Interprofessional Conflict: A Preventive Health Approach to Ineffective Communication in Nurse-Physician Relationships

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Abstract

This undergraduate thesis explores the underlying problem of interprofessional conflict and the resulting poor communication between physicians and nurses. It establishes the importance of understanding and addressing this subject within the health care community on a basis of reported negative outcomes, including compromised patient safety and quality of care. It also proposes a preventive health model as the most effective approach to describing the problem. An exploration of the antecedents to this interprofessional conflict identifies gender identity as having a significant role in setting the stage for the kind of relationships between nurses and physicians that harbor tension. Gender roles are discussed in the context of the developing professional identities of both physicians and nurses. The discussion further identifies how these social and professional distinctions result in the imposition of hierarchical arrangements that give way to oppressive relationships. The analysis proposes a need for dialogue—a form of primary prevention—regarding the oppressive internalized sexism that appears to have resulted from this hierarchical evolution.

Keywords: interprofessional conflict, poor communication, nurse-physician conflict, preventive health model
Author Note

The author thanks Dr. Judith A. Vessey for her dedication and commitment to advising this work. The author also thanks Dr. Rosanna DeMarco, Dr. Catherine Read, Rachel Difazio, and Joseph Zabinski for their thoughtful remarks and suggestions.
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Relationships between physicians and nurses have received considerable attention throughout history. The dynamic between the two professions has evolved over time in response to healthcare advances and the changing roles and demands of each profession respectively. One component of this relationship, however, that appears to have remained constant throughout this evolution, is the surprising problem of an unbefitting lack of effective communication. The ineffective communication often seen in nurse-physician relationships is especially worrisome given its detrimental effects on outcomes including: professional satisfaction, healthy workplace environments, and most importantly, patient safety and quality of care.

Although healthcare organizations have implemented policies and procedures to improve the communication between providers, problematic interactions still persist. This lack of progress appears to be a result of focusing on identifying and fixing the problem, rather than preventing it from occurring. Poor communication and ineffective interactions continue to trouble a healthcare community fixed on curative medicine. With the recent shift towards preventive medicine in health care as a whole – particularly primary prevention, in which health promotion and preventive measures precede the onset of disease – it seems appropriate to apply this principle in “treating” this “condition” too. The antecedents to poor communication have yet to be fully explored. In the case of nurse-physician relationships, a series of factors – cultural and social in nature – have been identified as often preceding poor communication. As a form of primary prevention for
the problem that is interprofessional conflict, it becomes necessary to look more closely at these factors that give way to poor communication.

Healthcare literature relevant to the subject of interprofessional conflict has been mainly descriptive to date. While the literature describes aspects of this phenomenon and accompanying negative outcomes, functional solutions and measurable outcomes have been limited. This is indicative of inadequate attention and work on the subject of interprofessional conflict. Interventions are needed to both prevent poor communication from occurring wherever possible as well as minimizing its effects when it does. In keeping with the Jesuit Catholic tradition of advocating for social justice, this thesis moves away from the politics and economics surrounding a culture of blame. Rather, the focus needs to be on identifying what approach might be used to effectively prevent nurse-physician conflicts, thus improving communication and subsequently promoting patient safety and quality of care. This thesis identifies and analyzes the factors preceding interprofessional conflict and its sequelae with a metasynthesis of Dana C. Jack’s *Silencing the Self*, Susan M. Reverby’s *Ordered to Care*, and Paulo Freire’s *Pedagogy of the Oppressed*.

**Professional Communication and Patient Safety**

Interprofessional conflict among nurses and physicians has gone unattended for some time due to a lack of evidence that supports its correlation to negative professional and patient outcomes. More recently there has been increased awareness of the far-reaching repercussions of poor communication, secondary to nurse-physician conflicts, within healthcare. Such poor communication generally takes place when there is omission of critical information, ineffective interactions, and confrontational behaviors
from participants in the communication. The interprofessional conflicts have thus been shown to not only affect the individuals directly involved, but also the institutional environment. More importantly, however, interprofessional conflict increases the incidence of poor patient outcomes. For this reason, interprofessional conflict as a contributor to poor communication, has become a primary area of concern in the patient safety literature (Zwarenstein, Goldman, & Reeves, 2009); improving communication is now recognized worldwide as a key patient safety goal.

In their 2008 report, the World Health Organization (WHO) recognized a patient can be harmed as a result of a variety of factors and circumstances; and that understanding these and devising solutions to eliminate or minimize them would result in improved patient care (World Health Organization, 2008). Among the critical factors identified as global research priorities in the area of patient safety is the reported lack of communication and coordination between providers. Proposed research questions include those designed to identify the incidence and root causes of poor communication, as well as effective forms of intervention. Of the professional relationships identified in this document as most lacking in communication and cooperation is that of nurses and physicians.

Other major policy and regulatory bodies share the WHO’s concern regarding poor professional communication. The Institute of Medicine (IOM) Quality of Health Care in America Committee recognized, and in doing so began to address, shortcomings in quality care provision with the Committee’s seminal report: To Err is Human: Building a Safer Health System. The report reviews the costs (not only financial) incurred by a decentralized and fragmented health care delivery system that impedes quality care.
The model proposed in the report describes quality care as consisting of (1) safe care, (2) practice consistent with current medical knowledge, and (3) customized care (for customer-specific values and expectations) (Kohn, Corrigan, & Donaldson, Editors, 2000, p. 18). Safe care as a prerequisite to quality care becomes of particular interest in the context of this thesis.

