

ORIGINAL RESEARCH:  
EMPIRICAL RESEARCH - QUANTITATIVE

# Do nurses rate diseases according to prestige? A survey study

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The research was supported by The Research Council of Norway (Grant number: 204324).

**Abstract****Aims:** To see whether nurses rate diseases according to prestige and, if so, how their ratings compare to the disease prestige hierarchy previously uncovered among physicians.**Design:** Cross-sectional survey.**Methods:** In 2014, 122 nurses in a continuing education programme for healthcare personnel in Norway rated a sample of 38 diseases according to how prestigious they see these as being among healthcare workers in general.**Results:** The nurses were found to rank myocardial infarction, leukaemia, and brain stroke at the top of the prestige hierarchy and depressive neurosis, anxiety neurosis, and fibromyalgia at the bottom. Their rankings overlap significantly with those previously documented for physicians and suggest that nurses assess the diseases through a 'cure' rather than a 'care' perspective on health care.**Conclusion:** The nurses ordered diseases in a prestige hierarchy and their rankings are strikingly like those of physicians. The findings are of significant relevance to nursing practice and set a new course for future research into prestige and nursing culture.**Impact:** The findings should encourage nurses – individually and collectively – to reflect on whether and how notions of disease prestige influence their decision-making. By showing that nurses as well as physicians are able to rate diseases according to prestige, the study suggests new avenues for future disease prestige research.**KEYWORDS**

clinical decision-making, culture, disease, esteem, nursing, prestige, survey

## 1 | INTRODUCTION

A series of studies shows disease prestige to be a central phenomenon in health care (Album, 1991; Album, Johannessen, & Rasmussen, 2017; Album & Westin, 2008; Haldrar, Engebretsen, & Album, 2016; Hindhede & Larsen, 2019; Johannessen, 2014; Nørredam & Album, 2007; Rosenvinge, Pettersen, & Olstad, 2009). Disease prestige refers to healthcare workers' systematic assessment

of the regard or esteem of medical conditions. Diseases such as leukaemia, brain tumour, and myocardial infarction are awarded high prestige, whereas fibromyalgia, anxiety neurosis, and hepatocirrhosis are awarded low prestige (Album et al., 2017; Album & Westin, 2008). As prestige is often a central motive for social action (Weber, 1978), notions of disease prestige can influence healthcare workers' everyday reasoning and decision-making, potentially in undue ways (Album et al., 2017).

The peer review history for this article is available at <https://publons.com/publon/10.1111/jan.14394>

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In principle, the concept of disease prestige encompasses prestige evaluations by all types of healthcare workers; in practice, however, empirical research has been confined to studies of physicians. It is therefore unclear whether previous results are transferable to other occupational groups. This study extends research on disease prestige to include nursing, a profession that has long and complicated ties to the medical profession (Allen & Hughes, 2002). Using a survey design from studies of occupational prestige (Treiman, 1977), the study asks whether and how nurses rank diseases according to prestige and how their rankings compare to those of physicians.

## 1.1 | Background

Prestige is a principle of stratification, referring to the regard or esteem of someone or something (Weber, 1978). A related concept is stigma (Goffman, 1968; Link & Phelan, 2001; Scambler, 2009), but this only covers the lower end of the prestige scale, whereas prestige encompasses both negative and positive evaluations of esteem. Prestige is a cultural phenomenon, referring to shared evaluations (Zhou, 2005, pp. 97–98); it is therefore not a matter of personal taste, but of what people generally take to be highly and lowly regarded within a particular culture. These shared evaluations have relative autonomy, in the sense that they cannot be reduced to other principles of stratification such as money and power (although they of course affect each other; see Hatch, 1989). Evaluations of prestige are also relational, in the sense that an object can only be evaluated in (implicit or explicit) comparison with other objects (Nørredam & Album, 2007).

According to Treiman (1977, pp. 19–20), the prestige concept applies to all meaningful objects. In practice, however, empirical research has predominantly treated individuals or groups as the unit of analysis – leaving the prestige of other objects underexplored (Album et al., 2017). Studies of disease prestige provide an exception, as they treat ‘disease’ as a cultural concept amenable to prestige research.

