How Physician Gender Shapes the Communication and Evaluation of Medical Care

In February 2001, the New York Times published a story describing the plight of a male obstetrician fired from his practice ostensibly because of his inability to compete with his female colleagues in attracting patients.1 The physician sued the practice for sex bias, raising questions regarding the right of the practice to accommodate female patients who request female doctors at the expense of equally qualified male doctors. Indeed, female physician gender is increasingly used as a marketing ploy to attract female patients in competitive markets.

The purpose of this editorial is to discuss the extent to which physician gender affects patient preferences and expectations for medical care, the communication dynamics of care delivery, and patient satisfaction with care.

Patient Preferences

Despite historical gender bias against female physicians,2 most studies reveal only a weak preference for physicians of the same sex when the presenting complaint is not gender specific.2,3 While female patients choose a female physician more often than does a male patient, both male and female patients overwhelmingly choose male physicians.6 A preference for a same-sex physician, however, becomes much stronger when patients are seeking help for intimate health problems, including gynecological and obstetrical care.2,3,5 These preferences have been linked to an expectation of special insight and experience with gender-specific problems and embarrassment and discomfort associated with physical exposure and discussion of sensitive matters across gender lines.2,5 Perhaps related to some aspect of comfort in the discussion of gender-specific problems, female physicians have been reported to provide more gender-linked preventive services, such as mammography and Pap tests to their female patients,4,6-10 as well as more general preventive counseling and mental health counseling for patients of both sexes.4,11

Even though the past several years have brought a dramatic increase in the number of women entering medical school, it will be some time before patients have equal access to physicians of both sexes. Mechanic et al12 note that while the proportion of physicians in office-based practice who are women increased from approximately 13% in 1989 to 20.5% in 1998, the average number of weekly office visits for male physicians is about 35% greater than the average weekly visits for female physicians. Limited supply of female physicians, especially in the female-specific specialty of obstetrics and gynecology, may intensify the competitive advantage of female physicians over their male colleagues.

Communication Dynamics

Communication studies in primary care have demonstrated that male and female physicians conduct their medical visits somewhat differently. Female physicians have longer visits and engage in more partnership building, emotionally focused talk, positive talk, and psychosocial exchange than do male physicians (unpublished data).13,14 These differences can have important implications for the nature of the therapeutic relationship developed by male and female physicians with their patients and can be discussed in terms of 3 broad areas of impact: patient-physician partnership, exploration of the patient’s psychosocial context, and patient expectations and judgment.14

Patient-Physician Partnership.—The first of these areas relates to communication reflecting collaboration and partnership. Female physicians use more partnership statements in their routine communication, such as asking for patient expectations and opinions and checking for patient understanding.15-21 They also use more facilitating behaviors reflecting attentive listening and showing interest through the use of nonverbal cues such as “umm-hmm” and head nodding.17 These behaviors engage the patient in the medical dialogue.15-21 Female physicians may also be more willing to use informational resources in front of patients and are thereby less protective of professional status and the appearance of infallible expertise. For instance, female physicians are more likely to refer to a book or other reference when with patients, and they are more likely to consult other physicians during a patient visit than male physicians.20,21

Finally, female physicians appear to be less dominant verbally during the visit than male physicians. Female physicians spend more time with their patients than male physicians,4,11,16,17,19,22-24 and they talk more than male physicians.17,19 Moreover, all patients—both male and female—of female physicians talk proportionately more during the course of a medical visit than patients of male physi-
The critical points are:

1. The Dutch study also reported more emotionally focused talk, and used more frequent partnership statements than female obstetricians.

2. The US study found that male obstetricians engaged in more emotionally focused talk, and used more partnership statements than female obstetricians.

3. The real meaning of effects is judged in terms of clinical or practical importance, not magnitude. In this light, it should be understood that even small communication effects are likely to be noticed by patients and thus be important to the patient. Nevertheless, more common ground than difference exists in the communication behaviors of male and female physicians.

4. The communication behaviors associated with female physicians are those generally valued by patients and predictive of positive patient outcomes, including satisfaction, recall of medical information, and compliance with medical recommendations as well as health status improvements.

5. In our own studies, we have also reported mixed results. Based on analysis of 2 independent studies, we found that both male and female patients of female physicians reported lower ratings of satisfaction than other patients if their physicians appeared more youthful or were younger than other female physicians.

6. An intriguing element of our finding, based on audiotape analysis, was that the communication behaviors generally valued by patients were not associated with patient satisfaction when these behaviors were practiced by young female physicians. We speculate that other patient values and prejudices, perhaps an inferred lack of authority or expertise because of her youth and gender, may offset whatever advantage the young female physician might have by virtue of her communication performance. Alternatively, expectations for positive communication skills (including partnership and emotional support) may have been so high that patients were disappointed despite the performance of these behaviors by their female physicians.

7. A related interpretation regarding raised expectations for female physicians may be given to the findings of Schmittidil and colleagues, who investigated gender preferences and satisfaction in a large managed care organization. Female patients who chose a female physician differed from the small number of male patients who also...
chose a female physician, and both male and female patients who did not opt to choose a physician at all, in 2 ways: the female patients who chose a female physician placed a higher value on their physician’s communication skills, and they were less satisfied with the medical care. In contrast, patients who did not express a gender preference for a physician did not differ in the satisfaction ratings they gave to their physician regardless of their own gender or the gender of their physician. The importance of these findings may be in the female patients’ raised expectations in regard to the interpersonal communication performance of their female physician. As noted earlier, female physicians engage in more of the communication behaviors generally valued by patients. Nevertheless, even good performance may not be sufficient to meet the high expectations of female patients for their female doctor, particularly under tight scheduling constraints typical of managed care.

A similarly unfair judgment process for male physicians in obstetrics and gynecology may also be evident. Within the context of at least the US study referred to earlier, it appears that patient expectations and preferences for female obstetricians, particularly among white, insured patients, drove subsequent patient satisfaction. In this study, male obstetricians conducted longer visits and engaged in more dialogue than female obstetricians. They were more likely to check that they understood the patient through paraphrase and interpretations and to use orientations to direct the patient through the visit. In addition, male physicians expressed more concern and partnership than female physicians. Even though patient satisfaction was generally sensitive to the physician’s communication, over and above the explanatory power of particular communication and patient variables, patient satisfaction ratings were higher for female physicians. The relationship of physician gender to patients’ ratings of a physician’s emotional responsiveness was especially strong and may reflect sensitivity to gender expectations; women are generally perceived as more emotionally communicative than men. This judgment was made despite the empirical evidence in the study that male physicians, in fact, engaged in more emotionally focused exchange.

Conclusions

The implication of these findings points to more than simply the “turning of the discriminatory tables” once favoring males now to favor females, at least in some contexts. The challenge for a more positive transformation in the everyday practice of medicine includes the generation of gender-neutral social norms regarding patient expectations and judgments of physician conduct, as well as the establishment of medical practice norms that value communication skills and interpersonal sensitivity. Simply having more women in medicine will help contribute to a societal norm that does not inherently define “doctor” in gender-linked terms, but this will not be sufficient in itself to transform medical practice. Physician training in interpersonal skill, emphasizing those aspects of communication identified in the growing evidence base of medicine, can contribute to the definition of quality standards for interpersonal communication for all physicians. Fortunately, training in this area has been shown to be effective.

The closing quotation from the male physician featured in the New York Times article mentioned earlier may well capture this phenomenon: “I think it’s similar to certain fields where women have to work harder to prove themselves. Men in this field have to be more sensitive.” Patients, for their part, will be similarly challenged to fairly evaluate their physicians for their performance and not simply their gender.

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