

Does gender have an influence on the patient-physician communication?

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Abstract

Does gender have an influence on the patient-physician communication? Obviously yes is the answer, but this influence may be quite different depending on the specific circumstances in the patient-physician encounter. In this review the starting point are the differences in male and female communication in general. Furthermore the literature regarding the question if female and male physicians communicate differently with their patients will be discussed. Another topic is the question if patients talk differently to male and female physicians and if men and women communicate differently with their physician. Recently the question if female and male patients get different diagnostic and therapeutic procedures has gained much interest. There are few data answering the question if gender dyads (e.g. female patient-female doctor) have specific communication patterns. Very little is known about how being gay or lesbian influences patient-physician communication. © 2004 WPMH GmbH. Published by Elsevier Ireland Ltd.

Introduction

As you read the first line of this paper I kindly ask you to answer the question. Then, if you have a partner, ask him or her. Read the article and check if your previous answer has been changed or challenged. If not, the reading was a waste of your time. If yes, it was worth the effort of your reading (and my writing).

In preparing and writing this review I also followed the procedure of

- first, asking my wife, and
- second, reflecting my personal experience, both as a male physician and facilitator for communication skills training for health professionals
- third, searching the literature in PubMed, entering the subjects gender, sex, communication.

“Obviously gender matters”, said my wife, when I asked the question, “but it makes no sense to answer this question in such a general manner, you have to ask more specifically.” As a result to answer the question “Does gender have an influence on the physician-patient relationship and communica-

tion?” I have structured this review on a series of further questions but this is somehow artificial as there is a close interdependence between them.

1. Do women and men communicate differently?
2. Do female and male physicians communicate differently with their patients?
3. Do patients talk differently to male and female physicians?
4. Do men and women communicate differently with their physician?
5. Do female and male patients get different diagnostic and therapeutic procedures?
6. Do gender dyads (e.g. female patient-female doctor) have different communication patterns?
7. Does being gay or lesbian influence patient-physician communication?

Do women and men communicate differently?

“Definitely”, said my wife, “just compare my style with yours”. I don’t want to bother you

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with the specifics of a long-term single couple observational study, but the success of books like “*Men Are from Mars, Women Are from Venus: (A Practical Guide for Improving Communication and Getting What You Want in Your Relationships)*” [1] may be linked to the experience that men and women differ in their communication style.

There is empirical evidence that women smile significantly more than men [2], disclose more information about themselves in conversation [3] and encourage and facilitate others to talk to them more freely and in a warmer and more intimate way than men [4].

When it comes to interpretation of these findings, there are two major, fundamentally different approaches: an essentialist interpretation, which sees these differences as fixed, essential elements of gender [5], in contrast to a social constructionist perspective, interpreting gender as something that is actively done in specific contexts rather than a property of individuals. In other words, gender is a verb rather than a noun [6].

Recent findings, such as gender differences in neural correlates of recognition of happy and sad faces in humans assessed by functional magnetic resonance imaging [7] may be a prerequisite for differences in communication styles, but they are still open for either essentialist or social constructionist interpretations.

Do female and male physicians communicate differently with their patients?

“I think so”, my wife said, “therefore I changed to a female gynecologist. But you should know more about it as a physician and having a specific interest in communication skills in health care.”

As part of physicians’ communication training I have observed physicians interacting with their patients for more than ten years [8,9]. In my experience, female physicians let patients speak more, they interrupt less, ask more questions, discuss more psychosocial issues, and console (prematurely). However, there are some male physicians who are very patient-centered in their communication style and a few female physi-

cians who behave like “tough guys”, taking patient-physician interaction for communication in a military boot camp.

In a recent paper 29 publications were reviewed for physician gender effects in medical communication [10]. The authors found that female primary care physicians engage in significantly more active partnership behaviors, positive talk, psychosocial counseling, psychosocial question asking, and emotionally focused talk. There were no gender differences evident in the amount, quality, or manner of biomedical information giving or social conversation. Medical visits with female physicians were, on average, 2 minutes (10%) longer than those with male physicians.

Using appropriate statistics to describe the magnitude of the effect size the most prominent differences were found in psychosocial discussion, asking more psychosocial and closed-ended questions. Women created a generally more positive atmosphere through verbal behavior such as agreements, encouragement, and reassurance [10].

