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Women's Experiences and Expectations of the Physician-Patient Relationship

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To the Graduate Council:

I am submitting herewith a dissertation written by Jill Denise Compton entitled "Women's Experiences and Expectations of the Physician-Patient Relationship." I have examined the final electronic copy of this dissertation for form and content and recommend that it be accepted in partial fulfillment of the requirements for the degree of Doctor of Philosophy, with a major in Psychology.

Cheryl Brown Travis, Major Professor

We have read this dissertation and recommend its acceptance:

Deborah R. Baldwin, Joanne M. Hall, Suzanne B. Kurth

Accepted for the Council:

Carolyn R. Hodges

Vice Provost and Dean of the Graduate School

(Original signatures are on file with official student records.)

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Accepted for the Council:

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Vice Chancellor and Dean of
Graduate Studies

(Original signatures are on file with official student records.)

WOMEN'S EXPERIENCES AND EXPECTATIONS OF THE
PHYSICIAN-PATIENT RELATIONSHIP

A Dissertation
Presented for the
Doctor of Philosophy
Degree
The University of Tennessee, Knoxville

Jill Denise Compton
August 2005

DEDICATION

This dissertation is lovingly dedicated to Mom and Dad. Thank you both for all your encouragement, support, love and understanding.

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ABSTRACT

Past research on gender and the medical encounter has tended to focus on gender differences in behavior of both patients and physicians. Less effort has been expended in assessing how gender shapes and structures the experience of the medical encounter. The present study aimed to provide insight into aspects of the medical encounter from the perspectives of women patients themselves and to offer insight into the ways gender emerges and is enacted in the medical encounter.

Seventeen women recruited from a population of undergraduate and graduate students participated in a semi-structured interview involving questions about their experiences with and expectations of their relationships with physicians. Participants were asked questions about their good and bad experiences with physicians, their experiences with decision making, their expectations about what happens during the typical medical encounter, and their preferences for male or female physicians. Analysis of interview transcripts utilized feminist theory, grounded theory, discourse analysis, and script theory perspectives and techniques.

Several themes emerged with respect to aspects of the medical encounter that were significant for the women. Participants indicated that it was very important to be involved in the information-sharing process and appreciated both giving and receiving information. Participants also showed a preference to be actively involved in the decision-making process. Participants indicated that it was necessary in some circumstances to provide information about the social and emotional contexts of their lives. There was a normative script for an office visit, but, notably, some elements were

missing in the script, namely, how to ask a physician questions and a how to negotiate disagreement with a physician.

Participants' accounts provided evidence that many aspects of their encounters were gendered and effectively reproduced traditional gender roles common to society in general. Several of the participants recounted stories of being ignored, dismissed and disempowered during their medical encounters. Some of these participants indicated that they thought they would have been treated more respectfully (i.e., would have been allowed to become involved in information sharing and decision making) had they been male patients. Participants' responses also revealed that some were reluctant to share emotional and contextual information with their physicians, and some indicated that they were reluctant to do this because of the likelihood of being labeled as overly-emotional females. Participants' comments also demonstrated a belief that male patients would differ in their preferences as patients. Many of the participants believed that most men would prefer to have briefer medical visits with more succinct verbal interactions. Many participants expressed a preference to see a female physician, citing reasons falling within two categories: women physicians know women patients better, and women physicians are better listeners and more caring and comforting.

This and related research may be helpful in training health professionals, who should be given opportunities to better understand how gender influences their own lives and their work. Perhaps an increased awareness may help healthcare professionals provide more equitable services to male and female patients, patients who may become more satisfied and healthy.

PREFACE

During my third year as an undergraduate student at Maryville University of St. Louis, I had the privilege of taking a course on the psychology of women. The class was comprised of about fifteen women of differing ages, ethnicities, religious backgrounds and viewpoints. I found the course incredibly exciting and was thrilled to find that two of my passions—feminism and psychology—could be combined!

When I began thinking of my dissertation topic, I decided to choose something that would be particularly meaningful. I looked back on topics that I had been excited about in the past. At this time, I began thinking about my experience with that course. I remembered class discussions where many of the women had aired their complaints about their experiences with their physicians.

I, too, had had many experiences with physicians. Having been diagnosed by that time with a chronic condition, I had been seeing several specialists as well as a general practitioner for several years. Although I did not participate much in those discussions, the stories of these women stayed with me.

These stories inspired me to begin research on the topic of the physician-patient relationship. I was also inspired by my own experiences, though. Although I felt righteous indignation on behalf of my classmates, I also felt thankful that I had had so many good experiences with my physicians. One, in particular, was pivotal in my growing appreciation of my self-efficacy in health matters. This physician was the first physician to provide options for treatment plans, listened to my concerns, and respected my wishes.

