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Gender Diversity and Nurse-Physician Relationships

Beth Ulrich, EdD, RN

You see a picture of a man and a woman, both dressed in scrubs. Your first reaction is probably to assume that the man is a doctor and the woman is a nurse, and odds are that you would be correct. U.S. Bureau of Labor Statistics for 2008 indicate that 68 percent of physicians are male and 90 percent of registered nurses (RNs) are female [1].

Perception, it has been said, is reality. Maybe it is more accurate to say that perception influences reality or creates a self-fulfilling prophecy. The original question posed for this article to the author was "Why does the nursing profession seem to be slower in achieving equal representation of male and female practitioners than law, teaching, the military, the clergy, or other sectors of medicine?" In actuality, none of these professions has equal representation of men and woman—65 percent of lawyers and 89 percent of clergy are male, 86 percent of the active military is male (though within the military, the percentage of RNs who are male is three times that of the civilian population [2]), and 81 percent of elementary and middle school teachers are female [1]. While gender diversity has improved in many professions, we are far from reaching gender equality.

Johnson & Johnson's Campaign for Nursing's Future has produced television ads, movies, and promotional materials that show nurses of diverse backgrounds and of both sexes and is credited with helping to turn around the overall decline in nursing school enrollments in the last 10 years. After talking with guidance counselors who said the "warm and fuzzy" materials promoting nursing as a career choice did not resonate with male students, the Oregon Center for Nursing developed a poster that features nine practicing male nurses (fireman, Navy Seal, snowboarder, motorcycle rider, executive, etc.) with the question "Are you man enough to be a nurse?" Programs in other states send male nurses to middle and high schools and community groups to talk about careers in nursing. As a result of these and many other similar efforts, the number of male graduates from schools of nursing has recently increased from 5.8 percent in 2004 [3]to 12 percent in 2007 [4].

Specialty and Subspecialty Choices

In addition to gender disparities between nurses and physicians, there are imbalances within specialties and subspecialties of both professions. While it is generally accepted that female nurses can take care of almost any patient (with some religious beliefs creating exceptions), such is not the case with male nurses. There are anecdotal reports of resistance, for example, to men who want to specialize in

obstetric and gynecologic nursing. In medicine, pediatrics is one of the few specialties in which the majority of the practitioners are women. American Medical Association (AMA) data for specialty practice by gender indicates that in 2006 (most recent data available), only 15.6 percent of internists and only 12 percent of general surgeons were women [5]. Gender diversity progress in medical specialties is evident, however, in areas such as obstetrics and gynecology (36.8 percent female physicians in 2006), with 77 percent of the 2008-2009 residents being women [6]. Female residents are also in the majority in pediatrics (63 percent), dermatology (62 percent), and medical genetics (59 percent). Based on resident data, however, surgery specialties are on a path to continue to be overwhelmingly male-dominated (neurosurgery and orthopedic surgery-88 percent, thoracic surgery-85 percent) [6].

Is It Really Just about Gender?

Given that the majority of physicians are male and the majority of nurses are female, are the conflicts between doctors and nurses just or even mainly a gender struggle? Certainly, gender is a contributor. But if it were the only answer, or even the greatest influence, one would expect some of the traditional RN-physician problems to have decreased as more women became physicians. Evidence does not seem to support this.

Sexual harassment reported by RNs has actually increased in the last decade, with 28 percent of hospital RNs in a recent national study reporting that they had personally experienced sexual harassment in the past year [7]. Another national survey of critical care RNs found that 27 percent had personally experienced verbal abuse from a physician in the past year [8]. In both of these studies, respect for RNs by physicians—another longstanding issue—was rated as excellent by only 11 percent of the respondents and fair or poor by 39 percent, slightly worse than in the same studies conducted in 2006.

In a recent survey by the American College of Physician Executives on doctor-nurse behavior, physician executives and nurse executives were asked who most often exhibits behavior problems—45 percent said physicians, 7 percent said nurses, and 48 percent said “a pretty even mix of both doctors and nurses” [9]. The top behavior problem was degrading comments and insults followed by yelling and cursing. There were many descriptions in the comments of the survey about patients and families being caught in the middle.

Alan Rosenstein, a physician who has done extensive research on disruptive behavior and its outcomes to physicians, nurses, and patients, notes that there are many potential contributors to disruptive behavior—gender, cultural beliefs, personality, education and training experiences, and situational characteristics (i.e., high intensity/high stress areas and specialties) to name a few [10]. Most important is the research that shows the direct effect that disruptive behavior has on patient outcomes [10. 11].