In discussing the high incidence of errors that result in a lack of safe care within the existing system, the report acknowledges that while “the literature pertaining to errors in health care has grown steadily over the last decade… we do not yet have a complete picture of the epidemiology of errors” (Kohn et. al., 2000, p. 28). It goes on to note how “most people view medical mistakes as an ‘individual provider issue’ rather than a failure in the process of delivering care within a complex delivery system”. Seeing as these mistakes are a product of shortcomings of this complex system, and not due to individual behaviors alone, issues of interprofessional collaboration are particularly relevant in addressing the epidemiology of errors more fully (Kohn et. al., 2000, p. 43). By looking more closely at interprofessional collaboration, the interactions and interdependence that make healthcare a complex system are both acknowledged and better understood.

In the discussion of error, the report makes a distinction between active errors and latent errors. An active error consists of more tangible, direct action that takes place at the level of the operator and has repercussions that are felt almost immediately. Latent errors are ones “that tend to be removed from the direct control of the operator and include things such as poor design… and poorly structured organizations”. These types of error then, “pose the greatest threat to safety in a complex system, because they are often unrecognized and have the capacity to result in multiple types of active errors” (Kohn et.
al., 2000, p. 55). The cultural, historical, and social factors explored in this thesis fall under the category of latent errors. Thus, it follows that the antecedents to interprofessional conflict, like latent errors, warrant significant attention given their persistent and damaging nature.

Lastly, The Joint Commission (TJC) cites “[Improving] the effectiveness of communication among caregivers,” as Goal 2 among the National Patient Safety Goals most recently identified in their report (2008, p. 4). While the recommendations for practice in this document do not directly address interprofessional conflicts, they offer interventions aimed at reducing sources of both written and verbal miscommunication. Also, The Joint Commission intends to reduce the detrimental “disruptive behaviors” that often give way to this miscommunication. Despite their limited ability to prevent poor interprofessional communication, seeing as they do not address the preceding factors that give way to, and continue to fuel interprofessional conflict, these initiatives successfully draw attention to the issue of communication.

Frequent report of a close relationship between poor communication and sentinel events supports ongoing efforts to address existing barriers in communication within nurse-physician relationships. TJC addresses the pressing need for increased safety and quality of care in its Sentinel Event Policy and Procedures. TJC’s use of the word “sentinel” is intended to signal “a need for immediate investigation and response”; this degree of urgency regarding what is often the result of a ‘medical error’ follows from the direct effects on safety and quality of care. In “[reviewing] an organization’s activities in response to sentinel events”, The Joint Commission plans to (1) improve patient care, (2)
focus organizational attention on the event, (3) increase knowledge about events, and (4) maintain the confidence of the public (2007).

The management of interprofessional conflict within the work setting is underdeveloped. Recommendations for avoiding a confrontation or ways of working through a conflict are current strategies; however, these acknowledge interprofessional conflict as a component of the healthcare system. They fail to promote efforts to significantly eradicate the problem. The focus has been on addressing active errors like those defined in the IOM report previously discussed, which tend to be easier to identify and work out. Such a focus, however, has proven to provide only temporary solutions. The problem of latent error demands a move towards a model other than the one used in the culture of curative medicine.

The Preventive Health Model proposes three distinct levels of prevention in the provision of care that adequately addresses the health needs of a community. These levels include primary, secondary, and tertiary levels of prevention. Primary prevention consists of taking action to avoid the onset of a condition before it occurs. In secondary prevention, the disease is already in existence; this “screening” level is where disease is identified and treated while still in a pre-clinical stages. The final, tertiary level of prevention involves caring for an existing disease (Fitzgerald, 2008).

Because the implications of a condition and the subsequent needs of a patient change between levels, different actions are taken at every stage of prevention. Primary prevention includes activities such as promoting exercise and low fat diets, administering immunizations, and discouraging cigarette smoking, among others. Secondary levels of prevention involve addressing the risk factors developed while the individual remains
asymptomatic. The third and final level of prevention involves aggressive interventions required to reduce symptoms and complications, restore function, and minimize negative effects of a disease process (Fitzgerald, 2008).

Of these three levels, primary prevention is not only the most cost-effective form of addressing issues within healthcare, but the most sustainable and clinically-effective, too. As a society, it has become necessary to move away from the established practices of curative medicine, which address disease at the tertiary level. Primary prevention offers improvements in costs (limited demand for interventions), access (not dependant on sustained, personalized attention from a provider), and ultimately quality (better clinical outcomes with reduced disease processes and complications).

This Preventive Health Model is generally applied to clinical diagnoses, but can also be used to analyze the issue of interprofessional conflict. If one was to consider interprofessional conflict the “disease”, current management of this condition remains limited to tertiary and secondary levels of prevention. Primary prevention of interprofessional conflict demands a review of the antecedents to this phenomenon.

**Antecedents to Interprofessional Conflict**

Having likened the current treatment of interprofessional conflict to the existing practices of secondary and tertiary prevention in the preventive health model, this discussion now moves to consider some of the antecedents to the problem. A series of factors—cultural and social in nature— are identified as having influenced the initial development of interprofessional conflict, its persistent presence in the health care community, and the changing relationships of the two professional groups in question. This paper now presents these factors sequentially.
Influential Cultural Pattern of Gender Role

Because the nature of interprofessional relationships and potential for conflict between physicians and nurses did not arise and evolve in a vacuum, it is important to first consider the greater cultural fabric of which they have been formed. An initial discussion of gender roles offers an understanding of men and women, independent of and in relation to one another. The subtleties of this particular relationship (man-woman), have had implications for both professional and personal relationships, among them, that of nurses and physicians. With this understanding of the cultural context in which the professional roles of nurses and physicians first emerged, the discussion goes on to consider the evolution of the two professions. The development in the history of nurse-physician relationships proves to have ultimately led to the preservation of the dynamic initially modeled by the social construct of gender-roles.

