The Influence of Race and Gender on Pain Management: A Systematic Literature Review

Sharon B. Hampton, MSN, James Cavalier, MBA, MSN, and Rae Langford, EdD

ABSTRACT:
Racial and gender disparities in health are well documented in health science literature. Racial minorities and women are known to receive disproportionately poorer quality of health care when compared to non-Hispanic Whites. It is unknown why women and particular racial and ethnic minorities are more susceptible to experience disparities in patient care. Moreover, with pain being the most common complaint for those entering the healthcare system, gaps in understanding the potential relationship between the nurse provider's gender and/or race and ethnicity and pain management deserve exploration. A systematic literature review has been conducted to explore the current state of knowledge related to providers, health disparities, and pain. Much of the research to date has focused on the provider–patient relationship to health disparities in pain management. Further research is needed to examine how provider–patient interactions may influence patient outcomes, satisfaction, adherence and disparities in health.

INTRODUCTION
The inadequate management of pain has sparked national attention and the presence of pain-related health disparities has become a national agenda item (Meghani et al., 2009). The literature suggests provider bias, clinical uncertainty, and stereotypes may contribute to this disparate treatment of minorities by affecting clinical decision making (Institute of Medicine [IOM], 2003). If this is true, might this same bias, clinical uncertainty, and stereotyping affect the nurse–patient relationship, and thereby pain management decisions?

Although the United States has one of the most sophisticated healthcare systems available today, research has found this system to provide disparate treatment based on race and ethnicity (Smedley, Stith, & Nelson, 2002). Disparities in health care are said to evolve from ‘a historic and social context in which racial and ethnic minorities receive inferior healthcare, reflecting broader,
socioeconomic disadvantages among minorities and societal discrimination" (IOM, 2003, p. 160). Racial and ethnic minorities experience disparities in health status and receive disproportionately poorer quality health care when compared to non-Hispanic Whites (Constantinescu, Gouche, Weinstein, & Fraenkel, 2009; Cooper et al., 2003; Cooper-Patrick et al., 1999; Ferguson & Candib, 2002; Malat, van Ryn, & Purcell, 2006; Mulvaney-Day, Earl, Diaz-Linhart, & Alegria, 2011; Stevens, Shi, & Cooper, 2001). As the overall health of the nation continues to improve, disparities in the access to and delivery of quality care for racial and ethnic minorities persist, leading to poorer patient outcomes (Meghani et al., 2009; van Ryn, 2002). These differences remain when social determinates, such as low socioeconomic level, insurance status, and education, are taken into account (Betancourt, 2006; IOM, 2003; van Ryn & Burke, 2000).

There is also a growing body of literature that suggests that there are health disparities that exist between males and females. For example, when compounded with race, African American women receive disproportionately lower quality of care and have higher mortality rates than all other individuals. In addition, females receive less aggressive pain management than men with postsurgical care, metastatic cancer pain, AIDS, and other comparable disease processes (Weisse, Sorum, & Dominguez, 2003). While there is no clear pathway that leads to the development of health disparities, increasingly the rationale for these health inequalities is moving away from the historical belief that certain individuals and groups have an intrinsic susceptibility to poor health and more toward the influence of material circumstances and social conditions (Lynam & Cowley, 2007).

Literature suggests provider characteristics, such as age, gender, race/ethnicity, and attitude are contributing to health disparities (Deepmala, Franz, Aponte, Agrawal & Wei, 2012; Meghani et al., 2009). Perhaps, as suggested by Meghani et al., race and/or gender concordant research has emerged in the quest to ameliorate racial and gender disparities in health care by drawing on the basic social question of "are people able to identify, relate, understand, and interact more with those who may share their values and culture" (p. 2). Gender and race concordance research is not only limited, but is inconclusive as well. Meghani et al. conducted a literature review to assess the relationship between patient-provider race concordance and improved patient outcomes. The review of 27 studies provided inconclusive results with 33% (9) finding a positive association of race concordance and patient outcomes, 30% (8) finding no association, and 37% (10) of the studies presenting mixed findings.

