Women and Their Health Care Providers: A Matter of Communication

Communication Between Women and Their Health Care Providers: Research Findings and Unanswered Questions

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Synopsis

Although much research has been carried out on communication between health care providers and patients, relatively few studies have investigated the effects of patient or provider gender on the communication process or its outcomes. Women use health services more than men and are more likely than men to report being influenced by health information in the media. No studies are available showing that physicians hold biases about male and female patients that translate into different communication patterns with each sex. Recent studies of verbal communication between patients and primary health care physicians show that female patients tend to ask more questions than men. Evidence that physicians are more likely to withhold information from female patients is not conclusive. Some evidence has been found that female physicians interrupt their patients less often than male physicians, provide more verbalizations of empathy, and provide clearer explanations in response to patients' concerns. Female physician-patient dyads might be expected to improve communication under certain circumstances.

COMMUNICATION BETWEEN women and their health care providers interests us for several reasons. The quality of communication between women and their physicians, who are predominantly male, has been widely criticized, and increasingly assertive female consumers of health care have pressed for change. In addition, women frequently are responsible for managing the health care and health behaviors of their families, particularly children, and thus their need for health information is considered to be higher than men's. Finally, as health promotion and disease prevention become more important components of health care in this country, the need for effective communication in educating patients about risk factors and influencing appropriate preventive behaviors is increased.

Women seem to be ideally positioned to benefit from improvements in the way in which health information is disseminated. For one thing, women use health services more than men and are more likely than men to have a regular source of health care and hence a regular source of health information: in the 1985 National Health Interview Survey of adults (*1*), 83 percent of women and 70 percent of men responded "yes" when asked, "Is there a particular clinic, health center, doctor's office, or other place that you go to if you are sick or need advice about your health?" In addition, a 1984 survey conducted by Louis Harris and Associates for the Prevention Research Center found that women are more likely than men to report being influenced to improve their personal health habits by information in the media (*2*).

Communication between health care providers and their patients has been investigated in numerous studies from a variety of perspectives. Most researchers focus on the transfer of information between provider and patient and study such phenomena as number of questions asked or symptoms disclosed by patients, amount of information given by physicians, patients' recall and understanding of information given, and amount of time spent in information exchange. Sociolinguistic studies, including discourse analysis, consider the form of doctor-patient communication (who asks questions or interrupts, who controls the interaction). Others have studied the communication of messages, particularly information about emotional states, through nonverbal channels such as voice tone, facial expression, and body movement; both the physician's

nonverbal expressiveness and the physician's ability to decode the patient's nonverbal messages have been studied.

Various aspects of verbal and nonverbal communication have been shown to affect patients' satisfaction with care received and their likelihood of returning for followup appointments and adhering to recommendations. Indeed, it has been argued that patients' satisfaction with the quality of communication with providers is a key component of their overall satisfaction with medical care and a key determinant of subsequent appointment-keeping and compliance with medical recommendations (*3, 4*).

The vast research literature on provider-patient communication encompasses a number of methodologies. Recently, much of the research has been observational and has been conducted in clinical settings, using audio or video tapes or literal transcripts of actual encounters. The verbal or nonverbal content of the physician-patient interaction is then subdivided into events that are classified, using some sort of taxonomy, and analyzed. Examples of recent studies of verbal communication between doctors and patients include the work of Waitzkin (*5*), Mishler (*6*), and West (*7*). Recent examples of studies of nonverbal behavior include the work of DiMatteo and coworkers (*8*) and Hall and coworkers (*9*). Other studies have used "vignettes" (that is, standardized descriptions of cases) to assess communication in hypothetical encounters. Such studies have the advantage of being able to manipulate systematically specific attributes of the encounter that would be difficult to control in the field, but suffer from the disadvantage of not observing actual communication between providers and patients.

Research focuses on different aspects of communication (for example, verbal versus nonverbal behavior) and uses different methods to observe and classify behavior. Aside from that, there is the additional limitation that most researchers of transactions between providers and patients have studied first consultations between patients and their primary care physicians and have not viewed continuing communication between a patient and a provider or the consistency of messages received from multiple communication channels (including providers and the media). Thus, it is difficult to draw conclusions about what people experience in their health care communications today.

Furthermore, and perhaps more important for our purposes here, there has been very little systematic research on the effects of gender (either patients' gender or physicians' gender) on the communication process and its outcomes. Feminist criticism of women's health care has emphasized the physician's tendency to use familiar forms of address (for example, first names rather than titles and surnames), to "talk down" to the patient, and to belittle the patient's need for information or her capacity to use medical information rationally (*10*). The assumption is that male patients do not experience these problems to the same degree. Much of the data, however, are anecdotal. The question remains, what do we know from research about gender differences in provider-patient communication?