Definition of Genders. Gender role identity has and continues to influence the personal and professional roles of individual nurses and physicians as well as their respective professional identity. In considering the definition of gender roles, the relational theory explored in Dana Jack’s *Silencing the Self* serves as the theoretical framework for this discussion. The theory contends that “the self (in both women and men) is part of a fundamentally social experience” where *attachments* provide a “foundation for self, mind and behavior”. Humanity then, strives to fulfill an inherent “biosocial motivation to make secure, intimate *connections* with others” (Jack, 1991, p. 10). This common ground for both men and women offers a reference point to help in identifying where and why the separation into two genders takes place.
With this as a starting point, it becomes easier to isolate the conditions and events that gave way to subdivision within a species of beings sharing common attachment needs. Jack suggests

“the female orientation to relationships arises out of culturally arranged, and therefore contingent, contexts of female caretaking and male dominance… forming a gender identity in relation to a female caretaker forces boys to separate from femininity and to define masculinity through differentness: to be male is, in part to be not-female” (1991, p. 12).

The defining biological features that make boys male provide the initial motivation for creating gender identity. This need to explicate physiological differences between genders ultimately leads to the separation of humans into two distinct groups on a basis of anatomical features. The above passage suggests that in order to achieve this separation, boys are expected to repress their earliest self, the one that identifies with the maternal figure, and in doing so, abandon the behaviors, attitudes, and values of the nurturing mother, despite that it is those features that have been identified as defining features of the self and all humanity. In this way, the once genderless desire for connections and valuing of relationship, begins to become female.

To understand these physiological differences, traits labeled “male” and “female” manifest themselves. These concepts then become increasingly defined:

“[Society discourages] the expression of attachment needs in boys, pushing them to be independent, while they allow girls to ask for closeness reassurance, and support more overtly. These gender-specific patterns of interaction encourage the development of certain traits: independence, exploration, and achievement in boys; proximity, nurturance, and responsibility in girls” (Jack, 1991, p.15)

With the establishment of two alternatives, male traits or female traits, it becomes possible to make comparisons and value judgments. The potential for not only individual preference, but a collective preference, arises from this separation. Within the global
society, the female traits of proximity, nurturance, and responsibility begin to be regarded as merely average, seeing as everyone is born with these traits. The male-specific traits of independence, exploration, and achievement appear as an addition to this existing groundwork. Men, become different, and in doing so develop these other traits that now appear to define them. Therefore, the fact that these developed traits of men are not common to everyone results in a collective understanding: these male traits must be more valuable than the universal female traits. In this way, the very act of becoming male, of having to separate, appears to begin the devaluation of the female role and gender.

**Developing Dynamic Between Genders.** With the distinction made between male and female, and the subsequent comparisons made between the gender-specific traits that evolved to identify each role respectively, society witnesses the exaltation of male traits. Female traits of intimacy and attachment are deemed inferior to those of achievement and independence, giving way to the assembly of a gender hierarchy. As the “male world” began to be viewed by society as the “ideal”, women became conflicted. This new “ideal” suggests that they should suppress their natural inclinations towards relationship and attachment in order to pursue the more desirable male qualities; however, the very society that exalts these traits negates women’s participation in male traits, because of their immediate association with being male. Thus, the ability to achieve this ideal appears to be a virtue of gender. Moreover, the expression of the female gender’s desire for those behaviors, attitudes, and values that become the social ideal, led to and continues to function as a social acceptance of male power over females. Power then, in the form of preferred gender-specific qualities, consolidates the gender hierarchy.
Over time, hierarchical relationships between men and women (whether it be man and wife, brother and sister, boyfriend and girlfriend) began to be perpetuated, silently endorsing the power distinction derived from these arrangements. These gender-specific traits influenced the development of professional relationships, including that of nurses and physicians within healthcare. The more desirable, male-specific traits made their way into the originally male-dominated field of medicine. Similarly, the nurturance and responsibility associated with the female gender becomes the cornerstone of nursing. Unfortunately, these female traits had already been tainted with negative connotations of inferiority. When such characteristics are embedded in professional identity, it is easy to see why, when interpreted through Jack’s theoretical lens of gender identity, nursing has been viewed as subservient to medicine—a potential contributor to interprofessional conflict.

Society has come to “internalize” a series of images that comprise the “nursing identity” (Jack, 1991, p. 116). By virtue of the perseverance of these images through time, these behaviors have acquired an authority that has gone unquestioned. These images that form the nursing identity are consistent with those used to define female traits. This phenomenon is the product of the development of a profession in the context of this social evolution. Nursing and medicine evolved in a culture with very pronounced social constructs regarding gender. Because the socially defined roles of men and women were originally used to define the professional roles of physicians and nurses, the current challenges in communication and interdependence faced by these professional communities are not easily resolved, and must thus, first be understood.
Professional Evolution Shaped by History

From Gender to History. After reviewing the creation of gender roles as a precedent to professional role development, the formative epochs for physician-nurse relationships need to be considered. Paternalism provides a context that has heavily influenced nursing and medicine through time. Understanding how a professional hierarchy evolved from the original gender hierarchy requires an analysis of the history of both nursing and medicine.

The factors of gender identity and professional evolution identified as antecedents to interprofessional conflict within this thesis, Dr. Susan Reverby refers to as “limitations –of imagination, of cultural ideology, of economics and ultimately political power” (1987, p. 2). These “limitations” are discussed in her work, Ordered to Care, which she describes as a study of professional constraints. In reflecting on the limitations Reverby identifies, those of “imagination” and “cultural ideology” specifically parallel the antecedent of gender roles identified in this thesis. For the purposes of this discussion then, the analysis of Dr. Reverby’s work will focus on these two limitations.

In explicating her motivation for her research, Reverby references “nursing’s urgent need for a more realistic understanding of the roots of [nursing’s] contemporary dilemmas”. These dilemmas include, but are not limited to, issues of subservience to medicine and biased public appreciation for the work of nurses –a public opinion that respects and appreciates the work of nurses, but offers little in terms of admiration. Furthermore, she supports this urgent need for understanding these roots with the statement that “the value of caring is too important for this to be ignored” (1987, p. 7). Although she establishes no direct correlation between existing understanding of these
antecedents and quality care provision, it becomes clear that the lack of appreciation of
the roots of contemporary dilemmas needs to be addressed in the interest of caring.

