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Gender and Communication Style in General Practice: Differences Between Women's Health Care and Regular Health Care

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ABSTRACT

Objectives. Differences were investigated between general practitioners providing women's health care (4 women) and general practitioners providing regular health care (8 women and 8 men). Expectations were formulated on the basis of the principles of women's health care and literature about gender differences.

Methods. Data were used from 405 videotaped consultations of female patients (over 15 years). Roter's Interaction Analysis System (RIAS) was used to measure the verbal affective and instrumental behavior of the doctors and their patients. These data were supplemented by various nonverbal measures. The data were analyzed by means of multilevel analysis.

Results. Doctors in the women's health care practice (called Aletta) look at their patients and talk with them more than other doctors. The general practitioners have approximately the same affective behavior, but the Aletta doctors show more verbal attentiveness and warmth. They also give more medical information and advice. Most of the characteristics of Aletta doctors fit female doctors providing regular health care too. Male doctors show a less communicative behavior in most respects. The differences between general practitioners are reflected in their patients' communication style.

Conclusions. The integration into regular care of some aspects of doctor-patient communiciation that were found in women's health care might be desirable in the light of the further improvement of the quality of care for women and men.

In the Netherlands, female general practitioners are providing women's health care in a general practice called Aletta, after Aletta Jacobs the first Dutch female feminist physician. The practice was established in 1985 and is allied to the Centre for Women's Health Care "Aletta," a national expert's centre that has developed and promoted knowledge of women's health care since 1980. The general practitioners running the practice have qualified in the normal way and provide care for all health problems and not only for female problems.

However, they emphasize different aspects of care, in accordance with the principles of women's health care, which had evolved from the feminist movement of the early 1970s. Guidelines and standards have been developed with respect to health problems, especially female problems. By using these examples the general practitioners try to treat their patients in the same way. They frequently communicate and discuss with each other. The Aletta practice is the only women's health care practice known where general practitioners provide this specific type of health care, in the Netherlands as well as in other western countries.

The principles can be summarized as:1 consideration of patient's gender identity and gender roles; consideration of the patient's personal and social situation; respect for the patient; encouragement of the patient's own responsibility and self-determination; demedicalization (eg, prevention of labelling daily life problems as biomedical problems). The first two principles are the most distinctive ones. The other three principles already are part of the body of thoughts that is being propagated by the Dutch College of General Practitioners, but they are especially emphasized in women's health care. Particular attention is being payed to information-giving, which is an important means for realizing the principles. It should be emphasized, however, that regular health care and women's health care have the same goal-improvement of the quality of care.

It is expected that the specific principles of women's health care influence doctor-patient communication. The objective of the current study is to investigate whether there are differences between women's health care and regular health care (both female and male doctors) in terms of the communication style of general practitioners and female patients, and to explore possible explanations for these differences.

Most studies found differences between the communication of female and male doctors with their patients.2,3 Empirical studies show that female physicians are more empathic,4,5 more accepting of patients' feelings,6 and giving more attention to psychosocial issues.7 Female doctors were more likely to engage in therapeutic listening and counseling,8 and were more egalitarian in their relationships with patients.9 Male physicians were more imposing and presumptuous,10 and they reassured their patients more often.11 Female doctors were more nondirective, talked more, and were more engaged in question-asking and information-giving than male doctors,3,7,12,13 and spent more time with their patients,3 especially with female patients.11

Patient expectations and the physician gender differences could be mutually reinforcing during the medical encounter. It was found that patients of female physicians talked much more than male physicians' patients did and, similarly to female physicians, engaged in more positive talk, more partnership-building, question-asking, and information-giving related to both medical and psychosocial topics.3

The overall impact of physician gender on the communication between female doctors and female patients compared with male doctors and female patients is expected to be more listening, showing greater affective instrumental behavior, and paying more attention to psychosocial aspects.

On the basis of the principles of women's health care, it is expected that consultations of women's health care doctors, in comparison with consultations of regular care doctors (both female and male) will be characterized by less speaking time of the doctor and more speaking time of the patient; more patient-directed gaze; more affective as well as instrumental behavior and (within instrumental behavior) more attention to psychosocial aspects, by both doctors and patients.

METHOD

Consultations of female patients with their general practitioners were videotaped in their entirety, with the exception of physical examinations, during which only the verbal doctor-patient communication was recorded. The observation of videotaped consultations has been proven to be a reliable method for analysing doctor-patient communication.14,15

The data is derived from 405 consultations of female patients (>= 15 years). The sample is restricted to female patients because 85% of the practice population of "Aletta" are women. Three groups of general practitioners are included in this study: (1) four general practitioners of the group practice Aletta, (2) eight female general practitioners, and (3) eight male general practitioners (both the female and male groups provide regular health care). The regular care doctors were included in a Dutch national survey of general practice.16 The type of health problems presented by the female patients in the videotaped consultations show only a few differences.

