

Looking into the differences of physician gender in medical practice

The feminisation of the medical profession is a relatively new phenomenon that has grown dramatically over the past two decades worldwide. Indeed, there is an increasing percentage of women in medical professions and its strong impact on medical knowledge and clinical practice is an issue for ongoing debate^{1,2}. Over the past century, women have progressed from being practically excluded from medical schools to forming the majority of new graduates in medicine, a trend referred to as the “feminisation of medicine”³. Women currently constitute more than 50% of the medical workforce gravitating towards general or primary care fields, and the number of women enrolled in specialist training programmes has risen considerably. As in much of the Western world, over the past two decades, the majority of medicine graduates have been women. The specialties that have been most widely feminized worldwide are primary care in family medicine, obstetrics and gynaecology, paediatrics and psychiatry. Surgical specialties (i.e. general and digestive surgery), the prerogative of men in years gone by, have been “colonised” by female doctors. This change must be analysed with special attention, focusing on the differences between female and male doctors. A complex social system may influence the working lives of male and female doctors differently, with female doctors being torn between behaving according to the stereotypically ‘feminine’ traits of being a woman and the ‘masculine’ stereotype of being a doctor. Potential differences in practice patterns between male and female physicians may have important clinical

implications for patient outcomes because male and female physicians practice medical care differently. Despite the substantial increase in the proportion of women practicing medicine today, cultural conventions and gender-related customs in medicine continue to exist and may influence the working practice of male and female doctor. Academic literature documents gender differences in the medical profession. Gender is a peculiar characteristic that is able to influence professional style. Male and female physicians have been shown to have different practice styles, with regard to medical communication, technical skill sets and patient-centred approaches^{4,5}. Sex and gender represent factors that modify the way doctors and patients communicate, with differences in the duration of consultations and the style and content of communication⁶⁻⁹.

Unlike male consultants, who often adopt direct, abrupt and didactic communication styles, female consultants are more understanding of problems with nursing staff, more affable with patients and less inclined to immediately redirect patients’ conversation back to their line of medical enquiry. Female consultants display varying levels of dominance in different contexts, for example, they appear assertive and formal with medical colleagues but often more friendly, approachable and personal with patients and nurses. Women tend to use more affective communication during consultations, with greater displays of nurturing, empathy and sympathy through their verbal and body language. The working style of female consultants, including relatively lower dominance and a more holistic approach, may contribute to reduced overall activity if they struggle to gain support from col-

leagues or if consultations overrun. Gender differences are particularly apparent when discussing upsetting news with patients. In routine conversation, differences in the interpersonal style of women compared with that of men are well documented. Male consultants, although clearly sympathetic, tend to focus on biomedical information. Female consultants convey greater warmth through their voice and body language and use physical contact more frequently. Some male consultants mention discomfort when discussing personal issues with patients, and also a concern that this can lead to excessive patient conversation, referred as “opening the floodgates”. Female consultants routinely ask patients if they have any questions at the end of consultations, but this occurs less often with men. This opportunity is often taken by patients to open social conversations, raise medical concerns that are outside the consultant’s specialty or to discuss psychological aspects of their condition. Women disclose more information about themselves in conversation, they have a warmer and more engaged style of nonverbal communication, and they encourage and facilitate others to talk to them more freely and in a more intimate way. Women are also more accurate in judging others’ feelings expressed through nonverbal cues and in judging others’ personality traits. Female doctors engage in a range of communication styles that may be associated with longer consultation times (medical appointments with female physicians are, on average, two minutes longer than those of male physicians), including a more ‘partnership-building’ approach which encompasses behaviour such as encouragement, reassurance, lowered dominance, positive talk, active partnership behaviour,

psychosocial counselling, psychosocial questions and emotionally-focused talk^{4,10}. Particularly, the lower dominance in interactions may also relate to patients' greater tendency to discuss 'additional' topics. On the basis of these gender-linked conversational differences, researchers have speculated for a long time that female physicians may find it easier than male physicians to engage in communication that can be considered patient-centred. Indeed, Tannen¹¹ uses the terms "report talk" and "rapport talk" to make a distinction between the communication styles of men and women. The potential impact on the quantity of care provided by female consultants and their greater tendency to engage in a patient-centred approach also have implications for the quality of care provided. Tsugawa et al.¹² have reported that female physicians may provide higher-quality care and that elderly hospitalised patients receiving impartial care from female internists had 30-day lower mortality and readmission rates compared with patients cared for by male internists. As regards technical skill sets, recent literature has shown that female physicians may be more likely to adhere to clinical guidelines and provide preventive care more often than their male colleagues. Female internists appear to have better outcomes for inpatient care than their male peers and, compared with male physicians, female physicians are more likely to practice evidence-based medicine and perform as well or better on standardised examinations. Taken together, these findings indicate that potential differences in practice patterns between male and female physicians may have important clinical implications for patient outcomes and that male and female physicians may practice differently. Patient-centredness in healthcare is important, suggesting that medical care may affect patients' emotional health, physiological outcomes and efficacy of care and improve treatment program compliance^{13,14}. Differences between male

and female approaches to the management of patient outcome exist but currently remain unexplained. Indeed, a growing number of articles published in the gender-specific medicine field investigate the sex/gender disparities in the development of diseases¹⁵, whereas the gender perspective in the medical professions is a neglected issue and constitutes a fundamental challenge for the improvement of human health. Finally, it is fundamental to stress the importance of more rigorous scientific investigations with appropriate statistical analyses to increase research in this field. In actual fact, gender awareness in the medical professions is essential to the planning and implementation of a new way of practicing medicine. Insight into gender differences could help us to understand correctly why gender diversity in medical care exists and how its influence on healthcare organisations in terms of physician productivity, patient compliance and satisfaction and the efficacy of care could guide future medical initiatives¹⁶.

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