Dr. Reverby contends that “nursing’s contemporary difficulties are shaped by the
factors that created its historical obligation to care in a society that refuses to value
caring” (1987 p. 7). Her description of a ‘society that refuses to value caring’ appears to
synthesize the ideas previously discussed on the paternalistic culture Jack describes. In
order to fully understand Reverby’s assertion, however, these ‘factors creating a
historical obligation’ will be explored. The intricacies and challenges of the analysis to
follow, are best expressed by Reverby in the following passage:

“Nurses are neither the poor victims of hospital and physician oppression and the
impotent descendants of a long line of women healers, nor the victors in a
difficult and long struggle to gain professional recognition and status. Their
history is more complicated than such simplistic analyses” (1987, p. 6).

**Etymology of “Nursing”**. Unlike terms that become exclusively descriptive of a
particular trade, the associations of the word nursing have made it increasingly difficult
to consolidate this professional field, even in language. In its earliest forms, “nursing”
was used in relation to the act of suckling and nourishing. Over time, this once intimate
tie to a specific biological function grew to encompass other behaviors such as providing
comfort to the meek or looking after the less fit (i.e., children, elderly, ill) members of
society. All of these activities demonstrated caring. Nursing eventually becomes
descriptive of what has culturally been identified as the female role -“it was grounded in
the expectation that caring was part of a woman’s duty to her family or community”
(Reverby, 1987, p. 2). Thus, nursing became equated to caring. Seeing as caring was
considered a woman’s duty, the act of “nursing” originally described a woman’s duty, not
a professional endeavor.
“Caring for family members was supposed to be central to a woman’s self-sacrificing service to others” (Reverby, 1987, p. 11). The previous discussion on gender roles and women’s need for relatedness supports the willingness to serve others is fitting of the female gender. It follows that women would care for, and service, others in order to ensure their greater goal of intimacy and fulfillment in relationships. With this evolution of the word nursing, however, where caring and sacrifice become “poignant manifestations of female virtue”, an unsteady foundation is set for the profession (Reverby, 1987, p.11). Because nursing did not evolve as a purely professional role, rather grew out of this cultural definition of feminine activity, nursing as a trade was bound to experience difficulties asserting itself in the professional arena.

**First Definitions of Nursing.** “Nursing” in its original form was used to refer to a woman who not only took on the care of her family, but that of other “unfit” individuals in her immediate surroundings. Although their services were intended for anyone unable to care for themselves, over time, the attention of “nurses” begins to gravitate towards those suffering from illness. Eventually, with the growth of communities and cities and their respective needs, treating illness began to require physical groupings of both the caregivers and the sick. Physical spaces—almshouses, hostels, hospital schools—were created where the sick and infirm were both isolated from society and where their care could be managed, gave way to the development of the modern hospital. Still, “Genteel ‘good’ women were to become disciplined soldiers in the war against disease and disorder, self-sacrificing mothers to the patients, efficient housekeepers for the hospitals, loyal and subordinate assistants to the physicians… Nursing [stressed] womanly duty, submission and practical labor” (Reverby, 1987, p. 3).
With the rise of the hospital, the idea of the hospital nurse was introduced. Like the work of the nurse who cared for her family and her neighbors, hospital nursing followed in the tradition of vocation, a calling, not a professional training. Moreover, institutional nursing was initially perceived as a move away from nursing as the “natural role of women” and was thus conceived as a more base form of nursing. Caring for strangers was not regarded as having the same womanly virtue. These particular women willingly became victims to the submission and self-sacrifice that characterized this aspect of a woman’s role.

Despite the challenges and resistance they encountered, women in the role of nurses used their consistent involvement in the delivery of care to establish themselves as an integral part of the hospitals’ functioning. A natural, next step in the path towards asserting nursing as a profession, required that nurses attain some form of monetary recompense for their labor. Once in effect, however, this only benefitted nurses as individuals in the form of added income; respect and appreciation for the profession of nursing as a whole did not see much change with its definition “[remaining] vague and linked to a variety of women’s duties” (Reverby, 1987, p. 13). Thus, the issues regarding formal consolidation of nursing as a profession remained. These issues proved to be more deeply rooted than the technicalities of work and work recompense.

“The domestic order created by a good wife, the altruistic caring expressed by a good mother, and the self-discipline of a good soldier were to be combined in the training of a good nurse… nursing was thus feminized” (Reverby, 1987, p. 41). Its association with womanly activities and behaviors initially gave way to the subservience of nursing to medicine. Gender distinctions established an initial hierarchy within healthcare, where
men (medicine) asserted their power over women (nursing). Although this power differential was the product of gender role definitions and not their roles as clinicians, this original hierarchy introduced a template for interactions and relationships between the physicians and nurses that would endure.

**First Definitions of Medicine.** Reverby confirms the hierarchicalism that evolved among these health care roles originally had little to do with the actual work being performed. She reports, “medical authority did not always translate into institutional power since the hospitals did not depend on the doctors for either their income or sense of purpose” (1987, p. 26). Such an assertion suggests it was, in fact, the gender hierarchy discussed earlier, that gave physicians power over the nurse. “Although physician authority was not established or accepted, implicit norms governed both nurse and physician behaviors” (Reverby, 1987, p. 31). The ‘implicit norms’ referenced in this passage refer to the cultural norms that dictated gender-appropriate behaviors. Thus, it was these gender roles that gave physicians—not as professionals, but as men—authority over nurses. The institutional and intellectual power associated with the clinical role of a doctor would develop in time within the structure determined by gender.

