FROM THE THIRD GENEVA CONFERENCE ON PERSON-CENTERED MEDICINE: CULTURAL DIVERSITY AND PERSON-CENTERED HEALTH CARE

Person-centered Care and Gender Diversity

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Introduction

As part of important efforts to provide person-centered care, the particular role of gender as an underlying social determinant in shaping the interaction between clients and providers, while often acknowledged, is still poorly understood. A definitive evidence base has yet to be established and most current data derive from descriptive studies, or evaluations of relatively small-scale interventions.

In this review, I address the question as to whether there are differential patterns of care provided by male and female healthcare workers to male and female clients and how gender-based discrimination might impact on provider-patient interactions.

Gender-based discrimination refers to any unfair or unequal practices based on gender identity, roles and relations and which prevents women and men of different sociological characteristics and ages from enjoying their human rights, particularly in the context of this article, the right to health.

Methods

This article reports the results of a literature review of peer-reviewed studies. Initial searches for research studies and meta-analyses were carried out on Pubmed using combinations of key words. Grey literature was identified through general Web searches on Google, Google Scholar and more focused reviews of relevant Web sites.

The selection of the articles was guided by the following questions:

1. Are different patterns of care provided by female and male health workers as a function the client's gender?
2. Do female clients show a preference for a provider's gender?
3. Are there harmful effects of individual and institutional gender norms within the context of client-provider interaction?

The following indices were used to define poor quality of interaction:

- lack of privacy and confidentiality
- poor communication between providers and patients, in terms of verbal abuse
- failure to communicate medical and health related information fully
- lack of a rights based approach that fails to give patients information to enable them to make informed choices and consent on the part of the provider

Initial database searches identified 118 articles from which all titles and abstracts were reviewed by one reviewer. The period of review was 1995 to 2009. 16 articles were finally identified for full text review.

Results

Differential patterns of care by male and female health workers:

Much of the data on the significance of provider gender emerges from developed countries. Overall, findings point to the fact that there are no gender differences in the nature and extent of biomedical information provided during the

consultation. Female physicians were found to engage in significantly more active partnership behaviours such as 'positive talk', psychosocial counselling, psychosocial question asking and 'emotionally focused' talk. They also spend on average two minutes longer with clients as compared with male physicians [1].

A number of studies has shown differences in treatment as a function of patient or physician gender. For example, one observational cross-sectional study carried out in Germany specifically examined the interactions between the physician's gender and medical treatment of chronicle heart failure. This study found that female patients were less likely to receive guideline-recommended treatment than males. With the success of treatment lower in female compared with male patients. The authors concluded that there was no difference in the treatment of males or female patients by female physicians, whereas males physicians used significantly less medication and lower doses in female patients [2].

Other studies have demonstrated that the patient's gender and physician's gender influence drug treatment in patients with heart failure [3,4], where patients treated for myocardial infarction had different drug treatments as a function of patient gender. In female patients, symptoms of coronary heart disease were significantly more often misinterpreted than in male patients. One reason for this could be a physician-related shift of diagnostic thinking away from the consideration of an organic cause to a psychogenic one, especially when symptoms are dependent on psychologically stressful situations [5].

Client preferences for provider's gender

The significance of provider gender has received most attention in Obstetrics and Gynaecology. Studies carried out in the USA have found that only a minority of women felt strongly about their provider's gender and provider choice was more a function of other attributes such as experience, communication, style and technical expertise [6-8]. In contrast, another study undertaken in the United Kingdom showed that women's preferences change according to the particular problem or procedure in question: a female health professional is not important to most women when they are consulting about general problems, but is more important for screening for mammography and particularly important for gynaecological health problems [9]. Other authors report similar findings when examining the preferences expressed by women for male and female gynaecologists. In cases where women preferred female gynaecologists, they were concerned with emotional factors and the experience of female biology, while a few women who preferred a male considered them to be more capable both emotionally and technically.