Disease prestige refers to healthcare workers’ systematic assessment of the regard or esteem of medical conditions (Album et al., 2017). In assessing diseases according to prestige, healthcare workers are not ranking the conditions themselves, but the meanings they associate with these conditions. To say that diseases are meaningful is to view them as cultural objects that convey stories, images, and identities – and these meanings can extend far beyond the ‘strictly medical’, as evidenced in how a disease like AIDS may conjure images not just of a patient’s immune system, but of drug use, frivolous sex, and other myths of irresponsibility (Sontag, 1989).

Although not by design, the disease prestige concept has hitherto been seen in close connection with physicians’ culture and education. The concept was first coined by Album (1991), who, during observations of physicians in breakroom conversations, noticed that their talk about diseases was highly laden with values and emotions. Influenced by the long-standing tradition of research on occupational prestige (Perrow, 1961; Treiman, 1977), Album decided to conduct a survey where he asked physicians to rate 38 diseases according to the prestige they believed health personnel would in general award them. He found

that physicians were able to rate all 38 diseases consistently, placing leukaemia, brain tumour, and myocardial infarction at the top and fibromyalgia, hepatocirrhosis, depressive neurosis, and anxiety neurosis at the bottom. The same survey was repeated in 2002 (Album & Westin, 2008) and 2014 (Album et al., 2017), showing largely the same results.

In interpreting these results, Album and Westin (2008, pp. 186–187) suggested three sets of criteria that structure the prestige rankings, related to:

1. *The disease and its typical trajectory.* High prestige is typically awarded to non-self-inflicted, acute and lethal diseases with clear diagnostic signs, located in the upper part of the body, preferably the brain or the heart.
2. *The typical treatment of the disease.* Diseases associated with active, risky and high technology treatment leading to a speedy and effective recovery are awarded high prestige.
3. *The typical patient with the disease.* Diseases associated with young patients, patients who accept the healthcare workers’ understanding of the disease and whose treatment results do not involve disfigurement, helplessness or other heavy burdens, are awarded high prestige.

While some of these criteria are perceived as illegitimate in the context of health care, research nevertheless suggests that prestige evaluations can be consequential. For instance, studies show that physicians prefer working with patients who have ‘interesting’ diseases (Dodier & Camus, 1998), that notions of disease prestige can have bearing on informal priority setting in intensive care units (Halvorsen, Førde, & Nortvedt, 2009), and that prestige is a relevant factor in students’ choice of medical specialty (Aasland, Røvik, & Wiers-Jensen, 2008; Azzadeh et al., 2003; Creed, Searle, & Rogers, 2010).

To date, there is only one study looking at disease prestige rankings in professions other than medicine. This was done by Grue, Johannessen, and Rasmussen (2015), who distributed a similar survey to workers in Norwegian disability organizations. These workers were found to rate diseases in a manner strikingly similar to that of physicians. The authors interpreted this as evidence of medicine’s power over the disability field, while remaining open that the rankings might also reflect more general evaluative patterns.

No study has yet looked at disease prestige rankings in the nursing profession. It is therefore an open question whether or how nurses assess diseases according to prestige. Answering this question is pertinent, as notions of disease prestige can influence nurses’ reasoning and decision-making. Investigating disease prestige rankings in nursing can also improve our understanding of the disease prestige phenomenon itself, as it allows us to see whether different occupational groups offer different rankings. On the one hand, some aspects of the nursing profession could lead us to suspect such differences. As several studies show (cf. May & Fleming, 1997; Salhani & Coulter, 2009), the nursing profession works hard to construct its difference from medicine. On the other hand, there are also reasons to expect similarities in nurses’ and physicians’ rankings, including the significant influence that medicine has traditionally exerted over

