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EDITORIAL

# The role of gender in healthcare communication

Good communication between doctors and patients is crucial for a high quality of healthcare. Gender is one of the factors that determine the communication, apart from, e.g. age, education, ethnicity, and type of health problems, especially mental health problems. This has been shown in several studies and will also be clear from the studies reported in this Special Issue.

Until now, studies have been focused on gender as an individual variable and not as a construct grounded in a conceptual framework to explain why gender differences exist [1]. Street [2] analysed previous findings from the perspective of an ecological model of communication in medical consultations. At the heart of his model is the idea that individual differences cannot be examined in isolation of other variables or processes that also count for communicative action. The evidence reviewed indicates that gender differences may come from several sources including— among others—differences in men's and women's communication styles. Taking into account the effect of context in healthcare has also been emphasized in recent studies into the non-specific (placebo) effects in healthcare [3–6]. The review study of van Dulmen [3] shows that some of the important non-specific factors promoting patient health are the constituents of the communication process, in particular affective communication (empathy, reassurance) transmitted both verbally [6–9] and non-verbally [10]. Street's theoretical approach may help to identify context factors and may enhance the quality of healthcare and, therefore, patient health.

Likewise based on a theoretical background, Bylund and Makoul [11] describe the development and initial validation of a measure of a specific element of communication, i.e. physician's empathic communication to a patient. This study provides an additional perspective on the relationship between gender and empathy in physician–patient communication and may be useful for educators in helping physicians to learn how to communicate empathically. Their study shows that male and female patients were equally likely to name an emotion in their empathic opportunity and to create such an opportunity.

These results were consonant with Hall and Roter's [12] findings in their meta-analytic review that male patients and female patients have no difference in propensity for emotional talk. However, the differences in patient behaviour as documented in this study reflect a heightened level of comfort, engagement, disclosure, and assertiveness on the part of patients speaking to female physicians. Both male and female patients seem to feel more empowered in interactions with female doctors.

Brown et al. [13] deal in their paper with the actively participation of patients in their communication with physicians, focusing on the process of women's decision-making about their healthcare, which was also discussed in Street's [2] and Hall and Roter's papers [12]. Brown describes three qualitative studies on key areas regarding women's health, which span the life cycle. Informationsharing appeared to be an essential component of care and a central aspect of the decision-making process. The women in Brown's study desire and need to be actively engaged in how and who will participate in their present and future health and well-being. The exploration and the understanding of the context is also emphasized in this paper, as being important for women making decisions about their health.

Meeuwesen et al. [14] focuses on communicating about one specific health problem, i.e. fatigue. Fatigue is a common health problem but it is seldom explicitly on the agenda in general practice visits, and it is also often ignored. Yet, chronic fatigue complaints may affect patients' quality of life [15]. Gender differences do matter, which is also shown in this study, e.g. by more psychosocial talk by female than male patients, and more affectiveness, and more sensitivity of female doctors to the patients' need. She pleads for a gender-sensitive approach in medical communication research.

Communication about specific health problems that are often not recognised by primary care doctors is also the theme of the paper of Sleath and Rubin [16]. She describes the influence of patient gender and ethnicity on doctor– patient communication about depression and anxiety. An interesting finding is that whether patients saw physicians of the same gender and ethnicity as themselves did not significantly influence any aspect of communication about anxiety or depression.

Likewise, the roles of gender and ethnicity (cultural background) were the topics of an international comparative study in Western-European general practices [17]. Doctor and patient gender influence the chance of a psychosocial communication pattern, especially if female general practitioners talk with female patients. Different cultural norms and values may be related to doctor–patient communication, as is shown by communication patterns of gender–dyads per country, especially in male doctors' consultations.

With the continuous feminization of medical care in the Western world, it becomes still more important to know how female and male doctors communicate with their female and male patients. Especially consultations of female doctors and male patients will be more common in the future. Therefore, gender should systematically be included in healthcare research. However, having gained more knowledge about gender differences does not automatically imply that this knowledge is applied in medical education, medical practice and health policy. Gender mainstreaming will be of utmost importance to achieve the integration of the gender perspective in the areas just mentioned. The development of applicable strategies for the implementation of the knowledge on gender differences will be a difficult but necessary challenge for healthcare educators and professionals in order to achieve a gender-sensitive healthcare.

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