Because of these experiences, I felt compelled to undertake a more systematic study of women's experiences and expectations of their relationships with their physicians. It is hoped that this study will provide some insight into the possible ways that processes within the medical encounter are gendered. Ultimately, it is hoped that evidence from this and other like studies will provide impetus to address the physician behaviors that women patients have found offensive and troubling.

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CHAPTER 1

INTRODUCTION AND REVIEW OF THE LITERATURE

The current study aims to discern possible ways that interactions between physicians and patients re-create and reflect cultural constructions of gender in our society. To this aim, transcribed interviews with women discussing their experiences with and expectations of their physicians were analyzed. There were two main goals of the current study. The first goal was to investigate the ways in which women's responses reflected gendered behavior in their reports of encounters with physicians. The second goal was to investigate the ways in which women's expectations, assumptions and scripts regarding the medical encounter reflect gendered relations within medical encounters.

Communication between patients and physicians has been widely studied by researchers in diverse areas of expertise, such as communications, sociology and medical philosophy (Smith, 1989). The reasons for researching physician-patient communication are many. The quality of communication between physician and patient is related to a number of important outcomes, including overall quality of patient care, patient satisfaction, patient compliance with recommended treatment regimens, and even physiological outcomes, such as the glucose levels of diabetics (Lipkin, 1996; Mann, 1998; Roter & Hall, 1993; Wyatt, 1991). Physicians as well as patients benefit from successful communication. In addition to having more satisfied patients, physicians who communicate effectively are less likely to experience burnout and are less likely to be sued for malpractice (du Pré, 2000; Hickson, Federspiel, Pichert, Miller, Gauld-Jaeger, & Bost, 2002; Levinson, Roter, Mullooly, Dull, & Frankel, 1997). A wide range of health care practitioners, including nurses, physical therapists, and technicians, must often

clarify for patient's explanations received from their physicians. Therefore, many of these practitioners may benefit from better quality communication between physician and patient (Williams & Gossett, 2001). Health care organizations may also benefit, in that they operate more efficiently when practitioners communicate in an effective manner (du Pré, 2000).

Physician-patient communication is crucial to the success of health care encounters. According to du Pré (2000), without communication, "...caregivers cannot hear patients' concerns, make diagnoses, share their recommendations, or follow up on treatment outcomes" (p. 10). Given the prominence and importance of communication in the physician-patient interaction, it is understandable that it has piqued the interest of researchers.

Many researchers have found it important to consider whether and how gender affects the physician-patient interaction (e.g., Del Piccolo, Mazzi, Saltini & Zimmerman, 2002; Hall, Irish, Roter, Ehrlich, & Miller, 1994a). Several studies have compared behaviors of male and female physicians during interactions with their patients (see Roter, Hall & Aoki, 2002 for review). Other studies have examined the effects of patient gender on interactions in the medical encounter (e.g., Roter, Lipkin & Koorsgard, 1991).

However, these studies have often viewed physician gender or patient gender as manifest variables. "Gender" in the current study is not viewed as an inherent trait residing within an individual—it is viewed as the constitution of, the "myriad ways in which we 'do' rather than 'have' gender" (Riger, 1992). "Gender" in the current study is conceived of as a more fluid notion, actively constructed by individuals and society

through everyday interaction (Beall, 1993; Hare-Mustin & Maracek, 1988; Unger, 1990; West & Zimmerman, 1992).

In order to underscore the importance of understanding gender in the medical encounter, this chapter will begin with a discussion of previous findings regarding disparity in medical treatment for men and women. The sections entitled “Physician Gender” and “Patient Gender” provide evidence of gender differences and similarities in physician and patient behavior, respectively, from previous research employing quantitative techniques in analyses of actual medical encounters. These sections are provided in order to ground the current study in a thorough knowledge of previous research regarding gender and the medical encounter. The section entitled “Doing Gender in the Medical Encounter” reiterates and expounds upon the importance of applying a social constructionist view of gender to the problems of physician-patient communication. Finally, a detailed account of the aims of the current study is provided.

Evidence of Disparity in Treatment

Research on gender in the medical encounter is more than warranted by the ample evidence that women and men often receive disparate treatment from health professionals. Some evidence suggests that male and female patients experience differing quality of care. For example, in a large study by Hall, Palmer, Orav, Hargraves, Wright, & Louis (1990), 353 male and female physicians and 73 female nurse practitioners were studied to determine whether physician or patient gender affected the quality of medical care provided. Although results showing differences due to physician gender were equivocal, patient gender was found to affect the quality of care in two

pediatric conditions—urinary tract infections and otitis media. In these cases, superior care was rendered to the gender with a higher prevalence of the condition (girls for urinary tract infection, boys for otitis media) (Hall, et al., 1990).

