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Informal Interactions, Gender, and Hierarchy: Barriers to Nurse-Physician Collaboration in a West Coast Hospital

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Oh please. We're the hired help.

Charge nurse, in response to the question “has the emphasis on collaboration improved the physicians’ understanding or respect of nursing?”

Contemporary Health Care and the Nurse-Physician Relationship

The American healthcare system is in a moment of tremendous change. Spurred on by inflating costs, changing patient needs and the Affordable Care Act (ACA), health care providers are scrambling to meet new demands and challenges. Nurses are at the center of these changes. In addition to the increasingly prominent role of Advanced Practice Nurses (APNs) and Doctors of Nursing Practice (DNPs) as primary care providers, the ACA’s emphasis on prevention, wellness, and coordination of care requires registered nurses to play a more pivotal role in healthcare.¹ While these changes have enormous potential to improve patient care, their success in many ways depends on building collaborative relationships and good communication between nurses and physicians.

Effective patient care depends on successful communication. Communication errors in health care are estimated to lead to approximately 98,000 deaths annually in the United States and to increase health costs by billions each year.² Poor communication between physicians and nurses is one of the primary areas where these communication errors occur. Differences in communication styles, terminologies and viewpoints can contribute to misunderstanding between the two professions; and tensions related to hierarchy (of professions, gender, and race and class) often exacerbate barriers to communication.³

Additionally, the quality of the physician-nurse relationship contributes significantly to the job satisfaction and retention of nurses.

¹Breana Lathrop and Donna R. Hodnicki. “The Affordable Care Act: Primary Care and the Doctor of Nursing Practice Nurse” *Online Journal of Issues in Nursing* (19:2; May 2014).

²Kathleen Sutcliffe, Elizabeth Lewton, and Marilyn Rosenthal. “Communication Failures: An Insidious Contributor to Medical Mishaps,” *Academic Medicine* (79:2; Feb. 2004), pp 186-194.

³Theodora Sirota, “Nurse/Physician Relationships: Improving or Not?” *Nursing* (37:1 2007), pp 52-55.

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Verbal abuse and disruptive physician behavior have been clearly linked to job stress, satisfaction and retention⁴. But more subtly, the subordination of nurses and curtailment of their autonomy also leads to burnout, which may eventually result in departure from the profession. Hospitals where nurses experience less autonomy report significantly higher rates of nurse turnover and burnout.⁵ As of 2006, 1.8 million registered nurses in the United States were not working as nurses; and in 2008, 1 out of 5 nurses reported that they planned to leave the profession within 5 years.⁶ This further contributes to a nursing shortage which is likely to deepen in the coming years as millions more Americans gain access to healthcare as a result of the ACA while the Baby Boom generation's health needs rapidly expand.⁷

The purpose of this brief is to report findings from a study of the relationship between nurses and doctors as they engage in professional communication and interact in the social space of the hospital. The study primarily examines three aspects of the nurse-doctor relationship: formal authority and autonomy; the "nurse-doctor game"; and informal relations and the domination of social space. Because nurses have less power than physicians, they are much more likely to be affected negatively and to experience a circumscription of autonomy as a result of interprofessional conflict. While nursing has seen a fairly dramatic transformation over the last half-century in terms of professionalization, education, status and compensation, nurse satisfaction and retention remain significant impediments to the success of the professional project.

Extended observations and semi-structured interviews were conducted over a one-year period in a large hospital that is part of a regional integrated health system.⁸ The research site represents a particularly useful example for examining the prospects and limits of change in healthcare. With the health system's strong emphasis on wellness, preventative care and avoiding lengthy hospital stays, the hospital's policies exemplify the logic that underpins the Affordable Care Act. Over the last decade, it has developed sophisticated electronic records and computer systems to facilitate coordination between physicians, specialists, nurses, pharmacists and other team members. The organization has explicitly made cooperation between providers a primary goal for delivering effective health care. Part of this effort has been the adoption of the SBAR protocol (see below for explanation) to facilitate cooperation and communication between healthcare professionals which, since its introduction initial introduction to health providers in the early 2000s, has gained tremendous popularity among health care providers across the nation.