**TABLE 1** Frequencies of nurse and physician respondents by age group and sex (with percentages in parentheses)

Age	Nurses (N = 122)			Physicians (N = 291)		
	Women	Men	Total	Women	Men	Total
<55	49 (51)	18 (69)	67 (55)	35 (38)	37 (19)	72 (25)
≥55	47 (49)	8 (31)	55 (45)	56 (62)	163 (82)	219 (75)
All ages	96 (100)	26 (100)	122 (100)	91 (100)	200 (101)	291 (100)

the nursing profession (cf. Allen & Hughes, 2002; Freidson, 1970). Melia (1987) gives some evidence of medical influence in her study of nursing education in the United Kingdom, where she found that “students were prepared to call the technical and largely medically prescribed aspects of their work ‘real nursing’ and to dismiss as ‘not really nursing’ those parts of their work which are not dependent upon medicine” (1987, p. 141). Findings like these might lead us to expect similar rankings between the two professions.

In short, then, attending to nurses’ notions disease prestige can help improve our understanding of nurses’ evaluative culture and of disease prestige more generally. These are the aims of the present article.

## 2 | THE STUDY

### 2.1 | Aims

The aim was to see whether nurses rate diseases according to prestige and, if so, how their ratings compare to the disease prestige hierarchy previously uncovered among physicians.

### 2.2 | Design

The article is part of a larger cross-sectional survey study to investigate whether and how Norwegian healthcare workers rate diseases according to prestige. The survey asked respondents to rate an identical set of 38 diseases on a scale from 1 (lowest) to 9 (highest) according to the prestige they believed most health personnel would award them. The 38 diseases were selected by Album together with several physicians, who sought to include diseases that differed in terms of their chronicity, curability, localization, treatment, objectivity of diagnostic criteria, and in the age and sex of the typical patient associated with the disease. Only diseases that might lead to hospitalization were included.

The survey was phrased in Norwegian. An English translation of the main question we asked is: ‘Below you will find a list of 38 diseases or disease categories. Please give each disease a number based on the prestige you imagine it has among health personnel’. The expression ‘among health personnel’ was chosen because the survey was distributed to a sample consisting of different professionals. Moreover, the survey asked for general rather than personal opinions because this more accurately reflects the shared, consensual nature of prestige evaluations; as mentioned, prestige

refers not to personal taste but to what people generally take to be highly and lowly regarded within a particular culture (Weber, 1978).

### 2.3 | Sample

A convenience sample was recruited by distributing the survey to 732 current and former students in a continuing education programme for health personnel, of which most were either nurses or physicians. We received a total of 485 responses (66.3%). In this article, we focus on the nurses in the sample; physicians’ answers have been published elsewhere (Album et al., 2017) and are only used for comparison. Reflecting the assumption that disease prestige is linked to physicians’ culture and education, the survey unfortunately did not include the option of ‘nursing’ under the section ‘Education’, only ‘healthcare workers with three years of higher education’. However, we find it reasonable to treat this category as representing nurses in our sample, both because 3 years of higher education is the educational requirement for being a nurse in Norway and because we know from contact with the education programme administration that, among the programme’s students, this category predominantly comprises nurses. Although we cannot rule out the inclusion of a few members from neighbouring professions (e.g., physiotherapy), we thus selected the 122 respondents who ticked this box to represent nurses in our sample (Table 1). In light of this uncertain and convenient sample, however, this study should be seen only as an initial investigation into disease prestige rankings among nurses.

### 2.4 | Data collection

The survey was distributed in paper-form in 2014, together with a stamped return envelope.

### 2.5 | Ethical considerations

The study was approved by the Norwegian Social Scientific Data Services.

### 2.6 | Data analysis

SPSS version 25 was used to analyse the data for simple stratifications, calculations of means, and 95% confidence intervals.