More plentiful, however, are studies finding that female patients especially seem to be at a disadvantage when seeking quality care. Armitage, Lawrence, Schneiderman, & Bass (1979) studied charts of 52 married couples who were patients of nine male family physicians. These researchers compared workups ordered for complaints of back pain, headache, dizziness, chest pain, and fatigue in these patients. For each type of complaint, they computed an extent-of-workup score based on the extent of history-taking, extent of physical examination, and number of tests and procedures ordered. They found that the only variable that correlated with the extent of the workup was patient gender. The extent-of-workup score was significantly higher for men for complaints of lower back pain and complaints of headache. In the case of low back pain, the difference was accounted for mainly during the history-taking segment; in the case of headache, in the extent to which laboratory tests and procedures were used. This evidence suggests that physicians may take less seriously some complaints made by female patients less seriously. This evidence may also demonstrate an instance where physicians' stereotypes of women affect physician behavior in the medical encounter.

Other studies have found disturbing trends regarding the diagnosis and treatment of heart disease. Tobin, Wassertheil-Smoller, Wexler, Steingart, Budner, Lense, & Wachspres (1987) studied 253 male and 137 female patients referred for cardiac testing. They found that the “examining cardiologist thought that there was a somatic, psychiatric, or other noncardiac explanation for the presenting problem in twice as many

female patients” (p. 21). The seriousness of this discrepancy becomes clearer when considering the patients who indeed showed abnormal test results. Of those patients who had abnormal test results, females were significantly more likely to have been predicted to have noncardiac explanations for their symptoms (27.5% of females compared with only 13% of males). Differences in referral for catheterization were also found, especially when the patients had abnormal nuclear scan results. Of these patients, 40% of male patients were referred for catheterization, while only 4% of female patients were. When considering pretest probability of coronary artery disease, men were at all levels (low-, intermediate- and high-probability and confirmed disease) more likely than women to be referred for catheterization. Via a logistic regression analysis, these researchers found that, even when abnormal test results, age, types of angina, presence of symptoms, and confirmed previous myocardial infarction were considered, physicians were six and one half times more likely to refer men for catheterization (Tobin, et al., 1987).

Ayanian & Epstein (1991) also utilized logistic regression analysis in their study of 49,623 discharge records of patients hospitalized for coronary heart disease (CHD) in Massachusetts and 33,159 discharge records of CHD patients in Maryland. They found that, after controlling for principal diagnosis, age, secondary diagnosis of congestive heart failure or diabetes mellitus, race and insurance status, the adjusted odds of undergoing angiography were 28% and 15% higher for men than for women in Massachusetts and Maryland, respectively. The respective adjusted odds of undergoing revascularization were 45% and 27% higher for men than for women.

More recent research suggests that drugs used for secondary prevention of myocardial infarction, including aspirin, beta-blockers, and lipid-lowering agents, are

underutilized in the treatment of women with coronary disease (Vittinghoff, Shlipak, Varosy, Furberg, Ireland, Khan, Blumenthal, Barrett-Connor, & Hulley, 2003). The evidence from these three studies (Ayanian & Epstein, 1991; Tobin, et al., 1987; Vittinghoff, et al., 2003) suggests that women may indeed be in grave danger of being undertreated for cardiovascular illness.

This evidence, combined with evidence that women may be over-treated with mood-modifying medications (Armitage, et al., 1979; Cooperstock, 1971; Hartigan, 2001; Martin & Lemos, 2002), may indicate that women are being misdiagnosed due in part to prevailing gender stereotypes (Fidell, 1980). Part of this disparity in care may be due to problematic elements of the physician-patient communication. Therefore, the myriad ways that gender affects physician-patient communication may be crucial to increasing the quality of medical care for women.

Physician Gender

Much of the research regarding gender and the medical encounter has focused on the differences in physician behavior that are associated with their gender. Two parallel trends account for this interest in physician gender—an increase in the number of women practicing medicine and a rising interest in gender differences in communication.

According to statistics provided by the American Medical Association (AMA, 2003), the percentage of practicing physicians who are female has increased from 7.6% in 1970, to 11.6% in 1980, 16.9% in 1990, and 24% in 2000. Comparable rates of increase have also been seen in rates of application to medical school and medical school graduation rates (see Figure I below; Bickel, Clark & Lawson, 2001).