How has the quality of the nurse-physician relationship responded to the hospital's continued push for collaboration? While efforts at collaboration seem to have made significant strides, gendered patterns

⁴ Helen Cox, "Verbal Abuse Nationwide, Part II: Impact and Modifications", *Nursing Management* (22:3 1991) pp. 66-69.

Lazar J. Greenfield, "Doctors and Nurses: A Troubled Partnership" *Annals of Surgery* (230:3 1999)

Joseph Congelosi, F. Scott Markham and William Bounds, "Factors Related to Nurse Retention and Turnover: An Updated Study," *Health Marketing Quarterly* (15:3 1998), pp 25-43.

⁵ Marlene Kramer, and Claudia Schmalenberg. "The Practice of Clinical Autonomy in Hospitals: 20,000 Nurses Tell Their Story." *Critical Care Nurse* (28, 2008), pp 58-71.

Ada Sue Hinshaw "Building magnetism in health organizations." In M.L. McClure & A.S. Hinshaw (Eds.), *Magnet hospitals revisited: Attraction and retention of professional nurses* (American Nurses Association, 2002) pp. 83-102.

⁶ Kramer and Schmalenberg *ibid*.

⁷ American Association of Colleges of Nursing, "Nursing Shortage Fact Sheet." (April 2014)

<http://www.aacn.nche.edu/media-relations/fact-sheets/nursing-shortage>

⁸ The study included approximately 150 hours of observation and interviews with 18 nurses and 4 physicians.

of interaction in both official and unofficial exchanges appear to undermine efforts at collaboration and to reinforce a relationship of domination and subordination. This brief illustrates how the dynamics of formal and informal nurse-physician interactions continue to undermine efforts to improve communication through organization-level change initiatives.

The contemporary issue of collaboration echoes the traditional boundaries of the nursing profession. Historically, the doctor-nurse relationship was defined by a much stricter delineation of power⁹ and informal relations continue to replicate this hierarchical configuration of interprofessional relations. In addition to illuminating the central role of gender in the negotiation of professional boundaries, the findings have critical implications for the changing healthcare landscape, which will increasingly rely on a collaborative relationship between physicians and nurses as well as a more central role for nurses in healthcare provision.

Formal Structures

The nurse-doctor relationship is first and foremost organized by the formal/legal structures which bound and define their respective roles. Formally, both physicians and nurses occupy autonomous roles but collaborate to deliver care to patients. However, in nurse-physician interactions, the direction of power ultimately flows from physicians to nurses. Since physicians write treatment orders for nurses to fulfill, treatment in the hospital is physician-driven. While nurses have autonomy in the management and application of patient care, ultimate responsibility over diagnoses and patient treatment decisions lies with physicians.

For much of the work day, nurses work without interaction with doctors but coordinate with each other, with the charges and with nurse's assistants (CNAs) or medical assistants. In creating nursing care plans, nurses autonomously assess, diagnose and plan treatment for the care of patients. Additionally, nurses tend to build closer relationships with patients (and patient families); during an average shift RNs usually are responsible for 4–6 patients, depending on turnover, while an MD might be responsible for dozens. This often leads nurses to feel that they are more knowledgeable about the patient's particularities than the doctor. However, because doctors unilaterally make the initial overarching decisions, and because nurses often cannot act on patient care decisions without doctor approval, many nurses feel their autonomy is circumscribed.

Formal Authority, Assessment and SBAR

The primary area of collaboration is in assessment, one of the principal responsibilities of nurses. Assessment also represents an area where the rules of professional boundaries, hierarchy, and authority are blurred. It is the nurses' responsibility to constantly assess their patients' wellness, to take appropriate action when needed, and to convey change of condition to physicians. When the response is outside of the nurse's scope of practice, the physician diagnoses the problem and initiates treatment orders for the nurse or another specialist to carry out. In this area of assessment and recommendation, communication between nurse and physician is most problematic and perhaps also most critical. The information gathered by nurses' triage and physical examination assessments make up the foundation of physician diagnosis. This information determines the initial course and sequence of treatment.

⁹ Eliot Freidson, *Profession of Medicine: A Study of the Sociology of Applied Knowledge*. (Dodd, Mead 1973).