First, we have considerable evidence from epidemiologic surveys that women use more health services than men, even after services related to reproduction have been taken into account, and that they report more symptoms than men (particularly symptoms of a psychiatric nature) (*11, 12*). A great deal of attention has been paid to the question of whether the sex difference in symptom reporting is attributable to a gender role difference in the way that symptoms are recognized and labeled or to true differences in morbidity between men and women (*13, 14*). However, the sex difference in symptom reporting has not been reported in studies conducted in clinical settings. Thus, we do not know whether men and women who are seeking health care differ in the *number* of symptoms they disclose to the physician or in the *types* of symptoms they disclose.

Women are known to receive more diagnoses of psychosomatic illness and more prescriptions for psychotropic drugs than men (*15–18*). Whether this results from physicians' biases about women or from women's greater reporting of certain types of symptoms is not known. No studies, to our knowledge, have shown that physicians' biases about male and female health and illness relate to actual interactions with patients. While some studies show that physicians tend to attribute psychosomatic diagnoses to women more often than to men with the same symptoms (*19, 20*), these are generally questionnaire or vignette studies and they do not demonstrate that the observed biases translate into actual diagnoses or differential communication with male and female patients.

Research on provider-patient communication has revealed, however, that female patients ask more questions in the medical encounter than do male patients (*21, 22*). This could be attributed to women's greater exposure to sources of health information, to women's greater acceptance of the help-seeking role, to physicians providing more opportunities for women to ask questions, or to women receiving less information, or less clear information, from their physicians (*23*).

As regards physicians' responses to patients' questioning, one can ask whether physicians are more likely to withhold information from female patients than from males. The evidence is not conclusive. Numerous studies report that physicians generally underestimate their patients' desire for information (*21, 24*), but it has not been demonstrated that this occurs more in the case of women than men. (Patients' social class and educational level appear to be more important variables than sex in influencing the amount of information physicians provide.) One study provides some tentative evidence that male physicians may discourage information exchange with female patients. In a study of 336 audiotaped interactions between male internists and their male and female patients, Wallen and colleagues (*22*) observed physicians' responses to patients' requests for information. They found that whereas women asked more questions and received more explanations than men, physicians tended to give shorter answers to women's questions and to give less technical answers to women than their questions were judged to require. The authors interpreted these findings as indicating a tendency for physicians to withhold medical information from women in order to maintain the traditional male-female power relationship. This behavior by physicians, in turn, could prompt women to ask more questions.

On the other hand, a recent study by Waitzkin (*21*) found no evidence that physicians generally withhold information from female patients or "talk down" to them. (This study used the same taped encounters with internists as the previously cited study by Wallen and colleagues.) Female patients asked more questions and engaged in more verbal behavior than male patients. Contrary to the author's expectations, female patients received more physician time, more total technical explanations, more explanations subsequently translated into simpler terms, and more responses at the same technical level as the patients' questions. The finding that women received more information than men was attributed to their tendency to ask more questions.

Some of the more interesting issues now being raised about provider-patient communication have to do with the effects of the physician's gender. With increasing numbers of women practicing in those medical specialties responsible for adult care (for example, internal medicine, family practice, and obstetrics-gynecology), it is often expected that the quality of communication between physicians and patients will improve. Martha Teitelbaum and I recently reviewed the available literature on physician gender effects, and we found that few studies have systematically compared male and female physicians as communicators (*25*). A number of studies have shown that female physicians spend more time than males in face-to-face interaction with patients (*18, 26*). One reason for this could be that female physicians are more attuned to the communication process and therefore spend more time in verbal exchange with patients. Several studies report that female medical students and physicians are more highly oriented than males toward communication issues. Female medical students are more likely than males to value information exchange and questioning by patients (*27*) and to prefer assertive and communicative patients (*28*). In a 1984 national survey of young obstetrician-gynecologists that we conducted, we found that female obstetrician-gynecologists were more likely than males to report that patients who ask a lot of questions are more interesting to treat, and women were also more likely to disagree that "information about the risks and benefits of drugs or treatments is confusing to patients."

