initiative in selecting your physician, pharmacist, or other health professional, in addition to checking out competency, costs, and other details. Women need to utilize that first visit to evaluate the provider's communications skills. Is the doctor going to be open with you, answer your questions, start a dialogue, be willing to communicate? Good communications at the beginning of the patient-provider relationship determine whether there is going to be the proper environment for communication and, as a result, better health outcomes.

The third bit of advice is that it would be well, before you visit your doctor, to have some knowledge, as much as you can assimilate, about your own health condition and a history of health patterns. It is important to keep your health records. Reading about the condition you have, before you go to see your health provider, will enable you to start a knowledgeable discussion. This should be helpful to the doctor who then brings his or her own health expertise into action.

Studies have shown that health care providers tend to seriously underestimate their patient's knowledge of health care and their ability to assimilate what information the health provider might give. One study reported that providers who underestimate a patient's knowledge tended to have more limited discussions. Some doctors did not think that the patient could understand detailed information.

At NCPIE, we have looked at some of the studies that the Food and Drug Administration (FDA) has conducted. How many people do you think ask questions about their prescription medicine when they go to see their doctor or pharmacist? About 5-6 percent. Yet 70 percent of the consumers said they were not getting the information they wanted from their health care providers. Why do you suppose that the health care provider was not giving information to the patients? Because the patients were not asking any questions, and the doctors assumed that the patients had all the answers they wanted because of the lack of questions.

Women and Their Health Care Providers: A Matter of Communication

The Physician-Patient Relationship

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Synopsis

There is a direct connection between the doctor-patient relationship and the quality of care. An increase in female and minority physicians leads to a corresponding increase in physician perspective, which allows for improved identification with the patient's feelings. Preconceived thoughts are difficult to overcome, and the physician must recognize all barriers to effective communciation.

THE SPECIAL HEALTH NEEDS of women *a priori* are related to gender, anatomy, physiology, and psychology over time. This idea is very simplistic but realistically it is impacted by health care—by the health care deliverer and the delivery system. The physicians or physician extenders are "the gatekeepers." Hence, communication at that level between the patient and the physician is essential.

The doctor-patient relationship has been proved many times to be directly related to the quality of care. Effectiveness of communication between the two parties enhances problem-solving, diagnosis, and treatment. Hence, the effectiveness is related to the quality of care. The determinants of the effectiveness are the attitudes and expectations of both the physician and the patient. There are rapid social changes taking place, characterized by the changing role of women in society and the changing modes of health care delivery.

Both the physician and the female patient bring personal expectations and attitudes based on their cultural and social backgrounds. The status of

patient implies a vulnerability and a dependency. This vulnerability is further enhanced by the culture or subculture from which the patient comes. Culture is a basis for definition and interpretation of health and illness. Influences on the female patient are her psychosexual orientation, her psychosocial orientation, cultural bias, and economics. We heard earlier in the conference that 78 percent of the poor are female and children. Poverty is associated with ill health.

Physician Profile

The physician, as well as the female patient, has a psychosexual orientation, a psychosocial orientation, and cultural biases and, although most physicians acknowledge that they do have these biases and that there are patients that they do not like or do not like to deal with, they do not feel generally that these biases will influence their patient care.

The physician is usually a member of a very select group: he is male, and he is white. Studies have been undertaken to determine what motivates people to go into medical careers. The male physician tends to be more science-oriented. He is more interested in the prestige of medical care, power, and, of course, financial rewards. Female physicians tend to be more service-oriented (service to society), they are people-oriented, and they are looking for personal independence.

In addition, most physicians feel invulnerable to disease, which has led to many studies about physician self-care. There is a correlation between the invulnerability belief and the apparent high suicide rate among physicians in some specialties.

The major ingredient or skills that are necessary for the doctor-patient relationship are listening and verbal and nonverbal communication. Those skills used to be termed the "bedside manner."

The setting itself brings some inherent conflicts, problems, and barriers to communication. For instance, the basic history and physical examination, when you are dealing with a female patient, increases her vulnerability because a significant portion of the history is directed towards the diagnostic incidence of female diseases, so we tend to focus around the reproductive and genitourinary systems. The physical examination itself is considered incomplete without a gynecological examination of the female. Who would not feel vulnerable if they were seminude, or nude, in a lithotomy position? Your vulnerability is related to your self-concept. Who would expose themselves to this unless it was absolutely necessary?

'The major ingredient or skills that are necessary for the doctor-patient relationship are listening and verbal and nonverbal communication. Those skills used to be termed the "bedside manner."'