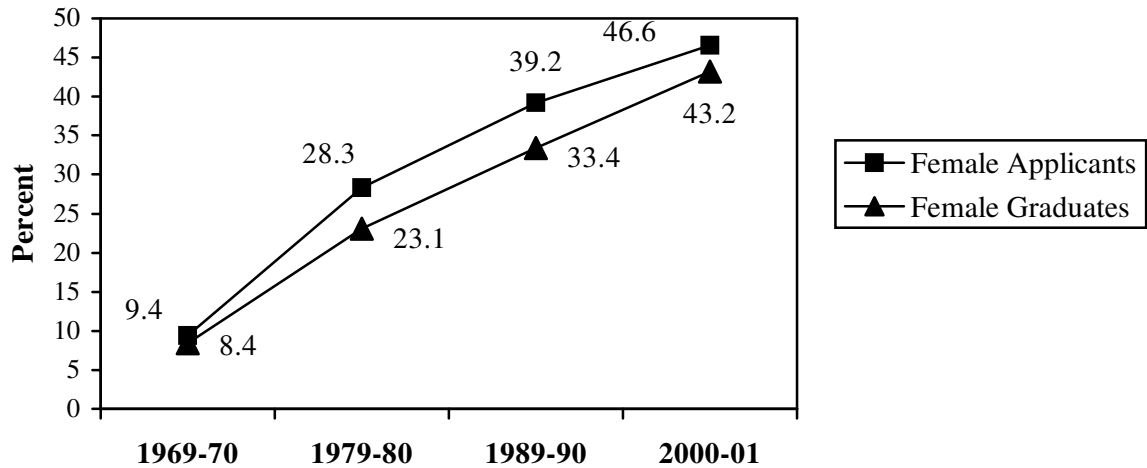


Figure I. Percentages of Female Medical School Applicants and Graduates.

Attention to gender differences in physicians' interactive styles has also been sparked by a growing interest in gender differences in communication (see Wood, 2001 for review). Aries (1987), after a comprehensive review of the literature, asserted that the communication style of women could be characterized as "more social-emotional, expressive, supportive, facilitative, cooperative, personal and egalitarian" (p. 171). Evidence suggests that women and men, on average, differ in nonverbal cues such as smiling, facial expressiveness, gazing, interpersonal distance, and touching, with women in each case expressing behavior that suggests greater openness and friendliness (Hall, 1984). There is also evidence that there is a small gender difference in rates of self-disclosure, with women engaging in self-disclosure more often, especially when communicating with other women (Dindia & Allen, 1992). Evidence also suggests that people tend to react to women in a warmer and more immediate way (Hall, 1984).

Given this evidence, it is not surprising that many researchers and patients began to question whether medical care, including physicians' "bedside manner", differed as a function of physician gender (e.g., Klass, 1988). Medical sociologists, health and social psychologists, as well as physicians undertook the task of identifying physician gender differences and similarities through empirical research, often examining recordings of actual medical encounters.

Opposing viewpoints on whether female and male physicians would practice medicine differently existed. Some theorists postulated that the only way to combat the disparity in medical treatment received by men and women was to increase the number of female physicians, who would undoubtedly be more sympathetic to women's concerns (e.g., Seaman, 1975; Waller, 1988). Others disagreed with this hypothesis, stating that this was a much too simplistic view and pointed out that, although male and female physicians bring different gender socialization to the medical encounter, they share the same professional socialization (Marieskind, 1975; Martin, Arnold & Parker, 1988; Roter & Hall, 1993). These theorists pointed out that gender differences in human behavior found in non-clinical settings might not translate into gendered physician behavior in the medical encounter. In the context of the medical encounter, the gender socialization of females may be at odds with the general expectations of physicians, whose role demands include authoritativeness and perceptible competence (Hall, et al., 1994a). The next section will address previous findings regarding differences and similarities in physician behavior that have been found to be associated with physician gender. The following section entitled "Outcomes Related to Physician-Patient Communication" addresses why

differences in physicians' communication styles may affect outcomes such as patient satisfaction, patient compliance, and malpractice.

Physician-Patient Communication

The most well-documented gender difference in physicians' behavior with patients is that female physicians spend more time with their patients than do male physicians (Bensing, Van den Brink-Muinen, & de Bakker, 1993; Cypress, 1980; Hall, et al., 1994a; Meeuwesen, Schaap, & van der Staak, 1991; Roter, Lipkin & Korsgaard, 1991). In analyses of videotaped physician office visits, it has been found that female patients both talk to their patients more than male physicians do (perhaps especially during the history and examination segments), and that patients talk more to female physicians than to male physicians (Hall, et al., 1994a; Roter, et al., 1991).

This suggests that longer visits with female physicians are partially due to a greater amount of talk between patient and physician. However, the quality of the communication may also differ by the gender of the physician. Most notably, much evidence suggests that female physicians may be more warm and engaging in their communications with patients. For example, some studies suggest that female physicians express more empathy with patients and with parents of child patients (Scully, 1980; Wasserman, Inui, Barriatua, Carter, & Lippincott, 1984). In a study of 100 videotaped medical visits, Hall and colleagues (1994a) found that female physicians asked their patients more questions, both regarding biomedical matters as well as psychosocial concerns, and exceeded male physicians on positive talk (laughing, agreeing, conferring approval). Another study of 250 videotaped medical visits revealed that female

physicians displayed greater interest in learning more about their patients' family and social milieu by devoting significantly more time to discussing family or social matters (Bertakis, Helms, Callahan, Azari, & Robbins, 1995). However, results from a study of 27 male and 23 female Dutch physicians showed that female physicians were *presented* with more social problems (Bensing, et al., 1993). Thus, the results in Bertakis, et al. (1995) could be due, not to gender differences in physician behavior, but to the influence of physician gender on patient behavior.