With the hope of gaining a more comprehensive understanding of this possible nurse-provider contribution to health disparities in patient pain management, the authors conducted a review and synthesis of the available research. Our quest was to determine if there was evidence to support relationships among the nurse-provider’s gender and/or race, the patients’ gender and/or race, and pain management decisions. For the purpose of this review, disparities is defined as "a marked difference or inequality between two or more population groups defined on the basis of race or ethnicity, gender, educational level, or other criteria" (Pearcy & Keppel, 2002, p. 274).

**NURSE (PROVIDER)–PATIENT RELATIONSHIPS**

To better understand the potential link from gender and/or race and ethnicity to nurses’ clinical decision making, it is necessary to discuss the nurse–patient relationship. The nurse–patient relationship is a complex interpersonal process that evidence has suggested is correlated with clinical outcomes (Hagerty & Patusky, 2003; Tarlier, 2004). The nurse’s role in the development of the nurse–patient relationship is grounded in the nurse’s personal, ethical, and moral foundations. Many elements of this foundation are developed through formal education and professional experiences as well as through their individual life experiences. These educational, professional, and personal experiences help nurses to form perceptions, and these perceptions help nurses to develop the critical reference points for ensuing clinical decisions (McDonald, 1994).

Patient care decisions are often unclear and complicated. When choices are unclear and/or when individuals are confronted with a difficult task, there may be a tendency to use stereotypes to help with problem solving (van Ryn, 2002). Stereotyping may occur when individuals ‘infer judgments about other people in a consistent manner-judgment based on their expectations and the anticipations of others’ (Griffin, Polit, & Byrne, 2007, p. 656). A stereotype is an unconscious, cognitive process, without an affective component, used to sort thoughts and to facilitate decision making. The absence of the affective and motivational component is said to differentiate stereotyping from prejudice (McDonald, 1994). Are nurses using race and/or gender stereotypes to make pain management decisions and, as such, unintentionally contributing to health disparities?
The lack of research on the possible association of nurse-provider gender and/or race and ethnicity to health outcomes increases the importance of an analysis of related research to help guide future researchers who are focusing on the nurse-provider as the source of positive health outcomes and health promotion. This review sought to (a) synthesize the evidence on the possible association of gender and/or race and ethnicity to pain management decisions, (b) use the evidence to identify measures that may have relevance to nursing practice, and (c) offer recommendations for future nursing research.

**LITERATURE REVIEW**

A literature search was conducted using the academic databases Cochrane, ERIC, CINAHL, ProQuest, Scopus, MEDLINE, PsycINFO, and ScienceDirect for articles to assess the possible associations between the health care provider's gender and/or race and the patients' gender and/or race on pain management decisions. Search terms used were *pain*, *pain treatment*, *pain management*, *race/ethnicity*, *minority*, *gender*, *health disparities*, *provider*, *nurse*, *clinical decision*, and *health outcome*. Terms were searched in keywords, titles, and abstracts, and keywords were combined to cover a large number of MeSH headings. Additional articles were retrieved by using reference lists of published journal articles and hand searches.

The eight major steps in formulating a research-based literature review as identified by Polit and Beck (2012) guided the review. The eight steps are: question formation, creating a search tactic, performing the search, collecting relevant data, abstracting data, critiquing studies, interpretation of collective data, and a written synthesis of the material (Polit & Beck, 2012). After deleting duplicate studies, 187 studies were initially evaluated for inclusion. Studies were included in this review if they (a) were research or outcomes-based, (b) were published in the English language in peer-reviewed journals between 2000 and 2014, (c) examined the association of the healthcare provider’s gender and/or race to pain management decisions, and (d) the outcome measures included pain management decisions. The search was limited to a 14-year period to obtain studies that reflected current behaviors and practices of healthcare providers. The studies were reviewed and produced five research articles for final inclusion in this review. The articles were classified using the hierarchy of evidence as defined by Polit and Beck, which provides a ranking of the evidence based on the power of the offered data. An adaptation of Polit and Beck’s evidence hierarchy by Alekseyev et al. (2012) was used to summarize the levels of evidence for the articles reviewed (Table 1).

**RESULTS**

The final five studies were all conducted in the United States and/or Canada. Four of the studies included primary care, general medicine, or emergency room physicians. The single nursing study included nurses recruited from a national nursing association. Two of the studies included data obtained during the Pain and Emergency Medicine Initiative (PEMI), which was a multicenter study that utilized data from 17 emergency department sites from across the United States.