“Nurses, the physicians believed, were supposed to defer to their authority and to keep the institution orderly and clean. Physicians, the matrons and nurses thought, were to be reasonable in their demands, gentlemanly, and responsible for the patients under their care” (Reverby, 1987, p. 31).

This passage not only depicts the distinctly feminine work of nurses, but illustrates how nursing initially embraced this subservient role. With the expectation that physician demands were reasonable, nursing acknowledged medicine as being in a position of charge by using the word “demands” to describe their interactions. Therefore, the formation of this hierarchy in healthcare did not only involve physicians assuming a
position of power, but also nurses acknowledging this relationship. As in the permanence established by society in defining gender roles, these habitual interaction patterns between nurses and physicians became adopted as the norm.

Reverby’s discussion of early nurse-physician confrontations asserts these interprofessional conflicts were not the product of growing professional aspirations for nurses. Conflicts were rather instigated by “ungentlemanly” behaviors. The use of this gender-specific terminology in referencing the source of conflicts is indicative of the way in which nursing originally related to medicine. The “behavioral lapses” and “professional failings” that comprised this “ungentlemanly” behavior speak to the way in which these relationships conformed to gender norms, and not the developing professional norms (Reverby, 1987, p. 33).

**Problematic Definition by a Pioneer.** In laying the groundwork for nursing, pioneers like Florence Nightingale heavily influenced the values, attitudes, and behaviors that would become prevalent for an entire community of professionals. For this reason, her agreement with American domesticity advocate Catharine Beecher, “who spoke in the language of women’s *duties* and *obligations* rather than *rights*,” helped predispose the nursing profession to a number of the challenges it continues to struggle with today. Reverby best expresses this in saying, “Although Nightingale sought to free women from the bonds of familial demands, in her nursing model she rebound them in a new context” (1987, p. 43). These “bonds of familial demands” reflect the gender-specific role of women. Furthermore, this “new context” she refers to, where women are “rebound” to their female-specific traits in their roles as nurses, refers to their workplace: the hospital. Rather than being subservient to a spouse or a father, however, they now became
subservient to a (male) physician. In describing nurses, the “list of virtues ran from attentive to trustworthy, but none was evoked more often than the general adjective: ‘womanly’” (Reverby, 1987, p. 49). Again, to be a nurse, was to be a woman from the onset of the profession.

**Nursing: A Threat to Medicine and Directed Efforts to Remove Threat.** As the field of healthcare began to evolve, the demands for the care delivered by (female) nurses grew increasingly complex – far more complex than these functions previously identified as merely women’s duties. This movement away from a practice consisting of basic knowledge and skills common to an entire gender, itself, began to solidify nursing as a profession. Along with increasingly specialized care-giving activities came increasing educational needs. Nursing was no longer something an individual would know from merely being raised as woman and learning woman’s work; it required education and training in specific ways of thinking and a series of specialized techniques: it became a trade. Because physicians trained in apprenticeship work, the “existence of hospital-trained gentle woman [was readily] perceived as quite threatening” (Reverby, 1987, p. 47). The idea of trained nurses offered an opportunity for female intrusion into a male domain. Physicians had to ensure their superiority to quell this threat.

The male-dominated medical profession would not let such a threat to their authority, and that of an entire culture, go uncontested. “Rituals [like physician rounds, which initially excluded nurses], as in other settings and societies,” evolved to fulfill more than one intended purpose. Apart from updating the group of clinicians on patient progress, “they reasserted, at the symbolic level, the social hierarchy that was [becoming] more ambiguous in daily life” (Reverby, 1987, p. 34). Regulations allowing nurses a
regular afternoon off, like the hospitals’ domestic help, also reinforced nurses into submissive roles. The kinds of initiatives attempted to stifle any growth and prevent any further threat to the order established by gender role traditions; ultimately, these very traditions asserted themselves in establishing a similar order within the confines of the hospital.

Nursing witnessed the championing of female virtues as a form of enticing women in nursing to embrace this position of submission. Like a manipulative child who expresses interest in a toy in order to deceitfully convince another child of its superiority, earning him/her the true object of their desire, medicine attempted to convince nursing of their worth and how appreciated they were. This is seen in the following passage:

“’You have become self-controlled, unselfish, gentle, compassionate, brave and capable –in fact, you have risen from the period of irresponsible girlhood to that of womanhood’… nursing was thus [portrayed] as an education in womanly virtue and female solidarity” (1987, p. 58).

In this passage, Reverby illustrates the aforementioned phenomenon. Such depiction of ‘womanhood’ in all of its glory not only presents nursing as a desirable and admirable goal, but in doing so dismisses ideas of independent thinking or autonomy that may have previously driven a number of these women. Physician expectations became that, “as their assistants, [nurses] would take on the increasingly technical and administrative tasks” (Reverby, 1987, p. 58). It is not the nature of the work that was inherently problematic, rather the way in which it was deliberately devalued as “assistant work”, for the sole purpose of preserving social structure. Throughout this evolution, “nurses felt they deserved better treatment”; their position of subordination was “reinforced by the very nature of nursing work as much as by class and institutional position” (Reverby,
1987, p. 29). As women, nursing’s tendency to put relationships ahead of all else left this developing dynamic temporarily uncontested.

As physician intellectual and professional power increased, the nurse was further steered away from learning and advancement. Within the hierarchy set up by culture and tradition, men in medicine began to assert themselves over their female counterparts with exponential growth in their professional knowledge base. Physicians were provided with the luxury of considerable time to learn, conduct research, and work exclusively with the more complex, unknown aspects of disease and illness. Unlike a physician, the nurse found herself living in the hospital, executing tasks repetitively and efficiently, and left with no time to grow outside of the toils of her day to day. The use of nursing students as part of the hospital workforce speaks to the kind of work that was left to nurses. It was assumed that a apprentice, whom by definition lacks the knowledge of the subject they are learning, in this case nursing, could be asked to do the work prior to learning about it—such was the complexity of their work (Reverby, 1987, p. 62). Thus, using student nurses as cheap labor was not only convenient in terms of hospital finance, but in preserving the order culture generously set in place.