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Female physicians, like females in general, are also expected to be better decoders of nonverbal communication cues. Hall (*29*), who has studied sex differences in nonverbal communication, found that women generally are better than men at "decoding" (that is, accurately judging) the emotional expressions of others, especially facial expressions. Women also smile more than men and gaze more at others. Men, on the other hand, speak at greater length and interrupt more. Unless such sex differences are totally obliterated by medical education, we would expect female physicians to be better than males at perceiving patients' emotions and to be less likely than males to engage in such gestures of verbal dominance as interrupting the patient. (We would also expect female patients to be better than males at decoding the physician's nonverbal messages; thus, for example, a physician who sends negative emotional cues, even if verbalizing positive ones, would be perceived more accurately by female than male patients.)

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Apart from the possibility that female physicians may have more favorable attitudes toward communicating with patients and greater skill at some forms of communication, there is reason for hypothesizing that female physicians may be more effective communicators with female patients in particular. The current norm for women in our society is to receive medical treatment from a male physician; when a woman is treated by a female physician, the social distance between her and the physician is reduced. That is, there is less of a status difference between the patient and physician in same-sex, as opposed to opposite-sex, physician-patient dyads. Several authors have noted that increased social distance or a greater degree of cultural difference between communicators results in more communication difficulties, including diffidence in questioning physicians among working-class patients (*3, 30, 31*). Hall (*29*) argues that same-sex interactions tend to be characterized by more sex-appropriate nonverbal behavior as compared to opposite-sex interactions; that is, the typical "feminine" aspects of nonverbal communication are likely to be displayed more in interacting with other women than with men. (She explains this tendency based on the cultural prevalence of same-sex interactions and the evolution of norms to govern those interactions.) All of these considerations support the argument that medical communication should be facilitated in same-sex dyads.

However, few studies have been designed to observe communication in same-sex versus opposite-sex physician-patient interactions. In a study involving student subjects and hypothetical male and female physicians, Young (*32*) found that male and female respondents were more willing to disclose symptoms to a physician of the same sex than to a physician of the opposite sex, especially when disclosing symptoms of a personal nature. In an analysis of 21 physician-patient conversations in a family practice center, West (*7*) found that conversations involving female physicians and female patients were characterized by proportionally fewer interruptions of the patient by the physician (as compared to male-male and male-female conversations), thus suggesting greater conversational symmetry "when the doctor is a 'lady.' "

Several studies in which all the patients were female, but the sex of the provider varied, suggest that communication is enhanced when women treat women (as compared to when men treat women). Scully (*33*) reported greater empathy expressed by female residents in obstetrics-gynecology than by males in dealing with dysmenorrhea or labor pains in their patients. In a study of 40 mothers' initial visits with 11 pediatricians and nurse practitioners, Wasserman and colleagues (*34*) found that more verbal statements of empathy by the clinician were associated with higher satisfaction with the visit and with a reduction in concern among the mothers; further, female pediatricians provided significantly more empathy than did males (4.3 episodes per visit as compared to 1.9 episodes per visit). Finally, in a study of 327 women seeking genetic counseling, Zare and colleagues (*35*) found that patients reported more in-depth discussion of certain topics and more willingness to raise issues of concern when the provider was a woman; patients of female providers also reported receiving clearer explanations than patients of male providers.

I would argue that physician-patient dyads in which both parties are female should enhance communication under certain conditions, namely, when the patient prefers to be treated by a physician of the same sex; when sex-specific conditions are being treated; when conditions of a highly personal or sensitive nature are being treated, such that sex or sexuality are salient (for example, in psychotherapy, family planning, treatment of sexual dysfunction); or when a long-term relationship between physician and patient is required, as in the treatment of chronic conditions or when modifications in lifestyle are required (*25*).

In this brief overview, I have considered the questions of whether female patients communicate with their providers differently from males, whether physicians communicate differently with male and female patients, whether female physicians are more effective communicators than males, and whether female physicians communicate more effectively than males with female patients in particular. We have only tentative answers to these questions. With more women entering the practice of medicine, opportunities to study sex differences in communication processes will be enhanced, and we hope that more definitive answers will be forthcoming.

