called SHD themselves.

2. Method

2.1. Design

The study had a descriptive design with a quantitative approach.

2.2. Sample and Setting

A convenience sample consisting of 157 nursing students, from three different university educational settings in central Sweden was used. The majority, 119 students, (105 females and 14 males), were on their third semester of the Bachelor education. Another 38 students (36 females and 2 males) were in the specialist education programme in district nursing. Participant characteristics are presented in Table 1.

2.3. Procedure

Informants filled out the questionnaire in a classroom situation. All students who were present in the classrooms answered the questionnaire.

2.4. Ethical Considerations

According to Swedish legislation (2003: 460), no formal approval of the study was needed. The study conformed to the ethical principles of the Declaration of Helsinki and to the Swedish Ethical Review Act (2003: 460). The students were informed that participation was voluntary, that they could withdraw from the study without giving a reason, and that the answers were anonymous. Informed consent was considered given when the questionnaires were answered and handed in.

Table 1
Characteristics of participants (n = 157).

Students	All participants (n = 157)	Women (n = 141)	Men (n = 16)	
Age M/SD	28.1/7.6	28.1/7.8	28.2/6.5	n.s.
Study programme				
Basic level	119	105	14	
Advanced level	38	36	2	

2.5. The Questionnaire

A study specific questionnaire was constructed by researchers with longstanding experience and competence in nursing education, telephone nursing, gender studies and questionnaire development/psychometrics. The questionnaire was pilot tested on a small group of participants, and some changes were made. The questionnaire has also been discussed repeatedly in research seminars and used as pre-post test in an intervention study (Höglund et al. 2016). Due to the SHD context in the present study, three aspects of power orders or intersects were chosen: gender, age, and ethnicity, as these mostly are known by telephone nurses when a patient calls. Twelve fictive people who differed in gender, age, and ethnicity were 'created': six with female-sounding names and six with male-sounding names; each belonging to one of three age groups, 25 years, 45 years, and 70 years; and every person described as either being born in Sweden or born outside Europe. The questionnaire was constructed so that short descriptions of two out of the 12 fictive persons were used for each informant.

The items concerned assessments of the probability of whether the fictive person had called SHD, whether or not s/he received a doctor's appointment when calling, whether s/he had a high quality of life, power over their own life, and had experienced discrimination.

The described persons used in the following study were:

A. – Woman aged 25 years born in Sweden (Isa)
B. – Woman aged 25 years born outside Europe (Lynn)
C. – Woman aged 45 years born in Sweden (Johanna)
D. – Woman aged 45 years born outside Europe (Manuela)
E. – Woman aged 70 years born in Sweden (Karin)
F. – Woman aged 70 years born outside Europe (Li-Xing)
G. – Man aged 25 years born in Sweden (Alexander)
H. – Man aged 25 years born outside Europe (Elliot)
I. – Man aged 45 years born in Sweden (Björn)
J. – Man aged 45 years born outside Europe (Urghesa)
K. – Man aged 70 years born in Sweden (David)
L. – Man aged 70 years born outside Europe (Ahmed)

First, each participant was randomly assigned two of the fictive persons and asked to assess those two. Thereafter, the participants were asked to comment on their assessments using free text. In total, 66 different combinations ($(12 \times 11)/2$) were assessed.

2.6. Data Analysis

The mean was calculated for each assessed person (A–L) for each item. In the next step, the assessments were ranked from the lowest probability to the highest probability (hence, 12 ranked positions were possible). The reliability/homogeneity of the "Good life-index" was calculated with Cronbach's alpha-coefficient (Chronbach, 1951).

The free text comments were analysed by inductive content analysis (Elo & Kyngäs, 2008). In a first step, the free text comments were imported to a word-document. This was carefully and repeatedly read through by two of the authors, to get a good grasp of the whole. The next step was organization of the data. This process included open coding, categorization, and abstraction. The comments were generally very short, and the analysis hence was made on a descriptive level.

In the following section, the results of the questionnaire analysis are presented with free text comments as illustrations.

3. Result

In Table 2, the number of assessments for the different persons (A–L) are presented.

The persons with Swedish-sounding names were assessed to have the highest probability of having a good life. Among the persons with Swedish-sounding names, the oldest woman Karin (70 years old) was assessed as having the lowest probability of a good life. The students assessed the two youngest persons with male-sounding names (Alexander, 25 years old and Björn 45 years old) to have the highest probability of a good life.