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<th>Level of Evidence</th>
<th>Definition</th>
<th>Articles Reviewed</th>
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<tr>
<td><strong>I</strong></td>
<td>Evidence from a systematic review or meta-analysis of all relevant RCTs, or evidence-based clinical practice guidelines based on systematic reviews of RCTs</td>
<td>0</td>
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<tr>
<td><strong>II</strong></td>
<td>Evidence based from at least one well-designed RCT or single nonrandomized trial</td>
<td>Criste, 2003; Weisse et al., 2001, 2003</td>
</tr>
<tr>
<td><strong>III</strong></td>
<td>Systematic review of correlational/observational studies</td>
<td>0</td>
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<tr>
<td><strong>IV</strong></td>
<td>Single correlational/observational study</td>
<td>Heins et al., 2010; Safdar et al., 2009</td>
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<tr>
<td><strong>V</strong></td>
<td>Evidence from systematic reviews of descriptive and qualitative studies</td>
<td>0</td>
</tr>
<tr>
<td><strong>VI</strong></td>
<td>Evidence from a single descriptive or qualitative study</td>
<td>0</td>
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<tr>
<td><strong>VII</strong></td>
<td>Evidence from the opinion of authorities and/or reports of expert committees</td>
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RCT = randomized controlled trial.

Source: Alekseyev et al. (2012).
States and three sites in Canada. Three studies used clinical vignettes to collect data. A summary of the reviewed studies can be found in Table 2.

Weisse, Sorum, Sanders, and Syat (2001) used convenience sampling to conduct a between-subjects, 2 (patient race) × 2 (patient gender) × 2 (physician gender) experimental design for the purposes of determining if patient race and gender and physician gender influenced pain management decisions. Primary care physicians in the Northeast were recruited using a variety of methods such as telephone directories, physician referrals, and physician staff meetings. Data were collected using surveys with three clinical vignettes that depicted fictitious patients with (a) chronic back pain, (b) kidney stone pain, and (c) sinusitis (control). All factors were constant except name (stereotyped), race, and gender. Roughly 220 surveys were distributed with 111 returned, representing 61 males and 50 females. Eighty-eight of the participants were White, 15 were Asian, 3 were Hispanic, 3 were Black, and 2 did not self-identify.

Of the physicians who indicated that they would treat kidney stone pain (96.4%), no significant difference was noted among physician gender, patient race, or patient gender. The analysis of variance (ANOVA) of initial doses and follow-up doses demonstrated that male physicians prescribed higher doses of analgesic to White patients than to Black patients, while female physicians prescribe higher doses of analgesic to Black patients than to White patients ($p = .003, p = .01$). For the physicians treating back pain with an analgesic (81.1%), no significant difference was noted among physician gender, patient race, or patient gender, nor did the ANOVA for initial doses demonstrate a difference. The ANOVA for follow-up analgesic doses demonstrated an interaction between physician gender and patient gender, with male physicians prescribing higher doses of analgesics to males and female physicians to females ($p = .03$). In addition, there was no difference noted between the initial treatment decision of male and female physicians on the control condition of sinusitis.

Weisse, Sorum, and Dominques (2003) repeated the 2001 study using a larger group of participants from across the United States. A 2 (patient race) × 2 (patient gender) × 2 (physician gender) experimental design was used to assess the main effect of and interaction between patient gender and patient race on physician gender and their pain management decisions. Clinical vignettes were sent to 2,952 members of the Society of General Internal Medicine, resulting in 712 eligible participants representing 414 males, 272 females, and 26 who did not self-identify. Of the respondents, 594 were White, 25 Black, 16 Hispanic, 44 Asian/Pacific Islander, and 33 identified as other or no response.

Analysis of covariance (ANCOVA) of the back pain treatment vignette demonstrated no difference in initial treatment by the 632 physicians who indicated that they would treat back pain. Follow-up treatment did demonstrate main effects between male and female physician dosing patterns in daily dose ($p < .031$), total dose ($p < .03$), and dose with refill ($p < .044$), with male physicians prescribing higher doses to all patients. When seeking follow-up care, male patients received more medication if the physician was male ($p = .049$). A Tukey post hoc analysis demonstrated that of all physician/patient gender combinations, male patients treated by female physicians were given decreased doses of analgesic.