**TABLE 2** Disease prestige: Rank, mean scores (on a scale from 1–9), and standard deviations, sorted after nurses' rankings

Disease	Nurses			Physicians		
	#	Score	SD	#	Score	SD
Myocardial infarction	1	7.4	1.3	2	6.7	1.6
Leukaemia	2	7.3	1.3	1	6.9	1.5
Brain tumour	3	7.2	1.5	2	6.7	1.7
Testicle cancer	4	6.8	1.6	4	6.6	1.6
Colon cancer	5	6.5	1.5	7	6.1	1.5
Spleen rupture	6	6.4	1.6	5	6.4	1.5
Pulmonary embolism	7	6.3	1.6	5	6.4	1.5
Pancreatic cancer	8	6.1	1.6	12	5.7	1.7
Meniscus rupture	9	6.0	1.9	14	5.4	1.7
Ovarian cancer	9	6.0	1.5	9	5.9	1.5
Angina pectoris	11	5.9	1.6	11	5.8	1.5
Kidney stone	11	5.9	1.6	14	5.4	1.4
Thyroid cancer	11	5.9	1.6	9	5.9	1.6
Cataract	14	5.8	1.8	19	5.2	1.7
Extrauterine pregnancy	15	5.7	1.8	8	6.0	1.7
Kidney failure	15	5.7	1.6	16	5.3	1.6
Lung cancer	17	5.6	2.0	16	5.3	1.9
Appendicitis	18	5.1	1.8	13	5.6	1.7
Ankle fracture	18	5.1	1.7	20	5.1	1.6
Ulcerative colitis	20	4.8	1.4	16	5.3	1.4
Duodenal ulcer	21	4.7	1.4	21	5.0	1.3
Sciatica	22	4.6	1.4	23	4.9	1.3
Asthma	23	4.5	1.3	21	5.0	1.3
Bechterew's disease	23	4.5	1.4	26	4.8	1.4
Femoral neck fracture	23	4.5	1.6	27	4.7	1.5
Multiple sclerosis	26	4.4	1.3	23	4.9	1.6
Arthritis	27	4.1	1.3	28	4.6	1.3
Inguinal hernia	27	4.1	1.7	29	4.2	1.5
Cerebral palsy	29	3.8	1.4	30	3.9	1.5
Apoplexy	30	3.5	1.5	23	4.9	1.6
Schizophrenia	30	3.5	1.6	32	3.5	1.6
AIDS	32	3.4	2.0	33	3.4	1.9
Psoriasis	32	3.4	1.4	30	3.9	1.3
Anorexia	34	3.3	1.4	33	3.4	1.5
Hepatocirrhosis	34	3.3	1.8	35	3.2	1.6
Depressive neurosis	36	3.1	1.3	35	3.2	1.3
Anxiety neurosis	37	2.8	1.3	37	2.9	1.4
Fibromyalgia	38	2.6	1.4	38	2.4	1.3
Means		5.0	1.5		5.0	1.5

## 2.7 | Validity and reliability

Our study adopts a valid and tested cross-sectional survey design from research on occupational prestige (Perrow, 1961; Treiman, 1977).

The survey and results from our previous studies have also undergone member validation through focus groups (Haldar et al., 2016) and recurrent engagement with the healthcare field.

## 3 | RESULTS

About 78.6% of study participants were female; 21.4% were male. 45% of the sample were below 55 years of age; 55% were above (Table 1).

Results are presented as the mean scores of the ratings of the diseases (Table 2). Diseases are listed in rank order from the most to the least prestigious according to the nursing sample. As analyses for age and sex differences in nurses' scoring show only insignificant differences, we focus on the scoring of the whole sample.

The distribution of mean scores among nurses ranges from 2.6–7.4, with standard deviations ranging from 1.3–2.0. While the differences between means are too low and the standard deviations are too high to allow a fine-grained analysis of nurses' rankings, we see a significant difference between the top and bottom of their hierarchy. Myocardial infarction, leukaemia, and brain tumour are ranked as the top three conditions, with mean scores of 7.4, 7.3, and 7.2 respectively. On the other side of the spectrum, we find depressive neurosis, anxiety neurosis, and fibromyalgia, with mean scores of 3.1, 2.8, and 2.6 respectively. We thus find a difference of 4.8 points between the most highly and lowly regarded conditions.

There is a remarkable similarity in scoring between the nurse and physician samples. The mean score of all ratings is similar in the two samples and the mean difference between their scores for each disease is only 0.28 points. The greatest difference is seen for apoplexy, which is rated 3.5 by nurses and 4.9 by physicians. Except for this and three other conditions (cataract, meniscus rupture, and myocardial infarction), all conditions are within a 0.5 margin of difference between the two samples.