Table 2
Number of assessments for the different persons (A–L) in the student sample (n = 157).

Person	Students
(A) Isa	22
(B) Lynn	25
(C) Johanna	29
(D) Manuela	28
(E) Karin	31
(F) Li-Xing	29
(G) Alexander	26
(H) Elliot	27
(I) Björn	25
(J) Urghesa	27
(K) David	22
(L) Ahmed	25

In the free text comments, the relationship between age and ethnicity was developed further:

> They are of different ages and ethnicity. The age aspect impacts on their need for healthcare services. They also differ regarding the possibility to express themselves in Swedish. (Student 6, male, fictive persons A/F)

Two questions concerned SHD. One question asked for the probability that the fictive person had called SHD, and the other for the probability of having a recommendation for doctor's appointment when calling. The answers are presented in Table 3.

The fictive persons with Swedish-sounding names were supposed to have called SHD more often than the persons with non-Swedish-sounding names, according to the students. This was true also for the question of having got a doctor's appointment. That ethnicity can be a determining factor was also expressed in the free text comments:

> My experience is that many persons of foreign origin perceive that they do not get help by calling SHD. (Student 9, male, fictive persons B/I)

> It's easier for men to get a doctors' appointment. A person of non-Swedish origin is not taken as seriously… (Student 84, female, fictive persons D/I)

Table 3
SHD. Assessment of the probability of the fictive persons having called SHD and receiving a recommendation of doctor's appointment when calling (n = 157). Swedish names are presented in italics.

Probability of having called SHD				Probability of having got an appointment			
Rank	Fictive person	Mean	SD	Rank	Fictive person	Mean	SD
1	*Johanna 45*	4.83	1.2	1	*Isa 25*	4.50	1.0
2	*Isa 25*	3.73	1.2	2	*Björn 45*	4.44	0.8
3	*David 70*	3.50	1.3	3	*Alexander 25*	4.42	1.1
4	*Björn 45*	3.44	1.3	4	*Johanna 45*	4.21	0.9
5	*Karin 70*	3.42	1.5	5	*David 70*	4.09	1.1
6	*Alexander 25*	3.15	1.0	6	Lynn 25	3.84	1.1
7	Manuela 45	2.93	1.2	7	*Karin 70*	3.71	1.2
8	Lynn 25	2.88	0.8	8	Elliot 25	3.59	1.1
9	Urghesa 45	2.59	1.0	9	Urghesa 45	3.44	1.2
10	Li-Xing 70	2.52	1.0	10	Manuela 45	3.32	1.2
11	Elliot 25	2.19	0.7	11	Ahmed 70	3.12	1.1
12	Ahmed 70	2.16	0.6	12	Li-Xing 70	3.00	0.8

In Table 4, the 'Good life-index' assessments are presented. The index consisted of quality of life, power over own life, and the reversed assessment for the question concerning experience of discrimination. The range of the index was 3–18. A high value indicated that the fictive person probably had a good life. Cronbach's alpha for the index was calculated to = 0.72.

In Table 5, the knowledge and use of SHD are presented.

The results revealed that all students knew about SHD, but more women than men had called themselves ($p = 0.000$). In addition, aspects of gender differences in the contact with SHD were highlighted in the free text comments:

> I think the man is more persistent in getting access to healthcare. The woman is probably used to take care of herself, has better health, is physically active and has a more healthy diet. (Student 98, female, fictive persons D/J)

> It's not as common for men to call and have contacts with the health care system, as it is for women. (Student 123, female, fictive persons E/K)

Since only 16 out of 157 participants were male, it was not statistically possible to compare the answers regarding gender differences in the assessments.

3.1. The Free Text Comments

Among the participants, a majority (145/157) commented on their assessment. These comments could be divided into three categories. The first expressed a high awareness of the intersection of the studied categories: gender, ethnicity, and age. Examples are presented in the above quotations, in relation to the questionnaire data.

The second category of comments concerned the difficulty of answering the questions due to lack of information on the fictive persons respondents were asked to assess. A number of the comments indicated that it was hard to make assessments based on the limited information provided, although they had made the assessments:

> I have in principle zero knowledge about these people, but I guess that age and gender have an impact, even though I made rather similar assessments. (Student 48, female, fictive persons G/I)

> There is far too little information which makes me feel uncomfortable judging these aspects. (Student 4, female, fictive persons B/D)

Table 4
'Good life-index' consisting of quality of life, power over own life, and the reversed assessment of experience of discrimination. (Range 3–18) The Means and Standard deviations (n = 157). Swedish names are presented in italics.