References

1. National Center for Health Statistics: Health promotion and disease prevention provisional data from the National Health Interview Survey: United States, January-June 1985. Advancedata No. 119 May 14, 1986.
2. Prevention Research Center: The prevention index '85: a report card on the nation's health, summary report. Rodale Press, Inc., Emmaus, PA, 1985.
3. Pendleton, D.: Doctor-patient communication: a review. *In* Doctor-patient communication, edited by D. Pendleton and J. Hasler. Academic Press, London, 1983, pp. 5–53.
4. Inui, T. S., and Carter, W. B.: Problems and prospects for health services research on provider-patient communication. Med Care 23: 521–538, May 1985.
5. Waitzkin, H.: Information giving in medical care. J Health Soc Behav 26: 81–101, June 1985.
6. Mishler, E. G.: The discourse of medicine: dialectics of medical interviews. Ablex Publishing Corp., Norwood, NJ, 1984.
7. West, C.: Routine complications: troubles with talk between doctors and patients. Indiana University Press, Bloomington, IN, 1984.
8. DiMatteo, M. R., Taranta, A., Friedman, H. S., and Prince, L. M.: Predicting patient satisfaction from physicians' nonverbal communication skills. Med Care 18: 376–387, April 1980.
9. Hall, J. A., Roter, D. L., and Rand, C. S.: Communication of affect between patient and physician. J Health Soc Behav 22(1): 18–30, March 1981.
10. Ruzek, S.: The women's health movement. Praeger, New York, 1979.
11. Kessler, R. C., Brown, R. L., and Broman, C. L.: Sex differences in psychiatric help-seeking: evidence from four large-scale surveys. J Health Soc Behav 22: 49–64, March 1981.
12. Tueting, P., Koslow, S. H., and Hirschfeld, R. M. A.: Special report on depression research. National Institute of Mental Health Science Reports, U.S. Department of Health and Human Services, Rockville, MD, 1981.
13. Nathanson, C. A.: Illness and the feminine role: a theoretical view. Soc Sci Med 9: 57–62 (1975).
14. Gove, W. R.: Gender differences in mental and physical illness: The effects of fixed roles and nurturant roles. Soc Sci Med 19: 77–91 (1984).
15. Cooperstock, R.: Sex differences in psychotropic drug use. Soc Sci Med 12: 179–186 (1978).
16. Milliren, J. W.: Some contingencies affecting the utilization of tranquilizers in long-term care of the elderly. J Health Soc Behav 18(2): 206–211 (1977).
17. Verbrugge, L. M., and Steiner, R. P.: Physician treatment of men and women patients: sex bias or appropriate care? Med Care 19: 609–632, June 1981.
18. National Center for Health Statistics: Characteristics of visits to female and male physicians. Vital Health Stat [13], No. 49, 1980.
19. Broverman, I. K., et al.: Sex-role stereotypes and clinical judgments of mental health. J Consult Clin Psychol 34: 1–7 (1970).
20. Bernstein, B., and Kane, R.: Physicians' attitudes toward female patients. Med Care 19: 600–608, June 1981.
21. Waitzkin, H.: Doctor-patient communication: clinical implications of social scientific research. JAMA 252: 2441–2446, Nov. 2, 1984.
22. Wallen, J., Waitzkin, H., and Stoeckle, J.: Physician stereotypes about female health and illness: a study of patient's sex and the informative process during medical interviews. Women Health 4: 135–146, summer 1979.
23. Korsch, B. M., and Negrete, V. F.: Doctor-patient communication. Sci Am 227: 66–74 (1972).
24. Faden, R. R., et al.: Disclosure of information to patients in medical care. Med Care 19: 718–733, July 1981.
25. Weisman, C. S., and Teitelbaum, M. A.: Physician gender and the physician-patient relationship: recent evidence and relevant questions. Soc Sci Med 20: 1119–1127 (1985).
26. Langwell, K. M.: Factors affecting the incomes of men and women physicians: further explorations. J Human Resour 17: 261–275, spring 1982.
27. Leserman, J.: Men and women in medical school: how they change and how they compare. Praeger, New York, 1981.
28. Bean, G., and Kidder, L. H.: Helping and achieving: compatible or competing goals for men and women in medical school? Soc Sci Med 16: 1377–1381 (1982).
29. Hall, J. A.: Nonverbal sex differences: communication accuracy and expressive style. Johns Hopkins University Press, Baltimore, MD, 1984.
30. Bochner, S.: Doctors, patients and their cultures. *In* Doctor-patient communication, edited by D. Pendleton and J. Hasler. Academic Press, London, 1983, pp. 127–138.
31. Mathews, J. J.: The communication process in clinical settings. Soc Sci Med 17: 1371–1378 (1983).
32. Young, J. W.: Symptom disclosure to male and female physicians: effects of sex, physical attractiveness, and symptom type. J Behav Med 2: 159–169 (1979).
33. Scully, D.: Men who control women's health: the miseducation of obstetrician-gynecologists. Houghton Mifflin, Boston, 1980.
34. Wasserman, R. C., et al.: Pediatric clinicians' support for parents makes a difference: an outcome-based analysis of clinician-parent interaction. Pediatrics 74: 1047–1053 (1984).
35. Zare, N., Sorenson, J. R., and Heeren, T.: Sex of provider as a variable in effective genetic counseling. Soc Sci Med 19: 671–675 (1984).