**Transition: Gender Hierarchy to Professional Hierarchy.** With advances in clinical practice, physicians’ power shifted from being derived from gender to power derived from knowledge and medical expertise.

“As both medical care and, subsequently, paying patients became increasingly important to the hospitals, the power of physicians began to grow. Administrative decisions once made primarily on moral grounds by trustees (i.e., patient admissions) began to be made on medical grounds by doctors” (Reverby, 1987, p. 71).
The “disappearance” of patriarchalism saw a movement towards a social model where women could begin to aspire towards the qualities, behaviors and power that was once exclusive to men. This movement towards a family model that replaced man as the sole unit with a “dual institution of the family” - one that acknowledged women-, however, failed to herald change for physician-nurse dynamics too (Reverby, 1987, p. 72). Changes in the social models became irrelevant to a role that had been defined based on women’s activities. With differences in responsibilities and education, nursing lagged behind medicine, which now claimed an intellectual power over nursing. This power, then, continued to enforce a hierarchy where nursing found itself continuously in a lower position.

Questions regarding nursing as a profession extended out into the public sphere, where the community, “barely convinced of the necessity for training in the womanly art of nursing, did not rally to [nursing’s] demands for professional status and autonomy” (Reverby, 1987, p. 121). Nursing continued to evolve in response to the evolution in medicine, which did not help advance nursing as an independent profession. The hierarchy originally created by the impositions of gender identity, overlapped with one created by differences in responsibilities and expertise of nurses and physicians. Once the former disintegrated, the latter hierarchy remained in place to enforce the distinctions made between nurses and physicians.

1 The use of the word ‘disappearance’ appears to indicate patriarchy was completely abolished; however, it continues to form part of communities today.
2 The hierarchical arrangement of gender roles never truly ‘disintegrate’ – they continue to define relationships to date - rather the global community’s acceptance of this as appropriate and normative is what changes.
**Nurses Working Within Hierarchy.** With the rise of research and the expansion of the scientific knowledge base, the clinical sciences witnessed significant growth too.

Scientific advances became largely responsible for increased “efficiency” in healthcare.

“Efficiency looked as if it would allow nursing to redefine and almost secularize, its ethic of order and caring. It promised to ‘de-gender’ nursing by taking it out of the secondary sphere of women’s labor by placing it in a more neutered and seemingly powerful arena. It was not that nurses expected to emulate medical practice, or the physicians’ reliance on science per se. Rather, they saw science as a gender-free zone that could transform the content of their work and the status of their field” (Reverby, 1987, p. 158).

As a ‘gender-free’ zone, science offered a leveling of the original gender hierarchy in healthcare. Furthermore, scientific knowledge seemed to offer mobility within the new hierarchy based on intellectual power rather than a power arbitrarily bestowed upon men by gender.

Since the publication of Reverby’s work in the 1980’s, nursing has sought to move away from the deep-seated notions of gender roles in healthcare with limited success, by adopting evidence-based practices. “Nurses [have] found it very difficult to make the collective transition out of a woman’s culture of obligation into an activist assault on the structure and beliefs that oppressed them” (Reverby, 1987, p. 201). After leaving behind the gender hierarchy with social movements for women’s rights, intellectual disparities have been identified as the source of this new hierarchy within healthcare. Nursing has focused much of its attention on asserting itself on equal intellectual and professional grounds; but in doing so, has neglected to pay further attention to those structures and beliefs that less overtly, continue to oppress them. For too long the “nature of [nursing’s] onerous work, the paternalism of the institutions, and
the lack of defined ideology of caring” has undermined the profession’s efforts (Reverby, 1987, p. 200).

Resolution of Historical Evolution in Acknowledging Present Dilemma

After discussing the reasons for addressing the existing issue of interprofessional conflict as well as the antecedents to the problem, the conflict will be examined in its present state using Paulo Freire’s *Pedagogy of the Oppressed* as a theoretical framework.

**The Oppressive Nature of Hierarchy.** The existing relationships between nurses and physicians are, in part, a product of gender identity’s influence over the culture from which nursing and medicine first emerged as professions. What has yet to be considered is the following: what about this professional relationship fosters the interprofessional conflicts that facilitate poor communication between nurses and physicians?

Paulo Freire preliminarily considers the need to *perceive* the “social, political and economic contradictions” we refer to as injustices, and acknowledge them as such, before addressing them; Freire refers to this activity as *concientizacao* (Freire, 1970, p. 19). Social responsibility stems from acknowledging these very injustices; this awareness then, creates the need for change. In the case of this thesis, reviewing the relationship between nurses and physicians has generated awareness regarding this matter that can be used to help create social responsibility. The discussion to follow traces the movement from *awareness* to *acting* on this sense of social responsibility.

From this starting point of *concientizacao*, Freire asserts, “the awakening of critical consciousness leads the way to the expression of social discontents precisely
because these discontents are real components of an oppressive situation” (1970, p. 20).

With this statement, the association between injustices or discontents and the idea of “oppression”, is introduced. The previous discussions on gender roles and professional evolution in healthcare have identified disparities between men and women and physicians and nurses, respectively, as “unjust”. Using Freire’s model then, it can be concluded that these relationships can be unjust when they establish oppressor-oppressed dynamics. Oppression as “[a] situation in which ‘A’ objectively exploits ‘B’ or hinders his pursuit of self-affirmation” is descriptive of the interactions that have been previously identified as a product of hierarchical arrangements (1970, p. 40).