In the event that the nurse assessment identifies a problem which necessitates physician intervention, communication between the two professionals becomes absolutely essential. Unfortunately, these interactions generate inconsistent outcomes. Physicians may be reluctant to accept the importance of the new information or to trust the assessment if it differs from the original diagnosis and treatment. These moments of assessment partially invert the nurse-physician role, since information from a patient's changing condition might alter diagnosis and treatment. This is further complicated by differences in orientation, communication style and hierarchical relationships. On the one hand, nurses' assessments are often holistic in nature, meaning they take into account the patient's whole physiological and psycho-social condition and often communicate assessment in a narrative form. Physicians on the other hand tend to be oriented towards the biomedical model and to prefer discrete information. Additionally, the imbalance in social and institutional power can result in doctors' unreceptiveness to unsolicited input from nurses and nurses' lack of comfort in communicating unsolicited information to doctors.

To counteract poor communication, the hospital system has adopted a formalized method of interprofessional communication called SBAR. Adopted from the United States Navy, SBAR stands for situation-background-assessment-recommendation and provides a framework for standardizing communication through structured conversation and common language. It has gained wide adoption as a "tool to facilitate understanding between people who interact frequently or infrequently but might not communicate in the same way".¹⁰ As such, the adoption of SBAR has been shown to improve perceptions of communication between nurses and physicians¹¹ and to improve the health outcomes of patients.¹² Although SBAR is generally framed as a tool of nurse-physician communication, implying that both parties would make equal use of the protocol, SBAR in practice is more one-sided: nurses use SBAR to communicate to doctors. SBAR structures much of the written communication between doctors and nurses but has not taken as strong a hold in verbal communication. Some newer nurses seem to have robustly adopted the protocol, but more experienced nurses tend not to utilize the rigid communication structure. Interviews and observations suggest that younger, less experienced nurses tend to incorporate SBAR into their communication easily. Many older, more experienced nurses indicated that, while SBAR may be helpful for others, they had already developed a workable system for communicating with doctors.

In addition to implementing the SBAR protocol, the hospital has also begun to implement a program of patient-centered RN-MD collaboration. The program aims to increase collaboration by having physicians include nurses in walking rounds and requiring the presence of nurses when physicians communicate the treatment plan to patients. This is meant to avoid the common situation in which the doctor comes to see the patient and leaves written orders for the patient while the nurse remains unaware of the interaction. To enforce these changes, the charge nurse asks each nurse daily if the doctor fulfilled the requirements, and the charge sends his or her report to a coordinating physician. Doctors who are outside of compliance can be taken into "captain's mast," as one doctor called it, and questioned about their behavior, which they have to justify at the risk of possible repercussions (the nature of which were unclear).

¹⁰ James M. Vardaman et al. "Beyond Communication: The Role of Standardized Protocols in a Changing Health Care Environment," *Health Care Management Review* (0:00 2011) pg 2.

¹¹ Lorna J. Woohall, Lisa Vertacnik and Maribeth McLaughlin, "Implementation of the SBAR Communication Technique in a Tertiary Center," *Journal of Emergency Nursing* (34:4, 2008) pp 314-317.

¹² Cynthia D. Beckett and Gayle Kipnis, "Collaborative Communication: Integrating SBAR to Improve Quality/Patient Safety Outcomes," *Journal for Healthcare Quality* (31:5, 2009), pp 19-28.

These changes seem to be successful to a point. Interviewed nurses reported that doctors at the research site tend to be more responsive to their calls, more receptive to their insights and less likely to be abusive than at other hospitals. Additionally, nurses who had worked at the hospital for 15 years or more indicated that, in recent years, the relationship had markedly improved. However, every nurse interviewed also noted that doctors remain insufficiently responsive and often act annoyed when nurses attempt to provide insight into a patient. Nurses find a significant minority of doctors, surgeons in particular, simply difficult to work with because of their arrogance, poor-attitude, lack of respect, etc. Despite reporting good relationships with certain doctors, many nurses appear to struggle to effectively communicate their concerns and ideas to those very same doctors.