What might these results mean for male physicians? The authors concluded: “We do not suggest that all or even most female physicians are patient-centered and male physicians are not; there is far more common ground than differences in the communication behaviors of male and female physicians.” [10]

The behavior of my wife to prefer a female gynecologist is in line with the results of empirical research [11,12]. However, she should re-evaluate her choice for a female gynecologist: male gynecologists show more patient-centeredness such as higher levels of emotionally focused talk than their female colleagues [13,14]. Maybe male physicians feel pressure to enhance their communication skills as there is the challenge of a growing number of female gynecologists.

Do patients talk differently to male and female physicians?

“I don’t think so”, my wife said, “as a patient I don’t care as long as it is not my gynecologist”. In my experience as a facilitator for communication skills training, patients tend to interrupt female physicians

more than male ones, and tend to talk longer, sometimes revealing more of their psychosocial concerns.

“Do patients talk differently to male and female physicians?” was the title of a meta-analytic review published recently [15]. According to the review, patients spoke more to female physicians than to male physicians, disclosed more biomedical and psychosocial information and made more positive statements to female physicians. Patients were more assertive to female physicians and tended to interrupt them more. Partnership statements were made significantly more often to female than male physicians. This was true for general medical visits, but not in obstetrical-gynecological visits.

Do men and women communicate differently with their physician?

“Sure”, my wife said, “but the difference begins even before seeing a doctor. Look at yourself, when you are ill you still go to work and I have to practically force you to see a doctor.”

My wife is right, and, being a physician is an additional burden when becoming a patient, as this fact enhances the general masculine unwillingness to ask for help [16].

But even before discussing the different health care seeking behavior in men and women we should keep in mind that the same disease can differ substantially in symptoms, diagnosis and therapy in men and women. For example, in coronary heart disease women often have mild or no symptoms until they have a fatal heart attack. The heart-related pain (angina) in the left side of the chest, common in men with heart disease, is less commonly present in women who have heart disease [17]. Pain or discomfort in the stomach area may be mistakenly dismissed as heartburn or indigestion. Women may also have nausea, fatigue, dizziness, pain in one or both arms, neck or jaw pain, or shortness of breath as their heart-related symptoms. In many women, the first heart attack is fatal because previous symptoms and risk factors were ignored [18]. Young women who survive hospitalization from myocardial infarction have a higher long-term mortality rate than men

Table 1 Male gender identity – masculinity [22]

Strong, silent type (restricted experience and expression of emotions)
Toughness and violence
Self sufficiency (no needs)
Being a stud
No sissy stuff (such as emotional sensitivity)
Be powerful and successful

[19]. This example demonstrates why in this specific case health care seeking behavior may differ from the general pattern according to which women seek more help for health problems than men.

Men are unwilling to ask for help when they experience health problems [16]. They are less likely than women to seek professional help for physical and mental health problems. If they finally do go to their physician their communication style will be shaped according to their male gender identity (Table 1).

When men finally make it to the doctor they are resistant to primary or secondary prevention. If it comes to psychological problems their resistance is even higher. Men are stressed, and not depressed, as depression questions male gender identity fundamentally. It is not astonishing that female patients initiate discussion about depression with their physician more than men, and doctors are inclined to ask more male patients about this issue than women [20]. In another study male fatigued patients expected more biomedical communication than fatigued female patients did [21].

Do female and male patients get different diagnostic and therapeutic procedures?

“Do you want to insult me?”, my wife said, “as you know, we have been fighting for equal rights in health care, as women were getting poorer health care than men, at least in some areas. You should know the recent scientific data that proves this.”

I prefer to not cite the recent literature, which does indeed provide evidence for the claims made by the feminist movement. Instead, I want to discuss in more detail my

preferred paper for medical student education [23]. It is a clinical trial to assess the influence of the female patient's presentation style on the physician's approach to evaluating chest pain. Forty-four internists were allocated at random to one of three treatment groups. Two groups viewed videotapes of the same actress performing the role in two distinct styles. One group saw a "histrionic" characterization, the other a "businesslike" portrayal. The third group read a verbatim transcript of the interview. Although these three portrayals differed in style and medium, the patient's spoken or written words in the two video and one written presentations were identical. Initial diagnostic impressions differed dramatically: a cardiac cause was suspected by 50% of physicians viewing the businesslike portrayal but by only 13% of those viewing the histrionic portrayal. Likewise, those viewing the histrionic and businesslike videos provided different coronary artery disease-likelihood estimates initially (10 vs 20%).

