The effect of the doctor's sex on the doctor–patient relationship

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SUMMARY. The differences between male and female doctors are investigated, and what patients expect from their doctors is examined. Some conclusions are drawn from the preferences which patients express for male and female doctors and from the different outcomes of male and female doctor–patient interactions.

Introduction

MUCH has been written about the interaction between doctor and patient but surprisingly little about whether the sex of the doctor makes any difference. For instance, when Mechanic (1975) looked at general practitioners' social orientation to medicine, he examined almost every conceivable variable (from "member of RCGP" to "uses of appointment system"), but failed to record the sex of the doctors. Where previous studies have examined sex differences, only the patient's sex was taken into account; the doctor was regarded as a doctor, neither male nor female. Yet it would be useful to know whether the relationship between women doctors and their patients is different from that between men doctors and theirs.

Why is this a crucial issue now? First, because increasing numbers of women are entering medical school. Second, because there are now movements and groups, such as the women's health movement and the well-woman clinics, which believe that a difference does exist. For example, well-woman clinics are staffed by women doctors on the assumption that women offer something male doctors do not or cannot offer. The women's health movement in the USA is now demanding nurse-midwife care in childbirth, as opposed to care by predominantly male doctors in hospital.

How are women doctors affected by their double socialization into female and medical roles? Do some qualities and characteristics of female socialization remain with women doctors after their medical training? The approach taken in medical school tends to be mechanistic, analytical and rational; even in the clinical phase of training, contact with patients is brushed over. These tendencies are further emphasized in hospital practice: patients are kept at arm's length, emotional contact is blocked and doctors pretend to a monopoly of knowledge. As a result doctors tend to be "distant, arrogant and patronising" (Young, 1981). Doctors seem to fear admitting ignorance and sharing decision-making, perhaps because both these practices could lead to a more equal doctor–patient relationship and a loss of power.

Women doctors are under a great deal of pressure from medical school and on the wards to conform as honorary men. Male socialization makes men detached, unemotional, strong and silent, characteristics which correspond with the kind of medical practice sketched above. But women are in a contradictory position: they are socialized to be caring, soft, gentle, emotional, involved and nurturing. Consequently, although women are recognized as good doctors, they are seen as incomplete people unless they marry and have children. But family responsibilities tend to exclude women from higher professional positions.

Women as doctors

Medical education and female socialization make contradictory demands on women medical students. While research has shown that women are more competent than men at medical studies (Walton, 1968; Roos *et al.*, 1977), women students tend to be introverted and lack confidence in themselves. The bias of medical education towards quantifiable results undervalues the qualitative aspects of care in which it seems that women make a greater contribution. Women students are more patient-orientated (Walton, 1968), have more interest in people's emotional problems (Roos *et al.*, 1977) and are more sensitive to relationship values (Cartwright, 1967).

These values and interests are undermined in medical education, and women are more intensively screened on admission with regard to motivation (see the BMA booklet *Becoming a Doctor).* These processes continue in the hierarchies of medical practice. The choice of specialty or practice for women has traditionally been heavily influenced by their sex. Mawardi's (1977) survey of American women doctors concluded that "being a

woman was a prime factor in making the specific career choice".

But as more women enter medical school, attitudes may be changing. A study of American women medical students (Bluestone, 1978) found an eagerness to work in all specialties rather than the three Ps: paediatrics, psychiatry and public health. The doctors surveyed were determined not to be second best and to have flexibility in their career models. Perhaps most importantly, these students were unlikely to substitute technology for human services and likely to be specifically involved in the health problems of women.

Patient preferences

Studies of patient preferences have found that patients like their doctors to be good at relating to them personally: "doctors should be understanding", "take a personal interest", "take time" and "explain fully" are all recurrent phrases. As Segall and Burnett (1980) noted, affective qualities were valued more highly than either procedural or administrative qualities. In addition, failure to communicate information may be a crucial area for dissatisfaction. Reynolds (1978) found that 69 per cent of patients in surgical wards were dissatisfied in varying degrees with the information they received, and Cartwright (1967) found that patients were most critical about the explanations they received from their doctors.

While male and female patients seem to expect similar qualities from their doctors, it might be suggested that these expectations are more likely to be met by female than by male doctors.

Most people seem to choose their general practitioner by geographical accessibility (Cartwright, 1967), but women patients also seem to prefer female doctors. Some American studies (Adams, 1977) suggest an overwhelming preference for male physicians. However, when we look at the patients in these studies who prefer female doctors we find that women make up a sizeable majority. Cartwright (1967) found in her original survey of British general practitioners that women accounted for 75 per cent of patients registering with female doctors, but only 50 per cent of those registering with male doctors.

