Response to review from professor Batalden
Thank you very much for valuable comments and questions. The general comments include several points that we would have liked to discuss:
The need to analyse the between-groups differences of staff working at different units, which are rarely done. Another point is the need to elaborate concepts that may serve as a common platform for communication across professional borders. A third is the role and legitimacy of local leadership across professional borders.
All these issues touch our core issue but are in fact separate articles waiting to be written.
Our responses below are related to what we have regarded as direct questions or comments, marked as 'fat font' in the reviews and numbered accordingly.

1. As we see it Nelsons term 'clinical microsystem' cover our term micro-unit, but we find it meaningful here to underline the difference between the formal microunit and the smaller and more ad hoc microteams. As our analytical focus is professional culture we have deliberately excluded the patient. Not because we think that patients have no impact on microunit culture but to explore the professional characteristics. The difference between Nelson and ourselves is further described in the introduction (p.3-4).

3. Sorry, but our over all response rate was 65%. (As given at p. 9)
3.a As our inclusion procedure was established to secure anonymity, our only information about non-respondents was their profession and their place of work (hospital and department) (p.6).

b. The length (years) of required professional formal education, of nurses and auxiliary nurses are now given in brackets p.6.

c. We have given some considerations about other surveys or survey items not used and why at p.7. In addition we provide a reference to another article describing the development of the first generation of WORQUA (1998).

d. The question of gender is an interesting one: We dare not conclude how much of the professional variance that may be attributed to gender. The issue is touched upon in the chapter of limitations. It is however more discussed in another article (Krogstad,U.; Hofoss,D.; Hjordahl,P., 2004 Doctor and nurse perception of inter-professional co-operation in hospitals, Int J Qual Health Care; 16(6):491-97)

e. It is a good point that hospital work organisation for different professions probably differ between countries. It also differs between different kinds of departments. At the start of the discussion we give an example of a typical way of organising work at Norwegian hospitals. The numbers of professionals may differ considerably according to patient groups, but the main point is that reasonably stable inter-professional teams may be established most places.

f. The term 'professional development' was formulated particularly cautious to be understandable by all professional groups. It refers primarily to the local and informal building of competence as both doctors and nurses have more formal ways of specialised training. It refers to the local leader's ability to organise supervision, regular up-dating sessions and internal courses. We do see that translation to English or other
countries' professional / cultural systems may carry different connotations. That said, the expression serves as an example of how identical questions may differ in validity between different groups of people. (ref. the discussion in 'strengths and limitations' p. 17).

Response to review from Dr Hanan Al-Ahmadi
We appreciate the comments and questions. We do see that we have not been clear enough in stating the purpose of the article; we have tried to improve this in the new version. It may also be that there is a disagreement between us with regard to the major condition of the critics: that the article only should discuss the measured variables.
We are not primarily interested in explaining job satisfaction, but rather to discuss the implications of differences between groups working closely together. We feel free to discuss any set of variables in any chosen theoretical perspective, here a cultural perspective. The important findings are therefore not the predictors themselves but the differences between professional groups and their potentials in establishing an interdependent microteam culture.
This means also that the relevant theoretical background and literature aims at supporting this discussion.

Specific points
* We see that the use of the term 'hypothesis' directly give associations to empirical hypothesis testing where the critics would have been very relevant. We hope that other formulations will broaden the methodological expectations.
* Number of indices. You are right. Only five indices are used in this article, this is now corrected in page 8. (Table 1). It also were a higher number of missing on the variable of gender (may be due to fear of being recognised in smaller hospitals). We have mentioned the issue in the limitation of the study.
* We have considered the title but we feel that it do reflect the main objective og the study so we decided to keep it.
* The point 'why the differences between the groups' is The other important question that we would have raised from these findings. We do feel however, that this question requires an article of its own. (Instead we go for the implications).
* Demographic data are presented for all groups in table 1. The reason why we brought some of them into the discussion for the auxiliaries is that they are clearly the group most skewed with regard to gender and also clearly older than the other groups. These facts are likely to have impact on their expectations and motivation in a discussion of working culture.