Interprofessional Respect and Understanding

Perhaps a larger contributor than gender is a lack of understanding about and respect for each other's knowledge and scope of practice. Both professions share a core knowledge base. The basics of anatomy and physiology are the same in both nursing and medical textbooks. Both professions use the same *PDR* as a reference. Beyond the basics, knowledge diverges according to specialty and level of care, but understanding and respecting the knowledge that each profession brings to the table and that both professions share could go a long way towards fostering positive relationships. With the steady increase in the number of advanced practice nurses in hospitals and practicing independently, opportunities for potential partnership and collaboration between nurses and physicians are increasing.

For more than 30 years, research has shown that when nurses and physicians collaborate, patients have better outcomes, and both physicians and nurses are more satisfied in their work. Several Institute of Medicine reports concerning improving patient safety and outcomes have recommended actions that support interdisciplinary collaboration such as shared education and input from both physicians and RNs in patient care processes.

Conclusion

Increasing gender parity in medicine and nursing is a worthy goal, but it is not the only or perhaps even the best method for increasing mutual respect and value between the professions. There are so many other issues—too little time, too few resources, sicker patients and pressure to move them through the system faster, struggles with insurance companies and lawyers, and working with patients and families at what is often the most stressful and vulnerable times of their lives.

Gender is one of the many aspects of cultural diversity, and the overall cultural sensitivity of a profession is enhanced by the diversity of its practitioners. Diversity that reflects the diversity of the population served is associated with improved access, patient satisfaction, communication, research, and positive outcomes [12]. In perhaps the best of all worlds, the gender diversity of medicine and nursing would more closely resemble that of our patients. As professionals, however, we must be able to do what is best for our patients (in their minds as well as ours) regardless of our own personal characteristics. We cannot become more diverse overnight, but while we strive for that goal, we can respect and value each others' knowledge and expertise, collaborate for the good of our patients and each other, and treat each other with civility.

References

1. U.S. Bureau of Labor Statistics. Household data annual averages. 2008. www.bls.gov/cps/cpsaat39.pdf. Accessed November 2, 2009.
2. The Women's Memorial. Statistics on women in the military, 2009. http://www.womensmemorial.org/PDFs/StatsonWIM.pdf. Accessed November 2, 2009.

3. U.S. Department of Health and Human Services. The registered nurse population findings from the national sample survey of registered nurses. Washington, DC: U.S. Department of Health and Human Services; 2004. ftp://ftp.hrsa.gov/bhpr/nursing/rnpopulation/theregisterednursepopulation.pdf
4. National League for Nursing. Annual survey of schools of nursing – academic year 2006-2007: executive summary. http://www.nln.org/research/slides/exec_summary.htm. Accessed November 2, 2009.
5. American Medical Association. *Physician Characteristics and Distribution in the U.S., 2009*. Chicago, IL: American Medical Association; 2007.
6. Accreditation Council for Graduate Medical Education. Data resource book. Academic year 2008-2009. Chicago, IL: Accreditation Council for Graduate Medical Education; 2009.
7. Buerhaus PI, Donelan K, DesRoches C, Hess R. Still making progress to improve the hospital workplace environment? Results from the 2008 national survey of registered nurses. *Nurs Econ.* 2009;27(5):289-301.
8. Ulrich BT, Lavandero R, Hart KA, et al. Critical care nurses' work environments 2008: a follow-up report. *Crit Care Nurse*. 2009;29(2):93-102.
9. Johnson C. Bad blood: doctor-nurse behavior problems impact patient care. *Physician Executive J*. 2009;35(6):6-11.
10. Rosenstein AH, O'Daniel M. A survey of the impact of disruptive behaviors and communication defects on patient safety. *Jt Comm J Qual Patient Saf*. 2008;34(8):464-471.
11. Grenny J. Crucial conversations: the most potent force for eliminating disruptive behavior. *Physician Executive J.* 2009;35(6):30-3. http://net.acpe.org/MembersOnly/pejournal/2009/NovDec/Grenny_Joseph.pdf. Accessed December 18, 2009.
12. Institute of Medicine. *In the Nation's Compelling Interest: Diversity in the Health-care Workforce*. Washington, DC: National Academies Press. 2004.

Beth Ulrich, EdD, RN, is the senior vice president of research and business analytics for Versant, an organization that provides hospitals with RN residency programs to facilitate the successful transition of new graduate nurses into the professional nurse role. Dr. Ulrich also serves as the editor of the *Nephrology Nursing Journal*, the professional journal of the American Nephrology Nurses' Association. Dr. Ulrich has been the co-investigator on several national nursing workforce and work environment studies and the principal investigator on studies to define respect in nursing and understand the experience of new graduate nurses as they enter the workforce.

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