

# How gender affects the relationship between physician and patient

Fulvia Signani

Psychologist, Professor in charge of Gender Sociology, Department of Humanities; Board's Member Center Studies on Gender Medicine, Department of Medicine, University of Ferrara

If we imagine the doctor-patient meeting as a path in stages, we see it characterized by the first step of anamnesis; a diagnosis phase; a therapeutic prescription and finally a stage of healing or temporary healing with risk of relapse, or stabilization of a chronic pathology. Aspects that have a different resonance in patients and in doctors based on their own gender.

Gender represents the most important independent predictor of patient reactions, availability, preferences and all those who have dealt with this subject affirm that medical dialogue works in different ways depending on whether the doctor is a woman or a man and if the patient is a woman or a man<sup>1,2</sup>.

Gender medicine is highlighting sexual and gender differences in symptoms and diseases. Bernardine Healy in 1992 identified the Yentl Syndrome, the phenomenon of the systematic undertreatment of women hospitalized in cardiology intensive care<sup>3</sup>. In 1999 Elderkin-Thompson and Waitzkin confirmed gender bias in diagnosis and treatment and that a sizable literature exists that notes physicians make more diagnoses and initiate more aggressive interventions with women than with men. The authors spoke of *misdiagnoses*<sup>4</sup>. Phenomena also confirmed more recently by the AHA which in the Statement of 2016 states that cardiovascular disease (CVD) is the leading cause of mortality for women globally<sup>5</sup>. Coronary heart disease (CHD) has traditionally been considered a disease of men. Despite stunning improvements in cardiovascular mortality for women in the past two decades, CHD remains understudied, underdiagnosed, and undertreated in women.

On the influence of gender in the doctor-patient relationship, a fundamental reference is the impressive meta-analysis carried out by Roter, Hall, and Aoki<sup>6,7</sup>, which confirms that female doctors include much more information in the conversation about themselves, compared to male doctors, and they have a style of non-verbal communication more engaging. They encourage and facilitate others to talk about themselves more freely, they prove to be more accurate in assessing the feelings and traits of the personality of others, even if expressed non-verbally. Male doctors, instead, have a tendency to emphasize the differences in status between themselves and the patient. Female doctors have a style of communication more emotional, less dominant and more pa-

tient-oriented, compared to men. Doctors, both women and men, when relating to a woman patient, give information and directions oriented to the patient's partner, even if absent, attributing to the woman, in a stereotypical way, the role of caregiver.

Male doctors prescribe more drugs, and in particular more sedatives, to female patients. On the other hand, the gender-mixed dyads (male doctor-patient female, and vice versa) are more difficult when it comes to the care relationship. In fact, patients show different behaviours depending on the sex/gender of the doctor. When a young female doctor visits a male patient, she may find it difficult to get the same consideration from him that he could have for a doctor male. Male patients, with female doctors, are more assertive and they tend to interrupt the conversation more often, however, in general, they declare themselves to be more satisfied with female doctors. Female patients demand safety, experience, skills and attitudes, from doctors and nurses, more than male patients require. Furthermore, female patients dwell more on psychosocial subjects and spontaneously provide much more information on health, illness or cures.

Schmid Mast et al.<sup>8</sup> focus on non-verbal communication aspects, for example, medical women speak with a higher voice, maintain a smaller interpersonal distance, are more expansive and hold their arms in an open position more than male doctors. Patients, on the other hand, interpret the non-verbal communication of physicians, male or female in different ways. Patients activate many of the social stereotypes of women against female doctors.

The time dedicated to patients is also an important communicative sign. The dyad of the same sex (a male doctor with a male patient, etc.) seems to favour a longer doctor-patient conversation time. Women doctors make clinical examinations longer than men (from 2 to 23 minutes) so, for the same number of visits, at the end of the day, due to the accumulation effect, spend more time with patients than their male colleagues. If the doctor is a woman, for the social stereotype on the woman, patients cannot stand that a visit might last less than 10 minutes.

The importance of having a permanent partner, being married or not, has been proven for some time and it is known how much men derive a greater advantage from this in terms of psychological well-being, but this factor,

beyond a 'registry note', is inexplicably given little importance<sup>9</sup>. The attention by a physician should also include the awareness that within families the weight of the caregiver role often falls almost exclusively on the woman who, if ill, usually has to be the caregiver for herself and, if she has an ill husband or partner, must act as caregiver for him, as well as for others in the family, elders and children. The increase in longevity and consequently the increase in the consequent chronic pathologies present in the elderly population, among other things, have meant that the domestic care services necessary for adult chronic patients represent more than 90% of the caregiver's activities<sup>10</sup>.