Rank	Students	Mean	SD
1	*Alexander 25*	13.54	2.0
2	*Björn 45*	13.31	1.6
3	*Isa 25*	12.87	1.7
4	*Johanna 45*	12.35	2.6
5	*David 70*	12.25	2.5
6	*Karin 70*	11.33	2.6
7	Lynn 25	10.73	2.9
8	Elliot 25	10.29	2.6
9	Urghesa 45	9.86	2.7
10	LiXing 70	9.53	1.6
11	Manuela 45	9.44	2.7
12	Ahmed 70	9.00	2.2

Table 5
Knowledge and use of SHD (n = 157).

	Knowledge of SHD		Have called SHD	
	Yes	No	Yes	No
All participants Students (n = 157)	157 (100%)	0 (0%)	127 (81%)	29 (19%)
Women in the Student sample (n = 141)	141 (100%)	0 (0%)	120 (86%)	20 (14%)
Men in the Student sample (n = 16)	16 (100%)	0 (0%)	7 (44%)	9 (56%)*

The third category consisted of comments that showed the topic of power and inequality created feelings of irritation for some respondents (6/157):

> Annoying questions! I guess the answer is that she is older, probably married and will continue working later in life. (Student 5, female, fictive persons A/E)

> This survey is based on prejudice only! (Student 10, female, fictive persons A/H)

> The survey is based on guessing only! (Student 119, female, fictive persons A/I)

4. Discussion

The results showed that the students were aware of inequity in health and on how different power structures interact. Further, the results show that it is possible to make an assessment of the probable life situation, the probability of having a good life, and access to SHD of a fictive person when only gender, age, and ethnicity are known. Earlier studies report that more women than men call SHD (Kaminsky et al. 2010), and that young and middle-aged persons of Swedish origin call more often than older and non-Swedish persons (Kaminsky et al. 2010, Hakimnia et al., 2015). The results of the present study revealed that the students thought that persons with Swedish-sounding names called SHD more often. Regarding the chance of receiving a recommendation of a doctor's appointment when calling SHD, men had the highest probability of doing so, according to the students. This is in line with previous studies which have reported that men more often than women are recommended to seek a doctor's appointment when calling SHD (Hakimnia et al. 2015; Kaminsky et al. 2010).

The results could be interpreted as a rather high awareness among the participants of how power and gender intersect. The students assessed the youngest person with a male-sounding name to have the most power. According to well-established theories, a central aspect of gender constructions concerns the power relations between men and women in a society and how hierarchical power relations are built up and constantly reproduced within the current gender system (Connell, 2003, 2012; Hirdman, 2001). This also holds true in healthcare and implies that power is connected to what is understood as cultural masculinity, rather than to cultural femininity. Hence, masculinity and power are connected theoretically according to these theories and awareness of this was expressed by the participating nursing students.

Another result concerned the assessment of probability of experiencing a good life in Sweden today. It is obvious that persons with Swedish-sounding names were assessed to have better lives than persons with non-Swedish-sounding names. However, it was also obvious that age and gender intersected with ethnicity in the assessments. The students assessed the two youngest men to have the best opportunities for a good life (Alexander, 25 and Björn 45). They further rated that among the persons with Swedish-sounding names, the oldest woman (Karin,

70) had the lowest probability of a good life, but still her life was assessed as better than all persons with non-Swedish-sounding names. According to the nursing students' ranking, the two persons with non-Swedish-sounding names (Manuela, 45 and Ahmed, 70) lived the relatively worst lives. These results can be understood in light of intersectionality theories. The respondents' answers, as well as their free text comments, show a high awareness of the intersection of gender, ethnicity, and age. In line with Collins (2000) and Lycke (2005), it is possible to interpret the results as an expression of how socio-cultural hierarchies and power interact and construct inclusion or exclusion according to gender, ethnicity, and age in Swedish society.