The Nurse-Doctor Game

First identified by Stein in 1967, the “Nurse-Doctor game”¹³ continues to shape the interactions between doctors and nurses in their official capacities in patient care, particularly when a nurse disagrees with a physician’s order or recognizes an error. Drawing from his own experience as a physician, Stein argued that the cardinal rule of the “game” of doctor-nurse interactions dictates that nurses and doctors never appear to disagree and hence that nurses would never offer direct recommendations to a physician. Rather, nurses learn that, to offer significant advice and to show initiative, they must always appear to passively defer to the doctor’s authority. Nurses then communicate recommendations using “nonverbal and cryptic verbal communication.” Ultimately, it remains imperative that any recommendation appears to be initiated by the physician. It should be no surprise that this game is entirely reminiscent of historical gender roles and the expectation that women show deference to male authority.

In the nearly 50 years since Stein’s report, the nurse-physician relationship has certainly transformed, with doctors now recognized as fallible and nurses venerated as far more than passive handmaidens. However, with important exceptions, nurses very rarely directly challenge the doctors’ expertise in cases where nurses disagree with physician decisions. Instead nurses are more likely to ask questions or to offer passive suggestions which allow the doctor to come to the “right” conclusion on his or her own. In some cases, nurses say nothing at all. When questioned about handling disagreements with doctors, nurses repeatedly reported some version of the same answer: “I try to get them to realize the problem and think it’s their own idea”.

In situations calling for nurses to make recommendations or to assert their point-of-view, they tended to employ methods that fall under two general approaches: suggestive or direct. Silence was also quite typical. In several cases, either before or after an interaction with physicians, nurses would talk to other nurses about the proper course of treatment for a patient but would fail to discuss it when actually speaking with the physician.

Suggestive approaches, the most common, include suggestive questions and quiet (or easily dismissed) suggestions. These methods fall in line with the imperative to make recommendations appear to have originated from the doctor. Suggestive questions were generally paired with key information that when taken together would lead physicians to come to the conclusion that the nurse wants. The following phone conversation between an RN and MD is typical of this technique:

¹³ Leonard Stein, “The Doctor-nurse game” *Archives of General Psychiatry*, (16, 1967), pp 699-703.

[The patient has two separate daily orders for potassium. At this point the patient's potassium is in the low normal range (represented in the patients chart) – continuing the daily order (as opposed to an as needed order) may result in her going above the normal range of potassium.]

“Hi Dr., the patient's order is for two doses of potassium one for 40 and one 20 daily”

“Fine, go ahead and give the 60.”

“I can do that, the patient's potassium is at 3.5, is that what you want?”

“I see that. You know what? I'm going to change the order to 20 mgs as needed. Thanks.”

Ultimately, as the nurse intended, the order was changed, while the doctor maintained his authoritative position by making the recommendation on his own accord. The quiet suggestion is similarly structured to the suggestive question, often paired with information but communicated in a low volume or with the inflection that conveys passivity and allows for dismissal without contention. Such suggestions tend to be uttered in a soft, lilting tone and often go unacknowledged by the physician. However, this does not necessarily mean that the recommendation failed. In fact, the outcome frequently coincided with the suggestion, but positional authority again was maintained. Even when quiet suggestions elicited a successful response from the physician, the nurse's contribution would frequently go unacknowledged.

Less frequent than suggestive approaches, direct approaches to communication include the prepared method and the assertive method. Utilization of these approaches varied by acuity of the unit, gender of the nurse, official authority of the nurse, and the nurse' status as signaled by a combination of education and tenure. The prepared method involves either formally utilizing the SBAR protocol or informally applying a similar strategy. In these scenarios the nurse approaches the physician with all available, relevant information at the ready so that the physician can suggest or recommend a course of action. Only young female nurses with bachelor's degrees were observed using this strategy (about half of the RNs in the hospital have bachelor's degrees, and half have associates degrees). One of these nurses explained:

I apply it because – when I was first out of school – I had been taught to use it [SBAR] in college. I had a patient I gave Benadryl to, IV, and she just, like, passed out. So I called the Dr. and I'm like “I gave the patient Benadryl and she went to the bathroom, and they came back and passed out on the bed. You need to come see them!”

And the Dr. said “well, what are their vital signs?”

“Oh, I don't know off the top of my head”

“Call me back when you know them” [CLICK]

So from then on, before I call, I need to know their blood pressure [...continues listing vitals ...]. So when I do call, I start with the vitals, what the issue is, why am I calling, and what do I suggest.