Applying Freire’s terminology to the initial conversation on gender identity and the resulting gender hierarchy, the male gender can be considered the oppressor – a result of the championing of male-traits. Similarly, in the discussion regarding the evolution of a hierarchy within healthcare, the professional role of physicians becomes the oppressor – a result of the oppressor-status originally given to them by virtue of being a male-dominated field. Regardless of the terminology used, agreement can be reached on the following assertion: hierarchical arrangements and/or oppressive relationships are unjust and need to be addressed.

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3 Freire uses the word dehumanization to refer to “the result of an unjust order that engenders violence in the oppressors, which in turn dehumanizes the oppressed”. The use of this particular word is more meaningful in the context of his complete work, given description of the end of human existence as fulfilling our humanity by becoming more human. This search for humanization is important in understanding Freire’s ideas of injustice, freedom, and the humanity of men and women.
Getting from Awareness to Change. Whether it be limited awareness or lack of action or resistance to change, the troublesome interprofessional conflicts between nurses and physicians have persisted. Before discussing how awareness—an aim of this thesis—engenders change, the shortcomings of existing approaches in addressing the existing relationship between physicians and nurses should be considered. Freire asserts that in correcting an injustice, the tendency is for the oppressed to “[seek] to regain their humanity [by becoming] in turn oppressors of the oppressors” (1970, p. 28). Such thinking coincides with women seeking to develop male-traits within a paternalistic society. Moreover, it would suggest that as a nurse, ridding oneself of oppression would mean becoming more like the oppressor: the physician. Although nurses do not intentionally adopt physician-like qualities, the efforts to assert the rigor of the nursing profession on a basis of complexity, critical-thinking, and clinical decision-making, would appear to liken nursing to medicine. In using the same features that have earned the medical profession the esteem it currently enjoys—unlike nursing—to portray itself, nursing attempts to achieve a similar status to medicine, namely one of admiration. This effort to achieve recognition as valued providers, has resulted in the transcendence of some of the oppressor-specific behaviors of medicine into the field of nursing.

The difficulty with achieving what Freire describes as freedom—an absence of oppression where individuals are best able to exist humanely—lies in the need to eliminate an entire way of thinking; the structure offered by oppressor-oppressed relationships

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4 Oppressors typically resist change, seeing as their position of power over other individuals tends to be compromised in situations involving change. They are “possessive of the world and of man” and they need the oppressed. For this reason, Freire asserts, people in positions of power will avoid having to give it up and are thus incapable of leading change.
would need to be “replaced with autonomy and responsibility”, a challenging prospect for a slow-changing global healthcare community (Freire, 1970, p. 31). In order to achieve this, Freire’s suggests the struggle for this “freedom” must be led by the oppressed. However, the relationship between nursing and medicine in particular, has evolved into something far more complex than a group of oppressors and a group of oppressed individuals. The very clear power distinctions that once made nurses appear subservient, in that they tended to be the oppressed, are no longer in existence. Power in the form of gender, educational opportunity, and authority, that used to weigh heavily on the side of physicians as a group, is no longer concentrated in the same way. Developments including growing numbers of female physicians, growing numbers of male nurses, formalization of nursing education, advanced degrees in nursing, and greater clinical responsibilities for nurses, now blur the once evident distinctions in power between the two fields. These developments warrant a combined effort of both nursing and medicine in effecting change as leaders in the healthcare community.

“One of the gravest obstacles to the achievement of [freedom] is that oppressive reality absorbs those within it and thereby acts to submerge men’s consciousness. Functionally, oppression is domesticating. To no longer be prey to its force, one must emerge from it and turn upon it. This can be done only by means of praxis: reflection and action upon the world in order to transform it.” (Freire, 1970, p. 36)

Thus, while this thesis may create the awareness that precedes change, success is contingent on its ability to inspire ongoing reflection and dialogue. Freire describes dialogue as an “encounter between [people], mediated by the world, in order to name the world”. Freire believes that “to exist, humanly, is to name the world, to change it. Once named, the world in its turn reappears to the namers as a problem and requires of them a new naming” (Freire, 1970, p. 76). In this passage, the act of naming things mediates
people’s ability to understand the world. Applying this thinking to the subject of nurse-physician relationships suggests the issue of interprofessional conflict is merely a matter of problematic naming. Gender identities and the professional roles of doctors and nurses were named in a certain way because it was how people understood them to be at the time, how they made sense of them. However, as professional roles have evolved, the previously established “names” that have remained unchanged become problematic – they reappear as problems, and require new naming. Thus, the problem with the nurse-physician relationship is one of naming, which requires the two parties become involved in a dialogue to re-name.

Synthesis of Ideas and Proposition of Dialogue as Primary Prevention

The ideas of (1) social construction of relationships and self, (2) historical trends of sexism and professional evolutions, and (3) oppressive relationships of hierarchical systems have each been discussed in their own right for years. Similarly, more recent publications have established connections between these ideas -independent of one another- and the nursing profession. This thesis attempts to demonstrate how it is necessary to consider these social constructs, historical trends, and oppressive relationships in relation to one another -as well as in relation to nursing- in creating the awareness that precedes change.

What this paper has done is proposed a sequential analysis of the events that have led to the present-day dynamic between physicians and nurses (refer to Appendix A and B). Starting with the discussion of gender identity, an initial hierarchy -where power is awarded based on gender- is established. This hierarchy becomes normative in time and goes uncontested by the very communities that begin to see its effects play out in
INTERPROFESSIONAL CONFLICT

relationships. It is within the confines of this structure imposed by gender that the professional roles of nurses and physicians evolve. Subsequently, the associations between nursing and women, and medicine and men, transfer a hierarchy solely based on gender into the healthcare arena. On a basis of the powers inherited by medicine as a male dominated profession, medicine asserts itself at the top of this new healthcare hierarchy. Thus, medicine inherits its original power from the male gender. In time, this hierarchy in healthcare more formally becomes a professional hierarchy; the dominant group (physicians), control the subservient (nurses) on a basis of prestige, power and status, now allotted by clinical knowledge and practice, rather than desirable male traits. Regardless of the powers keeping them in place, hierarchies engender oppressive relationships. Thus, nurses -as both women and professionals- have been identified as oppressed for some time.