The third research question concerned to what extent SHD was known among the students and to what extent they had called SHD themselves. All students were familiar with SHD, which was a rather expected finding as they were studying to become registered nurses. However, the female nursing students had called more often than the male students, which is in line with other studies (Kaminsky et al. 2010; Hakimnia et al. 2015). Our results thereby support earlier findings concerning telephone nursing and gender (Goode et al., 2004; Kaminsky et al. 2010; Hakimnia et al. 2015). Calling SHD seems to be an activity mostly performed by young and middle-aged women with Swedish as their first language (Hakimnia et al., 2015). This situation contrasts strongly with Swedish legislation, stating that healthcare should be distributed according to needs and with respect for each person's human dignity, with goals of equity in health for all citizens (SFS, 1982:763). Given SHD's gate keeping function it is important that all citizens have equal access to and outcomes when calling the service, and that healthcare professionals strive to achieve this goal.

The free text comments disclosed that the survey questions sometimes were perceived as provoking. The fact that questions related to gender and intersectionality might create such reactions has previously been reported (Manderson, 2003). Gender related issues were also perceived to be of low priority by medical teachers (Risberg et al. 2011). Currently however, many countries confront rapid cultural change and growing calls for diversity within nursing to recruit and retain minorities in the healthcare workforce (Kulakac et al. 2015). Flood and Commendador (2016) point out that transcultural nursing can be taught, but there is room for improvement. Nurses and nursing students' should understand cultural issues and act with cultural sensitivity when dealing with patients. Programmes to increase cultural competence have proven positive results (Gallagher and Polanin, 2015). Such programmes could be developed to include a broader, intersectional approach. We suggest consciousness-raising activities among students, teachers, registered nurses, researchers and policy-makers, in line with Risberg et al. (2009), and we suggest that the questionnaire presented in this study could be a valuable tool in such work.

4.1. Methodological Considerations

Since this is a first attempt to study the possibility of using assessments of fictive persons where only age, ethnicity, and gender are known, there are no tests of validity or reliability to present. The calculation of Cronbach's alpha for the Good-life-index was an attempt to assess the reliability or homogeneity of the index, and alpha = 0.76 is quite acceptable. The questions are examples of issues that could be used. Different questions could be used in different settings. In the present study, questions were formulated in the context of telephone nursing and the purpose was to reflect equality and discrimination connected to SHD. The study is relatively small scaled, and conducted in a Swedish setting, which are limitations in addition to the convenience sampling method. Further, no questions were asked about the ethnicity of the participants, why no analyses in relation to that could be made. However, as the sample consisted of a majority of undergraduate students, but also of students in specialist education, including male and female students of different ages and from tree universities of different size and location, we believe that a rich picture of the studied phenomenon was provided. As is common in nursing education, the student sample included few men (16/157 respondents).

5. Conclusion

Nursing student respondents were able to assess a fictive person's life situation when only gender, age, and ethnicity were known. The created good life-index revealed that the respondents rated younger persons with male-sounding names to have the best lives. Finally, all students knew of SHD, but more women than men had used the service themselves. Based on the free text comments, the questions and the intersectional perspective seemed to provoke some irritation and frustration which points to their sensitive nature. It might therefore be possible to use the questionnaire as a tool to start a discussion of equality in healthcare and in interventions where the aim is to raise awareness of inequality and intersectionality.

Acknowledgement

We are indebted to all students participating in this study, who so willingly shared their experience with us by filling out the questionnaires. We also thank research assistant Iza Johannesson for her input in the construction of the questionnaire and her excellent work with the data collection.

The study got financial support from The Swedish Research Council (Vetenskapsrådet) and The Faculty of Medicine, Uppsala University (344-2009-5853).