Almost all physicians (99.9%) indicated that they would treat kidney stone pain, with no significant differences noted in initial or follow-up care choices. A significant interaction between the race of the patient and the gender of the patient was noted for the total of hydrocodone prescribed, with Black females receiving less hydrocodone than all male patients, while White females received more medication than all males ($p = .018$). Tukey post hoc analysis demonstrated significance in the total dose of hydrocodone for Black versus White male patients, with more medication selected for Black males versus White males ($p < .05$). In addition, less medication was selected for Black women versus Black men, with the opposite occurring with White patients. No significant differences were noted in treatment of the control condition of sinusitis.

Heins, Homel, Safdar, and Todd (2010) conducted a multicenter prospective study that assessed the relationship between effective pain treatment (outcomes), patient race, provider race, and patient–provider racial concordance. A racially concordant relationship was said to exist when the physician and the patient were of the same race. The patient participants were drawn from 20 U.S. and Canadian emergency departments and presented with a chief complaint of pain >3 on a 10-point numerical rating scale (0 = no pain, 10 = worst possible pain). Of the 842 eligible participants, 776 had adequate data on race to allow analysis. Patients were 57% female and 43% male. Racial make-up of patients was 44% White, 26% African American, 26% Hispanic, and 4% other. Physicians were 61% male and 39% female and predominantly White (85%).

Only 49% of patients achieved the minimum clinically important reduction in pain. Results included the following: (a) Non-White patients arrived with more pain and received fewer opioids, (b) non-White physicians were significantly more likely to produce reductions in pain intensity, and (c) patient race and race concordance were not significant factors in pain...
<table>
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<tr>
<th>Reference</th>
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<td>Criste (2003)</td>
<td>To determine if CRNAs demonstrate gender bias in care decisions.</td>
<td>CRNA (n = 133)</td>
<td>A quasi-experimental design using a clinical vignette and questionnaire was mailed to a random sample of practicing CRNAs from the American Association of Nurse Anesthetists list.</td>
<td>There was no difference between male and female CRNAs when treating pain.</td>
<td>Small sample size with low response rate. Use of clinical vignettes may not reflect the outcomes of true nurse–patient encounters.</td>
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<tr>
<td>Heins, Homel, Safdar, &amp; Todd (2010)</td>
<td>To determine the association between effective emergency department pain treatment and patient–provider race and race concordance with a focus on direct patient centered outcomes.</td>
<td>Patient-physician ethnic concordance: 334 (43%) Patients (n = 776) Male = 332 Female = 444 Non-Hispanic White = 340 African American = 205 Hispanic = 203 Asian = 17 Native American = 7 Pacific Islander = 1 Other = 3 Physicians (n = 776) Male = 472 Female = 304 Non-Hispanic White = 661 African American = 18 Hispanic = 28 Asian = 42 Pacific Islander = 3 Other = 24</td>
<td>A multicenter, prospective, cohort study of patients presenting to one of 17 U S. and 3 Canadian emergency rooms</td>
<td>Non-White physicians achieved a greater reduction of pain in their patients ( p = .008 ) as compared to White physicians.</td>
<td>Small sample of minority physicians. Results are a subanalysis of observational data of a heterogeneous population with varied pain needs. Interest in improving pain management present at institution.</td>
</tr>
<tr>
<td>Safdar et al. (2009)</td>
<td>To gain an increased understanding of emergency department pain management and to examine the influence of patient and provider</td>
<td>Patients (n = 842)</td>
<td>A multicenter, prospective, cohort study of patients presenting to one of 17 U S. and 3 Canadian emergency rooms with a complaint of pain that</td>
<td>No different between patient genders ( p = .08 ) in analgesic given. Female physicians were more likely to provide analgesic ( p = .009 ).</td>
<td>Small sample of minority physicians. Results are a subanalysis of observational data of heterogeneous patient population with varied pain needs.</td>
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To examine if gender and race influence physicians pain management decisions.

Physicians (n = 712)
- Male = 414
- Female = 272
- White = 594
- Black = 25
- Hispanic = 16
- Asian = 44
- Other = 12
- No response = 21

Quasi-experimental design using a convenience sample of physicians to respond to medical vignettes (back pain, kidney stone pain, and sinusitis) varied by patient name, race, and gender.