Female physicians may also be more apt to attend to the emotions and comments of patients. Evidence of this comes from a study of physician-patient interactions that involved a conveying of distressing information. This study found that, on average, female physicians were more prompt than male physicians in dealing with the affective dimension of the interaction by being more involved in emotional-probing and reflections of feelings with the patient (Mendez, Shymansky, & Wolraich, 1986). A greater interest in empathic tuning and emotional probing may be related to the fact that female primary care physicians, on average, provide psychotherapy or therapeutic listening to their patients more often than male primary care physicians (Cypress, 1980; Henderson & Weisman, 2001; Keane, Woodward, Ferrier, Cohen, & Goldsmith, 1991). Also, in a study by DiMatteo, Sherbourne, Hays, Ordway, Kravitz, McGlynn, Kaplan, & Rogers (1993), female physicians were more likely to make a mental health referral or to obtain a mental health consultation during an initial patient visit.

Some evidence indicates that females may be more likely than their male counterparts to engage in mutual participation with their patients (Weisman & Teitelbaum, 1985). For example, the study by Hall and colleagues (1994a) found that

female physicians were more likely to attempt partnerships with their patients. This was evidenced by their greater number of partnership building statements (requests for other's opinion, requests for understanding, reassurance). In turn, Hall and colleagues' (1994a) results indicated that patients directed more partnership statements and statements of medical information to female physicians. This same study also found that female physicians uttered more back-channel responses (such as "um-hmm", "okay", and "right"). This is significant because these responses often facilitate further comments from the patient (Hall, et al., 1994a).

There is also evidence that there is less power asymmetry between patients and female physicians. For example, Hall, et al. (1994a) found that the filtered speech¹ of female physicians was rated as significantly more submissive than the speech of male physicians. A study by Meeuwesen, et al. (1991) also provides some indication that there are physician gender differences in employment of certain strategies to gain or retain control during medical encounters. This study of 85 audiotaped patient visits with six male and four female physicians found that male physicians showed a higher level of advisement (attempts to guide patient behavior via advice, commands, prohibitions, etc.) than female physicians in all segments of the medical interview. During the physical examination and the conclusion segment of the interview, male physicians were significantly more likely to be presumptuous with their patients, meaning that they presumed that their patients would be acquiescent with their requests. Also, male physicians were significantly more likely to be directive during the conclusion segment

¹ Filtered speech is speech that has been electronically altered in order to exclude actual verbal content but retain intonation, rhythm, etc.

of the medical interview (Meeuwesen, et al., 1991). In a study of 21 videotaped encounters between physicians and patients, West (1998) found similar results. According to West, male physicians in her sample were more likely to use imperatives, or explicit demands, with patients (“Lie down”, “Take off your shoes”). In contrast, female physicians were more likely to use proposals for joint action, as in, “Let’s talk about your pressure for a minute.” In a separate analysis of this same data, West (1984) found that, whereas male physicians were more likely to interrupt their patients than their patients were to interrupt them, female physicians were no more likely than their patients to interrupt. West concludes that the male doctors, by using imperatives and interrupting their patients, endorsed a hierarchical physician-patient relationship, whereas the female physicians tended to minimize status differences between physician and patient.

The sum of these results suggests that the behaviors of the male physicians were, on average, more representative of a paternalistic model of physician-patient communication (Meeuwesen, et al., 1991). However, this evidence is the result of only three studies (Hall, et al., 1994a; Meeuwesen, et al., 1991; West 1998) that considered only 48 male and 34 female physicians collectively. Therefore, this evidence should not be taken as conclusive.

More impressive is the evidence that female physicians are more likely to communicate in a warm, engaging style and adopt a less paternalistic model of interaction (Scully, 1980; Mendez, Shymansky, & Wolraich, 1986; Wasserman, Inui, Barriatua, Carter, & Lippincott, 1984; Weisman & Teitelbaum, 1985). Evidence suggests that they may on average spend more time with their patients, talk more with their patients, ask more questions of their patient, are more likely to be empathic, and are more

likely to build partnerships with patients (Cypress, 1980; Hall, et al., 1994; Meeuwesen, Schaap, & van der Staak, 1991; Roter, Lipkin & Korsgaard, 1991). Although this list is impressive, caution in interpretation is always encouraged. For example, it should not be understood that *all* female physicians are more empathic than *all* male physicians. Likewise, it should not be understood that these differences outweigh the many similarities in behavior that female and male physicians share.