References

Bauer, G., 2014. Incorporating intersectionality theory into population health research methodology. Challenges and the potential to advance health equity. Soc. Sci. Med. 110, 10–17.
Carlsson, E., 2013. Meaningful and enjoyable or boring and depressing? The reasons nursing students give for and against a career in aged care. J. Clin. Nurs. 24, 602–604.
Crenshaw, K., 1995. Mapping the Margins: Intersectionality, Identity Politics, and Violence against Women of Color. In: Crenshaw, et al. (Eds.), Critical Race Theory. The Key Writings that Formed the Movement. The New Press, New York.
Collins, P.H., 2000. Gender, black feminism, and black political economy. Ann. Am. Acad. Pol. Soc. Sci. 568, 41–53.
Connell, R.W., 2003. Gender and Power. Polity Press, Oxford.
Connell, R.W., 2012. Gender, health and theory: conceptualizing the issue, in local and world perspectives. Soc. Sci. Med. 74 (11), 1675–1683.
Chronbach, L.J., 1951. Coefficient alpha and internal structure of tests. Psychometrika 16 (3), 297–334.
Elo, S., Kyngäs, H., 2008. The qualitative analysis process. J. Adv. Nurs. 62 (1), 107–115.
Flood, J.L., Commendador, K.A., 2016. Undergraduate nursing students and cross-cultural care: program evaluation. Nurse Educ. Today 36, 190–194.
Gallagher, R.W., Polanin, J.R., 2015. A meta-analysis of educational interventions designed to enhance cultural competence in professional nurses and nursing students. Nurse Educ. Today 35, 333–340.
Goode, J., Hanlon, G., Luff, D., O'Cathain, A., Strangleman, T., Greatbatch, D., 2004. Male callers to NHS direct: the assertive carer, the new dad and the reluctant patient. Health 8, 311–328.
Hakimnia, R., Carlsson, M., Höglund, A., Holmström, I.K., 2015. Doing gender in the context of telenursing. Analyses of authentic calls to a telenursing site in Sweden. J. Clin. Nurs. Stud. 3 (2), 24–30.
Hakimnia, R., Holmström, I.K., Carlsson, M., Höglund, A., 2014. Exploring the communication between telenurse and caller – a critical discourse analysis. Qual. Stud. Health Well Being 24, 9.
Hirdman, Y., 2001. Gender: About Stable Changable Formats [Genus: Om Det Stabilas föränderliga Former.]. Liber, Malmö.
Holmström, I., Dall'Alba, G., 2002. Carer and gatekeeper - conflicting demands in nurses' experiences of telephone advisory services. Scand. J. Caring Sci. 16 (2), 142–148.
Höglund, A.T., Holmström, I., 2008. "It's easier to talk to a woman". Aspects of gender in Swedish telenursing. J. Clin. Nurs. 17, 2979–2986.
Höglund, A.T., Carlsson, M., Holmström, I.K., Kaminsky, E., 2016. Impact of telephone nursing education program for equity in healthcare. Int. J. Equity Health 15:152. http://dx.doi.org/10.1186/s12939-016-0447-0.
Kaminsky, E., 2013. Telephone Nursing: Stakeholder Views and Understandings from a Paediatric and a Gender Perspective. Acta Universitatis Upsaliensis, Uppsala.
Kaminsky, E., Carlsson, M., Höglund, A.T., Holmström, I., 2010. Paediatric health calls to Swedish telenurses: a descriptive study of content and outcome. J. Telemed. Telecare 16, 454–457.
Kulakac, O., Arslan, I., Sucu Dag, G., O'Lynn, C., 2015. Faculty experiences with rapid integration of male nursing students within a patriarchal societal context. Nurse Educ. Today 35, 1075–1079.

Kraemer, S., 2000. The fragile male. BMJ 321, 1609–1612.
Lycke, N., 2005. New Perspectives on Intersectionality: Problems and Possibilities [Nya Perspektiv på Intersektionalitet: Problem Och möjligheter]. In Swedish. Kvinnovetenskaplig Tidskrift 2-3 pp. 7–17.
Manderson, L., 2003. Teaching gender, teaching women's health. Women Health 37 (4), 1–9.
(migrationsinfo.se, accessed 2016-10-05).
Norén, A., Eriksson, H.G., Olsson, L.I., 2016. Selection for surgery and survival of synchronous colorectal liver metastases; a nationwide study. Eur. J. Cancer 53, 105–114.
Risberg, G., Johansson, E.E., Hamberg, K., 2009. A theoretical model for analysing gender bias in medicine. Int. J. Equity Health 8 (28).
Risberg, G., Johansson, E.E., Hamberg, K., 2011. Important… but of low status: male education leaders' view on gender in medicine. Med. Educ. 45, 613–624.
Röndahl, G., 2011. Heteronormativity in health care education programs. Nurse Educ. Today 31, 345–349.
SFS, 1982. Swedish Statute Book. Swedish Health Care Act 763.
Swedish Healthcare Direct, 2014. Retrieved from: http://www.1177.se/Uppsala-lan/Om-1177/Om-1177/.
Smirthwaite, G., 2014. *(In)equity in Health and Healthcare: A Systematic Review of Gender Medicine [(O)jämställdhet i hälsa och vård: en genusmedicinsk kunskapsöversikt].* Sweden's Municipalities and County Councils [Sveriges Kommuner Och Landsting], Stockholm, Sweden.