Physicians (n = 712)
- Male = 414
- Female = 272
- White = 594
- Black = 25
- Hispanic = 16
- Asian = 44
- Other = 12
- No response = 21

Quasi-experimental design using a convenience sample of physicians to respond to medical vignettes (back pain, kidney stone pain, and sinusitis) varied by patient name, race, and gender.

The overall initial decision to treat was not influenced by physician gender, patient race, or patient gender.

Back Pain: ANOVA did demonstrate main effects for physician gender in daily dose ($p < .031$), total dose ($p = .03$), and dose with refills ($p = .044$) with male physicians prescribing more than female physicians.

Male patients treated by female physicians received lower doses of hydrocodone than any other patient–physician combination ($p < .05$).

Kidney Stone Pain: Main effects demonstrate male physicians prescribed higher doses of hydrocodone in daily dose ($p < .039$), total dose ($p = .006$), and dose with refills ($p = .01$).

Black females received less hydrocodone than all male patients, while White females received more medication than all male patients ($p = .018$).

Response rate was low. Physician race and geographic location were not isolated. Use of computerized clinical vignettes may not reflect the outcomes of true patient–physician encounters.
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<td>Weisse, Sorum, Sanders, &amp; Syat (2001)</td>
<td>To determine if patient gender and race affect decisions about pain management.</td>
<td>Primary Care Physicians (n = 111) Male = 61 Female = 50</td>
<td>A 2 (patient race) × 2 (physician gender) between-subjects experimental design using medical vignettes.</td>
<td>Chi-square analysis revealed that treatment was not influenced by physician gender, patient race, or patient gender. Back Pain: ANOVA did demonstrate an interaction between the physician gender and the patient gender. Male physicians prescribed more follow-up doses of hydrocodone to males and females physicians to females ( (p = .03) ) Kidney Stone Pain: ANOVA demonstrated an interaction between the physician gender and the patient race in initial dose ( (p = .003) ) and follow-up doses ( (452 \text{ mg vs. } 218 \text{ mg}) ). Sinusitis: No significant differences were noted.</td>
<td>Sample was one of convenience, moderate in size, and restricted to the Northeast with small response rate. Unable to control for physician overall practicing habits. Use of computerized clinical vignettes may not reflect the outcomes of true patient–physicians encounters.</td>
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CRNA = certified registered nurse anesthetists; ANOVA = analysis of variance.
reduction. While race concordance did not appear to significantly influence pain reduction, it is suggested that nonwhite physicians in the study were better able to achieve a positive rapport during the clinical encounter, thereby creating a reduction in perceived pain.

Safdar et al. (2009) used the baseline data from the PEMI study to conduct a subanalysis to assess the association of patient-provider gender on pain management decisions. The participants were from 20 U S. and Canadian emergency departments who presented with a chief complaint of pain >3 on a 10-point numerical rating scale (0 = no pain, 10 = worst possible pain). Outcomes measured were (a) receipt of any analgesic, (b) receipt of opioids, and (c) attainment of analgesia. Analgesia was defined as a decrease in arrival pain ≥2, discharge pain divided by arrival pain ≤0.5, or a discharge pain score of <4 on the numeric rating scale.

Of the 2841 patients screened for inclusion, 842 met the inclusion criteria. The sample was composed of 470 female and 372 male patient participants. Included in the study were 322 female physicians and 507 male physicians. Analgesia was divided into two groups: opioid (e.g., hydromorphone, codeine, butorphanol, etc.) and nonopioid (e.g., acetaminophen, gabapentin, non-steroidal, etc.). Overall, there was no significant difference between genders in the administration of analgesics; conversely, a statistically significant physician–patient interaction ($p = .002$) was noted. Female physicians provided opioids more often to their female patients ($p = .006$) and male physicians provided opioids more often to their male patients ($p = .05$). Female physicians were also more likely to administer an analgesic than male physicians ($p = .009$). The achievement of analgesia was not impacted by the patient’s gender; the study noted that provider gender was a more significant predictor of pain management decisions than patient gender.