This nurse, having come into nursing with the expectation of a collegial relationship with physicians, learned to adopt extreme preparation as the best available option for ensuring productive collaboration. Though the nurses who utilized this method of communication were relatively inexperienced, only a minority of such nurses utilized this strategy.

The assertive method was utilized by three categories of nurses: ER nurses, charge nurses, and male nurses. Differences in trust and relative power likely afford these nurses more leeway in physician interactions. The fast pace and urgency of care in the ER demand a high degree of cooperation and trust between physicians and nurses. Additionally, the ER has robust standing orders which allow nurses to

act without physician approval on a number of treatments in a manner that is unavailable to nurses in other units. This expansion of autonomy requires organizational trust and conveys expertise and status. As a result, the nurse-physician relationship in the ER is qualitatively different than in other units. However, even ER nurses applied the assertive method only in a minority of cases, although male ER nurses and male charges deployed the tactic far more regularly. Typically, the nurse makes an assessment, sees a problem, knows the solution, and then calls the doctor with a direct request for the appropriate order. This is a typical example of a phone call in the ER:

*“Hi Dr., this patient is retaining urine and they are in pain. I need you to order a catheter.”
“OK.”*

The assertive suggestion circumvents the rules of the nurse-doctor game entirely. The nurse initiated the recommendation, leaving no pretense that the doctor must come to the idea on his or her own.

Physicians also displayed varied responses to nurse-initiated recommendations, ranging from receptiveness, to annoyance and dismissal, and even to ignoring the suggestion. Regardless of whether or not the nurse’s recommendation is adopted, receptive physicians seriously consider either alternative and explain the reasoning behind the decision to decline or to adopt the recommendation. The nurses’ suggestive and direct communication methods tended to elicit different kinds of receptiveness from physicians. When a physician was receptive to a recommendation communicated using a suggestive approach, he would often frame his acceptance as his own decision. In these instances, after the nurse would make a subtle suggestion, the doctor would frame his affirmative response as “I think” or “I will.” By contrast, when nurses utilized direct approaches, physicians would be more likely to frame their acceptance inclusively (“let’s do this”) or with a simple affirmative. Additionally, when rejecting a recommendation from nurses who communicated using the direct methods, doctors were much more likely to engage in a dialogue with the nurse about their reasoning.

When physicians were approached with suggestive communications that they subsequently rejected, they were much more likely to unceremoniously dismiss the suggestion outright – typically with a simple “no” or reiteration of the original order without explanation. Dismissal is often coupled with annoyance. The majority of these signals are non-verbal: rolled eyes, a lifted brow, or a change of tone that communicates “are you really bothering me with this?” Sometimes, the physician expresses dismissive annoyance through rudeness or verbal abuse.

The direct methods of nurse communication – preparation and assertiveness – were much more likely to elicit a collaborative response from physicians. But the more common methods of suggestion – both through suggestive questions and quiet suggestions – facilitated the physician’s maintenance of a traditional hierarchical and unidirectional relationship with nurses, where the nurses-physician relationship remains characterized by female deference and male authority. Additionally, both subtle and unsubtle displays of impatience and annoyance discourage collaboration. Thus the established forms of communication, particularly those which mirror gendered norms, informally reinforce hierarchy and reduce collaboration, despite the organization’s formal steps to the contrary.

Informal Relations and the Dominance of Social Space

The informal way in which doctors and nurses tend to interact in the social spaces of the hospital also maintains their hierarchical positions. Observations in the nursing stations of four hospital units reveal that while these are primarily nurses’ spaces, the presence of doctors consistently disrupts (both directly

and indirectly) the character of the setting. When doctors enter nursing stations where two or more nurses are engaging in conversation, the ensuing social interaction tends to express the dynamics of professional hierarchy in various ways. Most commonly, nurses' conversations change without direct intervention on the part of the doctor. When a doctor enters the nurses' station, conversation quiets or ends; or shifts in focus to centralize the doctor. Less typically, when nurses do not end or shift their conversations on their own, doctors will interrupt ongoing conversation between nurses, insert themselves into the conversation, and/or change the topic entirely. Self-regulation of conversation by nurses avoids the uncomfortable experience of doctor interruption. In the most extreme cases, doctors demonstrate callous assertions of dominance by disregarding the space and needs of nurses while seemingly refusing to acknowledge their presence. Somewhat atypically, the conversation of the nurses will continue unchanged in tone, tenor or topic while doctors go on with the work they need to do in the station (look up a chart, talk to the appropriate nurse, etc). Though in some ways more subtle than the "nurse-doctor game," the disruptive occupation of social space also works to reinforce the boundaries between nurses and doctors and to reassert professional dominance.