Intervention

One of the positive things that can be done to break down some of these natural barriers that go along with our health care and our health care delivery system is to foster education. We must educate our medical students and our health care professionals to be more sensitive to their own personal biases and values. This sensitization must be reinforced over and over again for the medical student in the predoctoral curriculum, in the postdoctoral residency training programs, and also in continuing medical education programs. There should be formal courses on psychosocial influences and on patient care, and they should be required—not voluntary.

There should be emphasis on teaching effective communication and also on effective listening skills. A study done recently at Wayne State University, although it was not gender-based, concluded that doctors do not listen. We have to start training and graduating physicians with broader psychosocial and cultural orientation. We need more female physicians. We need more minorities. Studies have shown that physicians tend to practice in areas or with patient populations that are compatible with their own social and cultural backgrounds. Attracting more female and minority students can be accomplished through aggressive recruitment. Medical schools have to be made more accessible; we need to increase health professions loans and to decrease professional education tuition rates.

We also need to convince the providers that they are indeed vlunerable, just like anybody else in society. It has been postulated that this "invulnerability" that doctors feel makes them insensitive to the vulnerability that their patients feel. Doctors are being made aware of this by physician self-help and self-care programs.

We have learned about some of the positive steps that patients can take, but we need better patient education. That education needs to start early, not

when you are 25, 35, or 45 and start to seek medical help, but early in elementary school, second or third grade. I am always surprised that women really do not know how their bodies work, and it is very difficult to try and glean the information when the patient does not know how significant a problem is, or waits too long or gives you the wrong information.

The patient needs to be informed. We have all read informed consent statements. Such forms are strongly influenced by medical-legal concerns, but there must be other considerations. Patients should know how and when to ask questions. An interesting aside to this is that occasionally a patient will refuse to follow your care, especially in the hospital. Patients will get up and walk out of the hospital. Just to show how seduced they get by the system—the patients are requested before they walk out to sign a form releasing the physician and the hospital from any responsibility for noncompliance, and I have never yet seen a patient who will say, "You didn't do it right. I don't like what you did. I'm walking out, and I am not signing anything." Patients sign those forms. They are intimidated by the system.

As a patient you do have rights. You can refuse or take any part of the system you want. It is your body, and you can expect and make sure that you get all the information you need, and of course second opinions are possible. Get a second opinion. It is your body. It is probably the most valuable thing that you have. Take advantage of the rights that are yours.

We, as providers, can decrease the vulnerability that our patients feel in the clinical setting by injecting some dignity into the process. We have to avoid demeaning identifiers, especially of women, and not just women patients. I am so tired of the telephone operators at the hospital telling me, "Okay, wait a minute, honey." The office visit should be structured so that it is not quite so demeaning. There is nothing worse than getting all dressed up to go and see your doctor. The first time you see him/her, you have no clothes on, and when he/she leaves the room, you still have no clothes on. I think it is important that the patient be allowed some dignity when meeting a medical professional, and she should, at least initially, have her clothes on.

We all have biases about some of the most interesting things that we do not recognize. I was in a medical school in which there were two females, and I was the only black female in the class. There was one black male student. So I felt very smug in that I knew that I was very sensitive to issues of bias and stereotypes and things of that sort.

Then when I was midway through my internship, I was one of the three people who were assigned to cover the hospital on Christmas Eve. On Christmas Eve there are very few patients in the hospital, and the only patients there are usually the chronically ill or those who are close to death. The emergency room called to say they were admitting a patient to the floor, and as an intern, I was expected to go and check the patient, but because the duty was so light and we were very bored, the resident who was on duty with me said, "Let's make this a teaching moment." So we all three went to the man's bedside.

He was an elderly derelict who was semicomatose at the time he was admitted. He had a cardiac arrhythmia, and he was malnourished. And so in the usual callous fashion of house staff, we began making bets as to how long this man had to live. So we made sure that he had adequate orders and went back to the lounge, and as we sat there with nothing to do on Christmas Eve, we speculated about the man. What if he were 29 years younger, if he didn't smell, what would we do for him? So we played this learning exercise on the blackboard, and after we got all these orders, we sat there for another 2 minutes, and then one of the interns said, "Let's go try it," and we went in there and we tried it. We did all of those aggressive maneuvers that we would have done automatically if he were younger and more "worthwhile". That man eventually walked out of the hospital. I have never been so ashamed. It had never been made so real to me that I have my own personal biases as all of us do. We have to deal with them, especially when we interact with patients. The patient is seeking unbiased health care as an individual, not as a woman, a derelict, a minority, or any other group about whom preconceptions may exist.