Certain factors predispose women to prefer female doctors. Most Asian women prefer women to men doctors (Henley, 1979, Homans, 1980); especially in antenatal care. Gynaecological problems also predispose women to women doctors. Haar and colleagues (1975) found that 40 per cent of the women they surveyed preferred female gynaecologists. Only 19 per cent preferred males; 41 per cent had no preference. The women patients who preferred female gynaecologists felt them to be gentler, more empathic and made them feel like human beings. Perhaps the most important finding in this study was that the women felt that, no matter how good a male gynaecologist may be, he can never experience women's problems or conditions.

Past experience of women doctors can also be an influence on patient preference. Engleman concluded in his 1975 study (Adams, 1977) that ". . . more patients who previously consulted female physicians were favourably inclined toward such doctors than patients who had never consulted one". This finding suggests that preference as to the sex of the doctor is at present influenced by the distribution of women and men in medical specialties.

Doctor-patient exchanges

Outcomes of doctor-patient interactions seem to underline the differences between women and men doctors. Sawyer (1979) has shown that in doctor-patient communication, women patients tend generally to be more 'mute' than men, but that, when the doctor is female, they are more likely to have something to say during the consultation. Interestingly, Sawyer found that both men and women could talk more easily to women than men doctors. This difference has been emphasized elsewhere. Cartwright (1967) found that 63 per cent of women doctors' patients felt that their relationship was friendly rather than businesslike. Only 42 per cent of male doctors' patients found that this was so. Furthermore, women doctors in her study tended to have longer surgery consultations than male doctors. They also tended to spend more time, on average, with women patients than with men. Male doctors allowed about the same time for men and women. Another study (Dickinson and Pearson, 1979) has argued that women doctors tend to have a better relationship with dying patients and their families than male doctors.

Differences between men and women also emerge during treatments. Doctors perceive their male and female patients' problems differently and men and women doctors adopt different kinds of solutions. For example, Australian data on pseudo-patients suggest that women and men with identical symptoms are often treated significantly differently (according to sex) by the same doctor (Hansfeld, 1976). Doctors, especially male doctors, appear to take illness far more seriously in men than in women. Thus Armitage and colleagues (1979) found that investigations for a variety of symptoms/problems were significantly more extensive for men patients than they were for women.

Male doctors are more likely than women doctors to propose more orthodox and technical solutions. Cartwright and Waite (1972) discovered that, although women doctors were no more or less active in birth control than their male counterparts, they were more likely to consider alternatives for women who were worried by the health implications of oral contraception. Male doctors were more likely to reassure the woman and persuade her to continue with the Pill. This tendency also emerges in prescribing patterns: Hemminki (1974) found that women physicians are less likely than men to prescribe psychotropic drugs, and Cypress (1980) found that psychotropic drugs were prescribed in

33 per cent of visits to male psychiatrists but in only 17 per cent of visits to female psychiatrists.

Conclusion

Four propositions are put forward in this article. Firstly, that women doctors and medical students are different from their male counterparts in certain respects. These differences seem to reflect differences in male and female socialization. Secondly, that the qualities which women doctors tend to have, and which women in general tend to have, correspond with the qualities patients desire in a good doctor. Thirdly, that female patients are more likely than male patients to prefer women doctors, and in effect recognize the link between the first and second propositions. Male patients, although they seek similar characteristics in their doctor, are less likely to associate these characteristics with a woman. Fourthly, the outcome of doctor–patient exchanges is significantly different in a number of respects according to whether the doctor is a man or a woman. Communication is easier, more time is given, drugs are less frequently dispensed and women patients are treated more seriously if the doctor is a woman.

All in all, it would seem to make sense for patients, particularly women, to seek out women doctors. This is suggested because it seems that women doctors bring into their professional lives certain features of female socialization which are positive. These attributes could well benefit male doctors. In other words, if it is true that not all aspects of female socialization are negative, then not all aspects of male socialization are positive; male doctors and their patients may suffer from patterns of socialization which encourage men to be tough and unemotional.

Medical teachers might well consider supplementing the influence of growing numbers of women in the medical schools with a programme of medical education aimed at socializing male medical students into losing some 'maleness' and gaining some 'femaleness', that is gaining such benefits of female socialization as care, warmth, patience and love.

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Coronary heart disease

Twelve hundred and thirty-two healthy, normotensive men at high risk of coronary heart disease were selected for a five-year randomized trial to show whether lowering of serum lipids and cessation of smoking could reduce the incidence of CHD. Mean fasting serum triglycerides fell by 20 per cent in the intervention group compared with controls. Mean tobacco consumption per man decreased by 45 per cent more in the intervention group than in the control group. At the end of the observation period the incidence of myocardial infarction (fatal and non-fatal) and sudden death was 47 per cent lower in the intervention group than in the controls. It is concluded that in healthy middle-aged men at high risk of CHD, advice to change eating habits and to stop smoking significantly reduces the incidence of the first event of myocardial infarction and sudden death.

Source: Hjermann, I. *et al.* (1981). Effect of diet and smoking intervention on the incidence of coronary heart disease. *Lancet,* **2,** 1304-1310.