Outcomes Related to Physician-Patient Communication

The communication between physicians and patients may affect important outcomes. Differences in communications styles associated with physician gender may impact such wide-ranging and important outcomes as patient satisfaction, patient adherence, and malpractice rates.

Patient Satisfaction. Patient satisfaction has widely been considered an important outcome to assess, and researchers have questioned whether physician gender affects this variable. The resulting research suggests that some patients are more satisfied with female physicians for a number of reasons (Bertakis, et al., 1995; Linn, Cope & Leake, 1984). For example, there is evidence that female physicians may be more friendly in their behavior, as analyses of videotaped medical encounters have shown that female physicians smile at their patients more and nod to their patients more frequently than male physicians (Hall, et al., 1994a). Some evidence also suggests that female physicians seem less bored in their interactions with patients than seem their male counterparts, which is also a likely reason that female physicians might have more highly satisfied patients (Hall, et al., 1994a). Some research has revealed that more time spent in

communication with a patient, a greater amount of positive talk, and a more affiliative communication style are correlated with greater patient satisfaction (Buller & Buller, 1987; Hall & Dornan, 1988; Hall, Roter & Katz, 1988). As mentioned previously, there is evidence that female physicians tend to spend more time with their patients, that they are more likely to engage in positive talk, and that they are more likely to adopt an affiliative style, suggesting that they may be more likely to have satisfied patients.

However, some results show that patients are more satisfied with male physicians (e.g., Bradley, Sparks & Nesdale, 2001; Hall, Irish, Roter, Ehrlich & Miller, 1994b). Male physicians have also been shown to exhibit greater rates of certain behaviors that might affect satisfaction. For example, male physicians' filtered speech was rated as friendlier and less anxious than the filtered speech of female physicians (Hall, et al., 1994a). Furthermore, studies examining the direct effect of physician gender on patient satisfaction have often found contradictory or equivocal results, suggesting that the issue of patient satisfaction may be quite complex (Bertakis, et al., 1995; Bradley, et al., 2001; Hall, et al., 1994b; Wolfensberger, 1997).

Patient Adherence. Although patient satisfaction is an important outcome variable to understand, some have emphasized the importance of the study of patient adherence or compliance. However, very few studies have considered physician-level variables such as physician gender as predictors of patient compliance (DiMatteo, et al., 1993). One extensive study of 186 different physicians and their patients with diabetes, hypertension and/or heart disease that considered physician gender found neither age, gender nor ethnicity of the physician affected their patients' likelihood to comply with medical advice (DiMatteo, et al., 1993). However, other evidence suggests that

behaviors that female physicians are more likely to exhibit, such as directing positive talk to their patients, are correlated with greater compliance (Hall, et al., 1988). This evidence, however, is weak in comparison with results of the extensive study by DiMatteo and colleagues (1993).

Malpractice. Another outcome variable that has become increasingly important to the health care community is malpractice. Besides the obvious financial ramifications, evidence suggests that malpractice suits can also negatively impact physicians' practices and emotional well-being (Shapiro, Simpson, Lawrence, Talsky, Sobocinski, & Schidermayer, 1989). A growing body of literature has attempted to assess predictors of malpractice and to orchestrate plans for malpractice prevention. What many have found is that "[r]isk [of malpractice] seems not to be predicted by patient characteristics, illness complexity, or even physicians' technical skills. Instead, risk appears related to patients' dissatisfaction with their physicians' ability to establish rapport, provide access, administer care and treatment consistent with expectations, and communicate effectively" (Hickson, Federspiel, Pichert, Miller, Gauld-Jaeger, & Bost, 2002, p. 2951). Therefore, often the prescription for lowering malpractice risk is to improve physician-patient communication (Shapiro, et al., 1989).

Given the evidence that female physicians may be better able to empathize with their patients, and therefore may communicate more effectively, one might predict that female physicians would have a lower risk of malpractice. In fact, there is evidence that this is true. A longitudinal study of risk management activities within a large medical group considered complaints made against a total of 645 physicians. Analyses of these data found that female physicians received significantly fewer patient complaints than

male physicians. This study also examined risk management files, files created by the medical group's Office of Insurance and Risk Management any time there was an incident (such as an adverse event or an attorney request for medical files) that signaled risk of a malpractice suit. According to analyses of these data, female physicians were less likely to be implicated in risk management files, including those files that were concluded with expenses (such as legal fees and settlements) to the group or physician. Females were also less likely to be sued (13% of female physicians had been sued, as compared to 24% of male physicians). Logistic regression analyses also found that male sex was significantly associated with having a risk management file opened, even when other factors such as area of specialty were considered (Hickson, et al., 2002).