Nurses typically failed to recognize this phenomenon until confronted with it during the course of interviews. In follow-up encounters, nurses confirmed noticing the behavior on the part of physicians and nurses, but few were able to provide an explanation. Older nurses recounted that, earlier in their careers (the 1980s), nurses still stood at attention when doctors entered the nurses' station. They theorized that the current behavior was an extension of historical practice. Intrusive interruptions, interruptions by a single person within a larger group, and the physical intrusion of space are socially masculine acts.¹⁴ As similar practices maintain traditional gender roles in the broader society,¹⁵ it is no wonder that they not only encroach into the workplace but also go largely unnoticed. Ultimately ending conversation upon physician entrance serves the same social purpose as nurses standing at attention; it is recognition and re-inscription of hierarchy. When nurses don't follow social procedure they risk being interrupted and decentralized from conversation, further reinforcing hierarchical relations.

Conclusion

The nurse-doctor relationship lies at the core of nurses' work life and professional status. Over the past century, the nursing profession has worked diligently to improve the esteem of nurses and to solidify their position as partners in medical care through professionalization in education, credentialing, and licensure – not as subordinates to physicians. There has been much resistance, of course, from physicians, as well as from hospitals and hospital associations that have tried to maintain nurses as a relatively cheap source of labor.

In recent history, several important healthcare and governmental institutions have begun to push for a more collaborative patient-centered approach to health care. The healthcare system under study here has implemented several important organizational policies to encourage physician-nurse collaboration. Formalized communication and enforced collaboration seem to have returned uneven success. Although collaboration has increased and the physician-nurse relationship has improved markedly compared to other settings and to its own past, the interactions between nurses and physicians remain heavily determined by gendered patterns which reinforce hierarchy and create barriers to effective

¹⁴ Kristin J. Anderson and Campbell Leaper, "Meta-Analyses of Gender Effects on Conversation Interruption: Who, What, When, Where, and How," *Sex Roles* (39:314, 1998), pp 225-252.

¹⁵ Irene Hanson Frieze and Sheila J. Ramsey, "Nonverbal Maintenance of Traditional Sex Roles," *Journal of Social Issues* (32:3 1976), pp 133-141.

collaboration. These issues have direct implications for the retention of skilled nurses and for the quality and coordination of care.

The adoption of the Affordable Care Act and the expansion of medical care necessitate large scale structural change in health care provision. This will entail reorganization and restructuring of professions. Aspects of these broad changes hinge on the nurse-physician relationship. Collaborative practice is crucial to meeting the new challenges of increased complexity and efficiency demands. Unfortunately, at the moment, old professional hierarchies inhibit effective collaboration, leaving the responsibility to nurses to adopt a mix of formal and informal strategies to promote productive communication with physicians. These strategies vary in their composition and effectiveness.

Even within organizations that explicitly and aggressively pursue the goal of improved collaboration, serious impediments remain. Successful implementation of nurse-physician collaboration on a large scale will demand sweeping changes. In addition to the widespread implementation of formalized communication like SBAR and institutional policies like enforced MD-RN rounding and joint MD-RN patient communication, training in collaboration for both professions will need to be greatly expanded within organizational and academic settings. As women continue to enter medicine and approach parity in other occupations, a commensurate gender exchange has failed to occur in nursing; less than ten percent of Registered Nurses are men.¹⁶ Radical reformulation of the gender composition of the two professions may ultimately be needed to completely overcome the deeply engrained gender dynamics that act as barriers to robust, successful nurse-physician collaboration.

¹⁶ U.S. Census Bureau, "Men in Nursing Occupations" (Feb 2013).