In the only study with the nurse-provider as the focus, the researcher examined the relationship between the nurse-provider gender and pain management decisions. Criste (2003) used a quasi-experimental design with random sampling to assess whether certified registered nurse anesthetists (CRNA) demonstrated gender bias when treating pain. A questionnaire containing a postoperative pain scenario was mailed to 225 male and 225 female CRNAs. Pain was measured using a numerical rating scale with a 0 to 10 scale of increasing pain. The variables in the scenario were held constant, differing by patient gender only. The data were analyzed descriptively and qualitatively. A total of 59 female and 74 male participants returned the questionnaire and the researchers found that there was no difference noted in the pain management decisions between the genders. What was of interest is that there was a statistical difference noted between male CRNAs and female CRNAs in the administration of a benzodiazepine in addition to an analgesic ($p < .05$), and that male patients receiving treatment from a male CRNA were more likely to receive a benzodiazepine than female patients treated by a male CRNA ($p < .05$).

DISCUSSION

The available research into the potential contribution of the healthcare provider’s race and/or gender and ethnicity is limited. The review of the five available studies demonstrated mixed results. Weisse et al. (2001) identified gender and racial differences in pain management decisions when the physician’s gender was examined. In a larger study by Weisse et al. (2003), physician gender was found to be related to pain management decisions when examined together with patient gender. Safdar et al. (2009) found provider gender, without a patient gender correlation, did affect pain management decisions. Heins et al. (2010) found that while non-White physicians ordered similar amounts of analgesics but fewer opioids than White physicians, non-White physicians were able to achieve more clinically significant pain reduction in patients. Interestingly, in the only nursing study, no difference was noted in the pain management decisions between genders. While four out of five of the reviewed studies demonstrated an association between the provider’s race and/or gender and pain management practices, the limited amount of available research, and nursing research in particular, prevents a conclusive assessment.

LIMITATIONS

While the lack of available research is an obvious limitation to this review, there are other limitations as well. The sample population was an issue for all studies either due to the size or the sampling technique. In the single study examining the impact of provider race on pain management decisions, the sample population consisted of 85% White providers, preventing a true analysis among White and minority providers. Three of the studies used convenience sampling and a heterogeneous population, which greatly increases the risk of sampling bias. These same studies used clinical vignettes to elicit the participant response. Even though
vignettes have been used since the 1950s to measure attitudes, beliefs, values, and abstract concepts, as well as to assess attitudes of ethnic minorities (Gould, 1996), the use of vignettes may elicit responses and behaviors that would not necessarily reflect real life situations. Two of the studies were subgroup analyses, and this may have limited the power of the studies. All of the studies were restricted to either a specific geographical location or to an area of clinical specialty, which, again, may prevent generalizability of results.

**NURSING IMPLICATIONS**

Pain is the most common complaint for those entering the healthcare system and is the reason for most emergent-care visits (Cordelle et al., 2002). Pain management and patient comfort comprise a major responsibility of nurses and other healthcare providers (Deepmala, Franz, Aponte, Agrawal, & Jiang, 2012). The gaps in understanding the potential relationship between the nurse provider's gender and/or race and ethnicity and pain management decisions are largely unexplored and provide a unique opportunity for nurse researchers. Nurses are well positioned to advocate for patients and lead change by advancing health if they challenge the institutionalized racial and gender disparities present in the healthcare system and actively assess if their own bias and prejudice may contribute to health disparities.

**REFERENCES**


**CONCLUSION**

There is empirical evidence that suggests that provider-patient interactions may influence patient outcomes, satisfaction, adherence, and disparities in health (Cooper et al., 2003; Ferguson & Candib, 2002; Tarlier, 2004; Hagerty & Patusky, 2003). This possibility has contributed to the effort in the United States to increase the non-White healthcare workforce, cultural competence training, and patient empowerment and activation approaches (IOM, 2003). Understanding how the race and gender of the providers and patients impact care choices is paramount in providing patient-centered, culturally competent nursing care. There is evidence that supports that the nurse-patient relationship contributes to patient outcomes, adherence to treatment regimens, and patient satisfaction.

However, there is little to no research that describes the interpersonal phenomena associated with the development of a therapeutic relationship between nurses and patients of different genders and/or racial and ethnic groups and how this relationship may affect nursing care decisions. Further research is needed to investigate the interpersonal phenomena that contribute to nursing care decisions. The impact of this knowledge may assist the profession of nursing to provide patient-centered, culturally competent care with the possibility of reducing gender, racial, and ethnic health disparities.