From the preceding sections, it should be clear that physician gender has the possibility of affecting a medical encounter. Likewise, it is possible that gender differences among patients may affect interactions during the medical encounter. The next section will focus on issues pertinent to patient gender.

Patient Gender

Although there has been a relatively recent increase in interest regarding gender in the medical encounter, the interest has been primarily focused on the gender of the physician. Researchers less often have paid attention to the effects of patient gender (Roter & Hall, 1992). This is perhaps because those few studies that have considered the effects of both patient gender and physician gender have found that patient gender has less influence on communication (Hall, et al., 1994; Roter, Lipkin & Korsgaard, 1991). It may also be because there is generally less interest in the how patient gender may affect

the medical encounter. In a meta-analysis of 61 studies of physician-patient communication, Roter, Hall, & Katz (1988) found that only about half of the studies even mentioned the sex of the patients included in their samples. Additionally, gender differences and similarities have not been the subject of studies regarding patient variables such as attitudes toward physicians or health optimism.

Despite this dearth of research, evidence of some gender differences in patient behavior exists. Most notably, female patients tend to utilize medical services more often. As discussed in the following section, this difference in utilization rates could impact the quality of physician-patient communication. The section entitled “Visit Characteristics and Communication” presents a discussion of the limited evidence of differences in the interactive styles of female and male patients. This section will also present the more convincing evidence that physicians interact differently with female and male patients.

Utilization Rates

One of the most well-documented gender differences in patient behavior can be seen in utilization rates. According to a recent report from the National Ambulatory Medical Care Survey (NAMCS), a survey conducted by the Department of Health and Human Services to assess health care utilization, a majority of patients making office visits to physicians in 2000 were female. The visit rate was greater for women in age groups between 15 and 74 years. However, some of this discrepancy may be due to women’s utilization of gynecological and obstetrical services, rather than a greater general propensity for making doctor visits. In fact, according to this same report,

obstetricians and gynecologists ranked fourth in the number of total visits by specialty, following only general and family practice, internal medicine and pediatrics (Cherry & Woodwell, 2002).

In an interesting study by Lewis, Lewis, Lorimer & Palmer (1977), children ages 5-12 were allowed to seek the care of their school nurse without the approval of their teachers. Results showed that before the study, utilization rates were approximately equal, but after two years, the rates were 1.5 visits by female students per 1 by male students. The authors of this study stated that this was comparable to the ratios of utilization rates of adults, thus showing that health-care seeking behaviors were different for males and females even in childhood. Although this is only one study, it seems to suggest that female's higher utilization rates may be due to more than women's use of routine gynecological and obstetrical services.

The greater utilization of services by women underscores the importance of understanding how interactions in the medical encounter are gendered and how these interactions affect important outcomes. It is also important to consider that greater utilization rates may affect physician-patient communication. For instance, it is plausible that female patients, due to their greater experience communicating with physicians, are better equipped to anticipate what will happen during medical encounters. Women's greater utilization of services may help them gain practice, skill, and general knowledge in interacting with physicians. They may, for instance, be better able to prepare questions for physicians, or they may be more likely to anticipate the consequences of not asking certain questions.

Visit Characteristics and Communication

The evidence regarding differences for men and women in their medical encounters seem to suggest, not that men and women *behave* differently, but that they *elicit* different behaviors from physicians. In fact, evidence suggests that the only difference between women's and men's behavior once they have entered the medical encounter is that women tend to ask their physicians more questions than do their male counterparts (Pendleton & Bochner, 1980; Waitzkin, 1985; Wallen, et al., 1979). Much more evidence suggests that patient gender serves a more important role as a stimulus variable, with a host of physician behaviors being affected by the gender of their patients.

The most notable of physician behaviors to be affected by patient gender is total time spent with the patient. Several studies suggest that physicians spend more time with their female patients (Bensing, et al., 1993; Blanchard, Ruckdeschel, Blanchard, Arena, Saudners, & Malloy, 1983; Waitzkin, 1985; Wallen, Waitzkin, & Stoekle, 1979). That physicians spend more time with their female patients may be explained by several factors. For example, there is evidence that female patients receive more back-channel responses from physicians, and these responses encourage female patients to talk more (Hall, et al., 1994a). However, more convincing evidence suggests that more time spent with female patients is at least partly attributable to the fact that female patients receive more information from their physicians than do male patients (Hall, et al., 1988; Hooper, Comstock, Goodwin, & Goodwin, 1982; Meeuwesen, Schaap, & van der Staak, 1991; Pendleton & Bochner, 1980; Waitzkin, 1985; Wallen, et al., 1979).