Roter's Interaction Analysis System (RIAS)17 was used to measure the affective or socioemotional (care-oriented) behavior as well as the instrumental or task-related (cure-oriented) behavior of general practitioners. The system is applicable both to verbal and nonverbal behavior.14 Roter's Interaction Analysis System codes each statement or complete thought made during the visit by either physician or patient into one of 34 mutually exclusive and exhaustive categories. The dimensions of affective behavior are:

Verbal attentiveness (agreement, paraphrase, empathy, legitimize, partnership);
Showing concern (worry, reassurance);
Social behavior (personal remarks, jokes, approval); and
Disagreement.

Instrumental behavior includes giving information; asking questions and counselling, each about medical as well as psychosocial aspects; asking clarifications (bids, ask for understanding); giving directions (directions, transitions). Affect ratings were measured by a 6-point scale, measuring anger/irritation; anxiousness/nervousness; dominance/assertiveness; interest/concern; warmth/kindness. The consultations were coded by three observers who had been trained for the RIAS observation scheme. Each of the three observers coded 20 consultations to calculate the reliability of the observation scores. Reliability mainly proved to be high, with most of the interobserver correlations (Pearson'Product Moment Correlation) between .70 and .95

Because of the nesting of 405 consultations within 20 general practitioners, there are two major statistical problems to address. The first is the clustering of consultations among general practitioners. The consultations of the general practitioners would be, on the average, more alike than consultations of different general practitioners. The second problem is that all the dependent variables are at the level of consultations, whereas the independent variable of main interest is at the level of the participating general practitioners. To solve these problems multilevel analyses were used to analyze the data.

RESULTS

General Practitioners' Behavior

The length of consultations did not differ significantly between the three groups of general practitioners (Table 1). Aletta doctors talk more than either other female or male doctors during the visit. With regard to the total speaking time, Aletta doctors use 54% of the time, which is about the same percent-age as male doctors (53%), whereas other female doctors talk less than their patients (46%). Aletta doctors look at their patients much more (patient-directed gaze) than the other doctors, who do not differ from each other in this respect.

The general practitioners providing regular care show approximately the same affective behavior in consultations (measured by affect ratings), but the Aletta doctors differ from them in some respects (Table 2). The Aletta general practitioners are less often irritated or angry than their colleagues providing regular health care. However, all the doctors are only rarely angry or nervous. The Aletta doctors show more warmth during visits than male

doctors. There was no difference in the total of affective behavior. However, the affective behavior of Aletta doctors, measured by means of the RIAS observation scheme, differs from male doctors' behavior in showing more verbal attentiveness.

The total number of instrumental "utterances" was higher for Aletta doctors than for male doctors. The Aletta doctors give more medical information to their patients than doctors in regular care, and more often counsel them about medical issues. The Aletta doctors less often ask their patients questions about psychosocial matters (that are not related directly to the problem) than do other female doctors.

[TABLE 1]

[TABLE 2]

Female Patients' Behavior

The Aletta patients have more speaking time than patients of male doctors, but less than female doctors' patients, who talk the most (Table 1). The affective ratings show that female patients are less irritated and nervous when they visit a female doctor than a male doctor (Table 3). Aletta patients are more assertive compared with other female patients. At the same time, the patients of female doctors are more friendly than male doctors' patients. The Aletta patients are more verbally attentive than other female patients, whereas patients of other female doctors show more social behavior than patients of either their male colleagues or the Aletta doctors.

Patients' instrumental behavior is especially different with respect to information-giving. Patients of female doctors inform their doctor, especially more about psychosocial issues by comparison with other patients, and also more about medical matters than male doctors' patients. Aletta patients ask their doctor for clarification less often than other female patients.

[TABLE 3]

DISCUSSION

Some restrictions have to be made before the results are discussed. Firstly, while the number of consultations (n = 405) is sufficient, the number of general practitioners studied is fairly small. Unfortunately, this problem cannot be solved by including more of such women's health practices, because there is just one such practice. But, we did everything possible to be able to compare the Aletta doctors with the other doctors, such as selecting general practitioners of group practices, and using multilevel analysis. Furthermore, the advantage of having only one women's health practice is that the study of the Aletta practice is a population study instead of a random sample. Notwithstanding the limitations, the study of the women's health care practice Aletta is an extraordinary and important opportunity to gather and to expand the knowledge about such an innovative and forerunning practice as Aletta, both from a social and a scientific point of view.