In highly patriarchal societies, the gender concordance between provider and client is important because of social, cultural and/or religious norms and practices which not only demarcate gender roles, but also restrict social and physical contact between men and women [10]. A qualitative study carried out in Cuba, Thailand, Saudi Arabia, and Argentina examined the experience of women seeking antenatal care and found that female doctors were preferred by Saudi and Thai women although Cuban women indicated being equally comfortable with both male and female doctors, even when warned against male doctors [11]. There is evidence, therefore, from a number of studies and evaluations that patients may avoid presenting for care at specific facilities because of the gender of the health care workers employed there. They may not think it acceptable, or their families might not feel it acceptable, for them to see health care workers of a given gender.

The effect of gender norms in provider-patient interactions

Most of the available literature which has examined the effect of gender norms on provider-patient interactions is descriptive, and focuses only on certain aspects of health, such as maternal and reproductive health. It is important to consider how transgressing gender norms can lead to a real breakdown in provider practice. This seems to be particularly the case in reproductive health services and in cases of women seeking help after gender-based violence. Patients may also avoid health care workers because of the fear that professional staff will be judgmental of the medical condition for which they are seeking help: for example: abortion, contraception, treatment for sexually transmitted infections (STIs), feeling that they have transgressed some societal norms to need to access these services. For example, in one study carried out in South Africa, health care workers were reported as making judgments of women who they felt should not be having children either because they were too young, because they already had many children, because they were too old, or not married, etc [12].

The abuse of patients by health care providers, which may take many forms, is a critical issue. A range of factors, including gender stereotyping are of relevance here. All patients, especially women and women who are socio-economically disadvantaged on account of race, class, age or property ownership status are particularly vulnerable to abuse. In relation to physical abuse, there is a large internationally derived literature on the physical abuse of women in labour by health care workers. As discussed earlier, verbal abuse of patients is relevant here, particularly when patients are accessing or trying to access reproductive health services [13]. The ways in which sexual assault survivors were treated by health care workers in many countries are often extremely judgmental in their nature and characterised by rude verbal abuse of women often linked to factors associated with health care workers presuming that women have transgressed certain gender norms.

While acknowledging the need to empower women of all ages at the societal level, it is asserted that health systems are "core social institutions". How people are treated in these core institutions forms an important part of experience of what it means to be socially marginalized or disempowered. Provider attitudes illustrated by the examples described above of poor and young women's experience of verbal abuse and scolding when they try to access reproductive health services, demonstrate some of the negative effects of gender discrimination on provider-patient interactions.

Conclusions

There is a growing evidence base across many countries and across many medical conditions in terms of diagnosis, treatment as well as patient adherence and patient satisfaction, that gender has a significant impact on provider-patient interactions. The impact of gender stereotypes and biases within the provider-patient interaction has been shown to be harmful for women as well as for men. With men, gender norms often make it difficult for them to utilize health care or express feelings of vulnerability. It is surprising, perhaps, that although there is a substantial body of literature that concludes that gender is an important factor that shapes the quality of care that patients receive, very few articles look in detail at the patient-provider interaction and describe or theorize the way in which gender impacts on this interaction. Indeed, no currently published studies appear to have investigated whether patients are more passive in their interaction with male providers compared with female providers. Likewise the factor of whether the interaction of gender with class and ethnicity of the provider influences the interaction remains uninvestigated, as does the question of whether it is more important for patients to consult with providers of their own race and ethnicity and gender or whether this is of secondary importance.

With regard to communication, gender dynamics appear clearly to affect the way patients communicate with health care workers as well as how they understand and follow treatment. Other factors are issues of literacy and language proficiency among women who tend to be less well educated and the belief that the patient is unable to ask relevant questions, difficulties mediated by a range of social factors, including gender. Sexual and reproductive health services are particularly impacted by gender bias and discrimination. Indeed, gender norms around sex and reproduction are particularly strong and there is also evidence that being seen to transgress gender norms elicits particularly strong reactions from health care workers. It is suggested that health workers delivering these specific services are those that need particular training and ongoing support on issues around gender. However, addressing gender biases and discrimination calls for action on multiple levels given the complexities of the patient-provider interaction.

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