Then, additional information about laboratory data was given to the internists (cholesterol: 8.2 mmol/L; complete blood cell count, urinalysis, chemistry 7 profile, thyroid function tests: normal; electrocardiogram: normal). The internists were asked if they would pursue further cardiac workup. Internists viewing the histrionic portrayal were far less likely to pursue a cardiac workup (53 vs 93%) than those viewing the businesslike women video. For internists reading only the written transcript the percentage of pursuing a cardiac workup was 73%.

What is the lesson to be learned? If you are a woman having symptoms possibly due to coronary heart disease you should behave in a more male stereotype to save your health or even life.

Do gender dyads (e.g. female patient-female doctor) have different communication patterns?

"As usual, you don't listen to me", and my wife continued in an ironical way, "this is why I changed my gynecologist, to have a 'female-female gender dyad'. Don't tell me now that your behavior is evidence-based as

men never listen to what women say. You are driving me crazy."

The behavior of my wife as far as her patient preferences are concerned is in line with empirical research not only for gynecology [11,12], but women described gender concordance as important to their relationships also with primary care physicians [24].

In a comparative study in western-European general practices across countries communication patterns of the female-female dyad differ from that of the other gender dyads [25]. Contrary to expectations, the biomedical pattern compared with a psychosocial pattern is more common in female-female than in male (GP)-female (patient) consultation. In this context it is interesting that patients of women physicians were aggressively screened for breast cancer at the youngest age, where there is little evidence of benefit from mammography [26]. In a recently published cross-sectional study using a questionnaire to survey final-year medical students [27] both genders were more attuned to the concerns of patients of their own gender, were more comfortable with personal rather than sexual issues, and were more uncomfortable with conducting more intimate examinations upon the opposite gender. Using similar case studies, it was shown that the female student-female patient dyad had significantly greater "patient-care" values than did the male student-male patient dyad [27]. It is obvious that more research in this area is needed.

Does being gay or lesbian influence patient-physician communication?

Finally, my wife asked, "Listen, if gender matters, I wonder how the patient-physician communication with gay and lesbian patients is different from heterosexual patients?"

This is indeed a very good question. Surveys estimate that 3-6% of the patients seen by physicians are gay or lesbian [28]. Certain health needs of gays and lesbians are unique and different from those of the heterosexual patients [29]. The most significant medical risk for lesbians and gays is the avoidance of routine health care [29]. Lesbians have lower

rates of preventive care, including cancer screening services such as mammography or Papanicolaou (Pap) tests than do women in the general population. It should be kept in mind that until recently the medicalization of the gay or lesbian state compounded the stigma of mental illness and homophobia (describing negative attitudes towards gays and lesbians) is common not only in the general public but also in the medical profession. In this context it is interesting to know that about 40% of physicians acknowledged that they were sometimes or often uncomfortable providing medical care to patients who were gay [30]. About 70% of health providers believed they had seen gay or lesbian patients receiving “substandard” medical care because of their sexual orientation [31]. It is therefore not surprising that many patients are unwilling to disclose their sexual orientation for fear of being treated with insensitivity. However, 89% of lesbians who had not come out to their physician stated they would have if given the opportunity, although 11% had no wish to disclose [32].

In a recent paper very practical strategies for enhancing communication with patients in a gender-neutral, non-judgmental manner including suggestions for enlisting the inclusion of patients’ families are made [33]. For example, until the sexual orientation of the

patient is known, frame questions using gender-neutral and sensitive language allowing patient permission to come out, i.e. “Do you have a partner?” or “Are you currently in a relationship?” as opposed to “Are you married?” [33].

Conclusions

- There is some empirical data which shows how patient or physician gender influences patient-physician communication.
- Our knowledge is mostly limited to observation of communication of male white primary care physicians during the delivery of outpatient care [34].
- In the future, research in neglected areas, e.g. patient-physician communication in hospital settings, or in gay and lesbian patients, is needed.
- The transfer of the empirical knowledge to communication skills training is still in its beginnings.

At the end of the article, I would like to know if you judge reading this paper worth the time you spent. At least for me, communicating with my wife, searching the literature, and writing the article was worth the effort, as it has made me aware of the gender issue in communicating with my patients, in medical student education, and in communication skills training.

This article introduces a series of articles on Physician-patient communication. Further articles in the series will take up specific areas of the subject in detail and will be published in future issues of the journal.

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