The current study confirms the results of other studies that verbal communication is shortest in medical consultations with opposite gender dyads, ie, male doctors with female patients, and that patients feel more at ease and less embarrassed in communication with female doctors.3 Aletta doctors and their patients talk with each other the most, which is largely

attributable to the doctors. The last finding is contrary to our expectation that assumed that Aletta doctors would talk less than other doctors and is probably related to the greater amount of information given by the Aletta doctors by comparison with other doctors. It also was expected that Aletta patients would talk more than other patients. This is found to be true for the comparison with patients of male doctors. But, in contacts of other female doctors patients talk the most. The finding seems to be related to more talk about psychosocial matters and by more social talk. Thus, the patients of female non-Aletta doctors have even more opportunity to tell their problems, especially nonmedical ones.

Relative to the conversation time, Aletta doctors look at their patients the most, the other groups do not differ in this respect. So, patient-directed gaze seems to be related to the type of health care, and not to opposite gender dyad. This is an important finding, because the proportion of time the doctor looks at the patient shows interest in the patient and her problems, and an inviting attitude may encourage patients to talk about worries that would otherwise remain concealed.[18,19] The positive influence of looking at the patient might be related to the relatively high registration by the Aletta doctors of psychological and social problems.[20] More attention should be given to this important aspect of nonverbal communication when future doctors are being trained in communication skills.

The three groups of general practitioners differ in verbal attentiveness but not in other aspects of affective behavior, which is contrary to our expectation. The Aletta doctors show more empathy (verbal as well as by eye contact), paraphrasing, encouragement, support, and sympathy than male doctors. They also are more kind and less irritated than male doctors. Female doctors providing regular care show about the same affective behavior.

It seems that the Aletta patients are like their doctors in this respect. They too are less irritated or anxious than male doctors' patients. Patients of female doctors are more like each other than like male doctors' patients. Women visiting male doctors tend to be more irritated, more nervous, and less kind. The findings emphasize the better understanding, the easier and more informal communication between doctors and patients of same gender than between those of opposite gender, a fact often cited in the literature. It makes it easy to understand why-when there is a preference-many women prefer female doctors.[21,22]

Aletta doctors give more attention to instrumental aspects as compared with other doctors. The reason is that Aletta doctors give more medical information, about illnesses and their possible treatments, and that they counsel their patients more about medical issues. Information-giving has proven to be of great importance for patients,[18] and it goes back on the principles of women's health care, like encouraging patients' own responsibility and self-determination. In line with the high amount of information-giving is the copious supply of information materials in the practice as well as in the allied Women's Health Centre. An additional explanation may be that the Aletta doctors, being specialists in women's health problems to some extent give therefore more "specialist-like" information and counselling, especially on biomedical issues.

Aletta patients give about an equal amount of medical information compared to other female doctors' patients, but more than male doctors' patients do. All patients ask relatively few medical questions, possibly because they get enough.

Female non-Aletta doctors ask their patients more about psychosocial and lifestyle issues that are not directly related to health problems, but may be important in the whole context of those problems. An explanation could be that they know one another for a longer time and better, and therefore are in general more intimate, especially with patients having psychosocial problems.

Likewise, female doctors' patients inform their doctor relatively more about psychosocial matters than Aletta doctors' and male doctors' patients. This finding is likely a reflection of the reciprocity effect. For, when a doctor asks psychosocial questions, the patient will easier disclose psychosocial information. This finding is reasonable because one may suppose that the doctors have a more powerful effect on setting the stage in regard to conversational style than patients do.[23]

Reviewing the findings, there is apparently a discrepancy between theory and practice. Most of the expectations were not met, particularly about general practitioners' communication style. The rather high similarity of Aletta and other female general practitioners seems to indicate that all of them aim at a good communication with their patients, as expressed either in the principles of women's health care, or in the body of thoughts that is being propagated by the Dutch College of General Practitioners.

The communication style of the Aletta doctors may best be described as both caring-creating a good relationship (affective behavior) and curing-giving a great deal of information and advice (instrumental behavior). The principles of women's health care seem partly to be reflected in their (verbal and nonverbal) communication with their female patients. Most of the characteristics of Aletta doctors fit female doctors providing regular health care too. Male doctors are in almost every respect less pronounced than female doctors. The differences between general practitioners are reflected in their patients' communication style.