This conclusion of nurses as an oppressed group is not a new one. What then, does this lengthy discussion and synthesis add to the present state of the conversation around these subjects? The answer is most effectively arrived at using existing publications that take part in this conversation.

The discussion of oppressed group behaviors (OGB) and theories of oppression in relation to nursing is first documented in Dr. S Roberts’ scholarly analyses as early as 1983. Dr. Robert’s original work explores how the philosophical ideas on oppression –as explained by literatures of oppressed peoples- can be transposed to the nursing profession. Dr. Roberts uses the identification of nursing as an oppressed group to substantiate claims regarding the kinds of behaviors expected and observed in this professional community (Roberts, 1983). Understanding OGB, is cited as capable of “not
only [explaining] and [predicting] behaviors of nurses… but also [helping] empower them with strategies to break the cycle of OGB” (Roberts, DeMarco & Griffin, 2009).

In these discussions about OGB, the focus has been on understanding the cycle, on understanding the behaviors. Behaviors, from “silencing” of nurses to horizontal and lateral violence, have been described at length (DeMarco 1997, 2000, DeMarco & Roberts 2003, Roberts 1983). Understanding the workings of the cycle, however, does not explain the long-standing tradition and history of this oppression. While the behaviors seen in the cycle of oppression have been identified and attempts are being made to address them, a seemingly larger question has not received equal attention: where did this oppression originate? This is further evidenced by the focus of the nursing literature on the oppressed, the nurse, and not the relationship from which this oppression is derived (DeMarco, Roberts, Norris & McCurry 2007, 2008, DeMarco & Roberts 2003, Roberts 2000, Vessey & DeMarco 2007).

The process of personal reflection and professional considerations needed to change this cycle and subsequently these behaviors has to include a review of the events and conditions that lay out the groundwork for them to develop in the first place. In order to fully understand how these oppressive relationships play out, an explanation of why they evolved has to be acknowledged. The difficulties involved in discussing OGB -due to negative perceptions- are no different for this discussion of the sources of OGB (Roberts, DeMarco & Griffin 2009).

It has been widely accepted in the ongoing conversation of nursing as an oppressed group that the first step in addressing the problem, whether it be poor communication or OGB, involves awareness -which can often be liberating on its own
(Freire 1970, Freshwater 2000, Roberts 2000, Roberts, DeMarco & Griffin 2009). What varies between the existing literature and this thesis is not the means by which this awareness is created—reflection and dialogue continue to offer the best approaches to this challenge (DeMarco, Horowitz & McCurry 2005, DeMarco, Roberts & Chandler 2005, Vessey & DeMarco 2007). Rather what varies is the very subject of this awareness (see Appendix C). Discussing and addressing OGB, like discussing and addressing poor communication, appear to offer temporary solutions to immediate problems—secondary and tertiary levels of prevention. Primary prevention involves tackling the problem before it is a problem, discussing and addressing poor communication and OGB before they present a problem to the health care community. It would appear that acknowledging the origin of (2a) the interprofessional conflicts and (2b) oppressed-oppressor relationships that precede (3a) poor communication and (3b) OGB respectively, offers such level of prevention (see Appendix C).

Effecting change requires more than just will; it calls for action. In the case of interprofessional conflict, the preventive health model has offered a framework for moving towards long-term solutions. The current focus of practice on secondary and tertiary levels of prevention is limited to addressing the behaviors and interactions of individuals as opposed to entire professional communities. Because the form of action most suited to addressing this issue of interprofessional conflict on a primary level of prevention is dialogue, improving the current state of affairs demands that we be individuals of action and reflection—that we make use of our words in expressing ourselves, rather than acquiesce and remain silent (Freire, 1970, p. 13). Let us be
individuals willing and able to look critically at this “culture of silence” and actively pursue dialogical encounters with others in an effort to change.

De Marco R. (1997). The Relationship between family life and workplace behaviors: Exploring the gendered perceptions of staff nurses through the framework of systemic organization. Dissertation, Wayne State University, Detroit, MI.


http://www.jointcommission.org/SentinelEvents/PolicyandProcedures/


http://www.who.int/patientsafety/research/priorities/article_bmj_may09/en/index.html


APPENDIX A

FIGURE WITH SCHEMATIC REPRESENTATION OF SYNTHESIS
*Diagram does not illustrate a proportional representation of time; it merely offers a visual for sequence and co-existence of the two hierarchies.

**First hospital in the United States and Women’s Suffrage are used as landmarks for time periods.

***Note the actual figures are representative of the actual hierarchies discussed.
APPENDIX B

VISUAL REPRESENTATION OF OVERLAPS IN HIERARCHIES
*The power differences created by gender and knowledge between men/women and physicians/nurses respectively, have been challenged, and continue to be contested, by the evolving global community. This diagram only offers a generalized depiction of the powers and roles/relationships seen when these hierarchies first developed, as perceived by the author of this thesis.
APPENDIX C

DIAGRAM ILLUSTRATING LEVELS OF PREVENTION
INTERPROFESSIONAL CONFLICT

Primary Level of Prevention

Practical

Antecedents: Social constructs, historical evolution and hierarchical arrangements.

Theoretical

Antecedents: Social constructs, historical evolution and hierarchical arrangements.

Secondary Level of Prevention

Interprofessional Conflict

Oppressor-Oppressed Relationships

Tertiary Level of Prevention

Poor Interprofessional Communication

Oppressed Group Behaviors