## 4 | DISCUSSION

The results show that nurses rank diseases in a prestige hierarchy, with myocardial infarction, leukaemia, and brain tumour rated as the top three conditions and depressive neurosis, anxiety neurosis, and fibromyalgia rated as the bottom three. Their rankings are remarkably similar to those of physicians, with all but four conditions being within a 0.5 margin of difference between the nurse and physician samples. The greatest difference in rating is for apoplexy (rated 3.5 by nurses and 4.9 by physicians), a condition that, among physicians, has seen its average score increase from 3.5 in 1990 to 4.9 in 2014 (Album et al., 2017). Future research could investigate the potential explanations for these few discrepancies between nurses and physicians. Here, we instead focus on the striking overlap between the two samples.

The similarity in ratings seem to suggest that nurses rate diseases according to a similar logic as physicians. As mentioned in the

introduction, physicians' rankings seem to be structured by three sets of prestige criteria, related to the disease and its typical trajectory, to the typical treatment of the disease and to the typical patient having the disease. Interestingly, these all seem to reflect a "cure" rather than a "care" perspective on healthcare (Baumann, Deber, Silverman, & Mallette, 1998, p. 1,041), valorising diseases that are, among other things, "objective", critical and treatable.

This apparent overlap in ratings can be interpreted in various ways. For one, nurses' ratings could be taken as evidence of the 'medicalization' of nursing (Conrad, 2007), as medicine's dominant position allows it to exert significant influence on nurses' understanding and valorization of healthcare work. The rankings could also be seen to reflect changes in the organization of healthcare work; as Prowse and Allen (2002, p. 76) argue, nursing is "located in a changing healthcare scene which produces a blurring of the caring and curing functions." As nurses are increasingly handed (bio) medically defined work tasks, it could follow that their valuation of healthcare work changes accordingly.

However, it could also be argued that nurses' ratings do not, in fact, reflect nurses' perspective. As the survey asked nurses to rate diseases according to the prestige they typically have among healthcare personnel in general, we cannot draw any strong conclusions about the frame of reference used for rating. One possibility is that nurses' ratings reflect their perceptions of the group of healthcare personnel that is widely perceived to dominate modern health care – physicians – and that this, at least partially, explains the overlapping ratings between the two. Adjudicating between this and the other explanations of overlap requires further research; hence, our study should be considered an initial investigation into evaluative patterns in nursing.

What the present evidence does suggest, however, is that nurses and physicians share knowledge about how healthcare personnel in general would rate diseases according to prestige. The shared character of this knowledge might indicate a broader evaluative culture in health care, which can have significant implications for nurses' actions. As sociological research has shown, a shared evaluative order can exert significant normative force on an individual's actions, regardless of whether this individual personally subscribes to its relevance or validity (Ridgeway, 2014; Willer, Kuwabara, & Macy, 2009). Thus, regardless of whether nurses personally subscribe to the underlying principles of the disease prestige hierarchy, they can interact with and be held accountable to other actors who do. This, in turn, highlights the importance of thinking sociologically about nurses' actions. Nurses cannot reason and act only in accordance with their own professional ideals but must also take into consideration and negotiate what relevant actors consider important and worthwhile. By implication, if we want to understand the rationale of nurses' everyday work, we need a broad understanding of the values and ideals that guide their actions, of which notions of disease prestige form a potentially significant part.

The overlap in ratings between nurses and physicians also has implications for our understanding of the disease prestige phenomenon more generally. Previous studies have associated notions of disease prestige almost exclusively with physicians, seeing this as

reflective of their medical perspective. The fact that nurses – in some sense or another – share this knowledge should lead us to question this physician-centredness. For instance, previous studies (Johannessen, 2014) have linked the reproduction of disease prestige closely to *medical* education. While the present findings do not rule out its relevance, they do suggest that medical education is *a* site, not *the* site, for the transmission of disease prestige.