Löffler-Stastka et al.<sup>11</sup> analyzed how doctors and students tended to describe the doctor-patient communication and found a gender-dependent communication style influenced by stereotypes. Females use positive adjectives (helpful, sentimental, sociable, etc.) and the most frequent associative words are "empathy", "confidence", "openness". Male students and physicians instead used "overbearing", "robust" and "inhibited" adjectives and the most frequent word association was "medical history". Male medical students reported self-doubt during conversations with female patients, demonstrating a low consideration of a female's description of an illness, while one-third of the male physicians talked surprisingly about "the power over the patient" as a factor that they take into constant consideration. Researchers have finally considered that physicians need to be attuned to the different factors that affect their behaviour<sup>12</sup>.

Male and female doctors report more difficulties with male patients, which are attributed in large part to the fact that male patients are not familiar with the outpatient clinics and health facilities in general, unless they are chronically ill.

General practitioners, when requested what suggestions they would give to improve the fairness of diagnostic treatment for patients, asked to be able to take advantage of training that would allow them to communicate more effectively with male patients<sup>13</sup>.

The different approaches of a male-female physician emerged also in analyzing little aspects, i.e. certified sickness behaviours. A research involving a total of 3906 patients certified sick by 67 general practitioners (GPs), discovered that certification of male patients by male GPs was significantly associated with increased prevalence of intermediate (6-28 week) certified sickness outcomes, compared with females certified by females GPs<sup>14</sup>.

## Conclusions

Data refer doctor-patient relationship's description in a situation of spontaneity. The considerations should not be used in the sense of stigmatizing one or the other

gender; they could be a useful starting point, instead, for involving doctors in dedicated training, useful to make them aware of the daily "gender traps" of communication in which they risk falling.

## References

1. Lagro-Janssen AL. Medicine is not gender neutral: influence of physician's sex on medical care. *Ned Tij Gen* 2008; 152 (20): 1141-5.
2. Wessels H, de Graeff A, Wynia K, de Heus M, Kruitwagen CL, Woltjer GT, et al. Gender-related needs and preferences in cancer care indicate the need for an individualized approach to cancer patients. *Oncologist* 2010; 15 (6): 648-55.
3. Healy B. The Yentl Syndrome. *N Engl J Med* 1991; 325: 274-6.
4. Elderkin-Thompson V, Waitzkin H. Differences in clinical communication by gender. *J Gen Intern Med* 1999; 14: 112-21.
5. AHA Acute myocardial infarction in women. A scientific statement. *Circulation* 2016; 133 (9): 916-47.
6. Roter DL, Hall JA, Aoki Y. Physician gender effects in medical communication. A meta-analytic review. *JAMA* 2002; 288: 756-64.
7. Roter DL, Hall J. Doctors talking with patient/patients talking with doctors: Improving communication in medical visits. Greenwood Publishing Group Praeger, Westport USA, 2006.
8. Shmid Mast M, Hall JA, Cronauer CK, Cousin G. Perceived dominance in physicians: are female physicians under scrutiny? *Pat Educ and Couns* 2011; 83 (2): 174-9.
9. Williams K. Has the future of marriage arrived? A contemporary examination of gender, marriage, and psychological well-being. *J Health Soc Behav* 2003; 44 (4): 470-87.
10. Adelman RD, Tmanova LL, Delgado D, Dion S, Lachs MS. Caregiver burden. A clinical review. *JAMA* 2014; 311 (10): 1052-60.
11. Löffler-Stastka H, Seitz T, Billeth S, Pastner B, Preusche I, Seidman C. Significance of gender in the attitude towards doctor-patient communication in medical students and physicians. *Wien Klin Wochenschr* 2016; 128: 663-8.
12. Zaharias G, Piterman L, Liddell M. Doctors and patients: gender interaction in the consultation. *Acad Med* 2004; 79: 148-55.
13. Lyons Z, Janca A. Diagnosis of male depression-does general practitioner gender play a part? *Aust Fam Phys* 2009; 38 (9): 743-6.
14. Shiels C, Gabbay M. The influence of GP and patient gender interaction on the duration of certified sickness absence. *Fam Pract* 2006; 23: 246-52.

Correspondence to

Fulvia Signani  
Università degli Studi di Ferrara  
via Savonarola 9  
44100 Ferrara, Italy  
email fulvia.signani@unife.it