It appears that not only women's health care but also regular care has done much to enhance the quality of care for women. Nevertheless, the integration into regular care of some aspects of doctor-patient communication that were found in women's health care, like patient directed gaze and information giving, might be desirable in the light of the further improvement of the quality of care for women and men.

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TABLES

	Consultations		
	Aletta GPs ($n = 89$)	Female GPs ($n = 164$)	Male GPs ($n = 152$)
Mean consultation length	11.98	11.60	10.95
% GPs' speaking time	39.21[b,c]	31.23	31.44
% pats' speaking time	33.12[b,c]	36.25[d]	28.28
% eye contact	68.60[b,c]	51.40	46.47

[a]Means are calculated in Hierarchical Linear Models. Number of Aletta GPs is 4, number of women GPs is 8, and number of men GPs is 8.
[b]$P \leq 0.05$ Aletta GPs versus female GPs.
[c]$P \leq 0.05$ Aletta GPs versus male GPs.
[d]$P \leq 0.05$ female GPs versus male GPs.

Table 1. Mean Length of Consultation, and GPs' and Patients' Mean Scores[a] on Speaking Time and Eye Contact, by Type of GP, and Controlled for Patients' Age, Type and Number of Problems Presented and Type of Consultation (First or Repeat Visit)

	Consultations		
	Aletta GPs (n = 89)	Female GP (n = 164)	Male GPs (n = 152)
Affect ratings			
Anger/irritation	0.98[b,c]	1.10	1.13
Anxiousness/nervousness	0.98	1.05	1.11
Dominance/assertiveness	4.79	4.59	4.74
Interest/concern	4.82	4.65	4.57
Warmth/kindness	4.93[c]	4.69	4.58
Affective behavior			
Total	47.02	43.05	38.07
Verbal attentiveness	39.85[c]	32.74	29.08
Showing concern	2.84	3.84	3.64
Social behavior	4.34	6.52	5.39
Disagreement	0.17	0.35	0.25
Instrumental behavior			
Total	65.57[c]	60.23	50.71
Giving information			
Medical	32.29[b,c]	24.93	23.23
Psychosocial	1.70	1.24	0.78
Asking questions			
Medical	13.79	15.79	13.30
Psychosocial	1.72[b]	4.16	2.68
Counseling			
Medical	16.37[b,c]	12.08	9.44
Psychosocial	1.40	1.90	1.23
Asking clarification	6.17	6.64	6.35
Giving directions	18.86	15.71	20.53

[a]Means are calculated in Hierarchical Linear Models. Number of Aletta GPs is 4, number of women GPs is 8, and number of men GPs is 8.
[b]$P \leq 0.05$ Aletta GPs versus female GPs.
[c]$P \leq 0.05$ Aletta GPs versus male GPs.
[d]$P \leq 0.05$ female GPs versus male GPs.

Table 2. Mean Scores[a] of GPs' Behavior in Consultations, by Type of GP, and Controlled for Patients' Age, Type and Number of Problems Presented and Type of Consultation

	Consultations		
	Aletta GPs (n = 89)	Female GPs (n = 164)	Male GPs (n = 152)
Affect ratings			
Anger/irritation	1.07[c]	1.06[d]	1.22
Anxiousness/nervousness	1.17[c]	1.34[d]	1.77
Dominance/assertiveness	4.65[b,c]	4.31	4.38
Interest/concern	4.83	4.77	4.81
Warmth/kindness	4.55	4.60[d]	4.42
Affective behavior			
Total	46.45	40.98	37.51
Verbal attentiveness	34.49[b,c]	24.56	22.70
Showing concern	6.37	8.06	8.17
Social behavior	5.75[b]	8.64[d]	6.79
Disagreement	0.20	0.42	0.42
Instrumental behavior			
Total	71.77	85.76[d]	62.97
Giving information			
Medical	47.84	50.18[d]	42.86
Psychosocial	18.43[b]	30.46[d]	15.35
Asking questions			
Medical	4.13	3.89	3.57
Psychosocial	0.10	0.01	0.03
Asking clarification	2.36[c]	3.08	3.67
Giving directions	2.45	1.98	2.68

[a]Means are calculated in Hierarchical Linear Models. Number of Aletta GPs is 4, number of women GPs is 8, and number of men GPs is 8.
[b]$P \leq 0.05$ Aletta GPs versus female GPs.
[c]$P \leq 0.05$ Aletta GPs versus male GPs.
[d]$P \leq 0.05$ female GPs versus male GPs.

Table 3. Mean Scores[a] of Patients' Behavior in Consultations, by Type of GP, and Controlled for Patients' Age, Type and Number of Problems Presented and Type of Consultation