This, in turn, raises the question of how nurses acquire notions of disease prestige. Multiple avenues seem likely. For one, several of the values underpinning the disease prestige hierarchy – such as the valuation of life-saving, agency, and drama – seem to reflect membership in a common culture rather than a professionally distinct subculture; as Album et al. (2017, p. 50) argues, "it is certainly not exclusively medical to equate the prestigious with action, vigour and drama." This suggests that significant parts of the hierarchy may be acquired through primary socialization into the common culture of Western societies. However, to rank the units under study (i.e., diseases), nurses need at least some knowledge about the stories, images, and identities associated with them; and to rank these units in line with 'healthcare personnel in general', they must have some sense of what characterizes this perspective (compared with other perspectives, such as those of patients). Knowledge about the latter two (i.e., diseases and the perspective of healthcare personnel) is most likely developed through everyday interactions in the workplace (cf. Melia, 1987) and through the formal and 'informal curriculum' of nursing education (Hafferty & Franks, 1994). However, to go beyond these general hypotheses and make more precise statements about how notions of disease prestige are (re)produced, more empirical research is needed.

#### 4.1 | Limitations

The study is limited by not being based on a representative sample of Norwegian nurses and the results can therefore not be statistically generalized. Compared with Norwegian nurses in general, participants in the continuing education programme are older, most of them having several years of practice behind them. Several of them are also leaders or heading into leadership roles in the branches of the health services where they are employed (the same is true for the physician sample in previously reported studies; see Album et al., 2017). This should therefore be seen only as an initial investigation into disease prestige rankings among nurses, to be followed up in future research with more representative data.

A further limitation is that by asking nurses to rate diseases, we might have invited a 'physician bias' in the nurses' responses. It is possible that other categories would resonate more fully with nursing culture. For instance, it could be interesting to have nurses rank Nursing Diagnoses (Herdman & Kamitsuru, 2017) according to prestige, to see if a different rank order is revealed. At the same time, diseases are undeniably central categories in many aspects of daily medical life. They act as organizing principles for much healthcare work, including the categorization of patients, the planning and

allocation of tasks, the setting of priorities at micro, meso, and macro levels, and the teaching of several aspects in nursing and medicine. A widespread prestige ordering of diseases may therefore influence many understandings and decisions in the healthcare community, possibly without the awareness of decision-makers (Martin & Singer, 2003). This makes disease prestige an important phenomenon in both nursing and medicine.

## 5 | CONCLUSION

We found that nurses rank diseases in a prestige hierarchy and that their rankings are remarkably like those of physicians. This similarity suggests that nurses rate diseases according to a similar logic as physicians, reflecting a 'cure' rather than a 'care' perspective on health care. Although we cannot be certain whether these rankings in fact reflect the distinct perspective of nurses, there is nevertheless a chance that this rank order can have significant implications for nurses' actions; as sociological research shows, shared convictions can exert significant normative pressure on an individual's actions, regardless of whether this individual personally subscribes to these convictions (Ridgeway, 2014; Willer et al., 2009). The findings should therefore encourage nurses – individually and collectively – to reflect on whether and how notions of disease prestige influence their decision-making. The findings also suggest a need to conduct further research into disease prestige in nursing, to learn more about the patterns and logics in nurses' disease prestige evaluations.

## ACKNOWLEDGEMENTS

The authors thank the administrators of the continuing education programme, as well as all those who responded to the survey.

## CONFLICT OF INTEREST

No conflict of interest has been declared by the authors.

## AUTHOR CONTRIBUTIONS

LEFJ, DA, EBR made substantial contributions to conception and design, or acquisition of data, or analysis and interpretation of data; involved in drafting the manuscript or revising it critically for important intellectual content; given final approval of the version to be published. Each author should have participated sufficiently in the work to take public responsibility for appropriate portions of the content; agreed to be accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved.

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**How to cite this article:** Johannessen LEF, Album D, Rasmussen EB. Do nurses rate diseases according to prestige? A survey study. *J Adv Nurs*. 2020;76:1691–1697. <https://doi.org/10.1111/jan.14394>

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