The issue of information giving in the physician-patient interaction is very important. According to a meta-analysis by Hall, Roter & Katz (1988), higher rates of

information giving corresponded with higher rates of patient satisfaction and compliance. This meta-analysis also found that gender was significantly related to information giving, with females receiving significantly more information from their physicians. Of course, that physicians spend more time with female patients and give female patients more information may also be partly attributable to the tendency of female patients to ask more questions (Pendleton & Bochner, 1980; Waitzkin, 1985; Wallen, et al., 1979)

Some researchers have focused not only on the amount of information given to patients, but also on the quality of the information that patients receive. One study found that the level of technicality used by a physician was significantly higher with female patients (Hall, et al., 1994a). However, contradictory evidence also exists. An extensive study of 336 audiotaped visits between a stratified random sample of physicians (34, all male) and a sample of their patients (184 male, 130 female) found that physicians did not distinguish between male and female patients in the level of technicality of their explanations. However, results also indicated that physicians had trouble “matching” their answers with the same level technicality of their female patients’ questions. Whereas physicians were fairly able to “match” their responses to male patients’ questions, they were significantly more likely to reply to the questions of female patients with a lower level of technicality (Wallen, et al., 1979).

Some studies also show that female patients are less likely to be interrupted by their physicians (Hall, et al., 1988; Hooper, et al., 1982). More partnership-building statements and positive talk may be directed at female patients (Hall, et al., 1988) and female patients may be more likely to receive empathy from their physicians (Hooper, et al., 1982). Most of these differences, however, seem to benefit female patients. Other

evidence suggests that females are not always the recipients of better treatment. For example, one study of 85 audiotaped medical interviews showed that physicians were less attentive to and gave more advisements (advice, commands, prohibitions) to female patients (Meeuwesen, et al., 1991).

Studies of physician-patient communication have also discovered some evidence that physicians tend to differ in their consideration of and reaction to the emotions of female and male patients. For example, Wallen and colleagues (1979) found that physicians were more likely to consider the psychological component of the patient's illness to be important when the patient was female. A study of 140 audiotaped medical visits by Stewart (1983) found that physicians were more likely to express tension release with female patients and to ask about their opinions or feelings. Although this greater focus on the emotions of female patients may be beneficial to the patient, it may also be indicative of physicians' stereotypical views of overly-emotional females who are affected more by affective fluctuations than their male counterparts.

As stated above, there is much more evidence that patient gender stimulates different communication styles from physicians than evidence that female and male patients behave differently towards their physicians. This may be because this is actually the case. However, this discrepancy in evidence may also be due to the questions asked and the methodologies employed in past research. Regardless, that men and women are recipients of different communication styles raises many questions about how these differences affect the quality of care received by both men and women, but perhaps especially women. As discussed earlier, women may experience a differing quality of care as compared to their male counterparts. Some women may be especially

disadvantaged when it comes to interacting effectively with their physicians, as some research suggests that patients who are older, of a lower social class, and/or are ethnic minorities may be at a disadvantage when speaking to physicians (Cooper & Roter, 2003; Roter & Hall, 1993). Since women live longer and, on average, earn less income than men, women may be at a larger risk for double minority status. Again, this underscores the importance of understanding how gender affects the medical encounter and subsequent outcomes.

Doing Gender in the Medical Encounter

Despite the existence of a large, diverse body of literature pertaining to the topic of physician-patient relationships, and to the role that gender plays in physician-patient encounters, gaps in our knowledge of how patients and physicians communicate remain. Although much research has focused on gender differences in the behavior of both patients and physicians, there has been less effort to examine why these differences exist and how they may affect patients' experiences.

Candace West (1993) has suggested that, instead of conceptualizing gender as a manifest variable to be included in a regression analysis, gender as it relates to physician-patient interactions should be conceived as something that we all enact, something that we "do". If scholars are to come to a more complete understanding of the interactions within the medical encounter, strides must be made to more fully understand how the enacting of gender affects physician-patient communication.

For example, although there is evidence that female and male physicians may adopt different communication styles with their patients (see section "Physician Gender")

above), it should not be assumed that this evidence is indicative of an essential difference between female and male physicians. Rather, these differences in communication style may result from differences in power, status and the professional climate experienced by female and male physicians.

Power, status and professional climate differentials are evidenced by gender differences in physicians' choice of medical specialty, salary, and academic status. Female physicians are less likely to choose the highly prestigious field of surgery and more likely to choose the field of pediatrics, a field which seems to compliment women's socialization into the role of child rearing (AMA, 2003; Martin, et al., 1988). Female physicians earn less money than male physicians on average (Income, 2003), a fact that remains even when statistically controlling for factors such as area of specialization, age, number of patients seen and years in practice (Kehrer, 1976; Langwell, 1982; Median Unadjusted Income, 2000; Ohsfeldt & Culler, 1986). Female physicians in academia, as compared to their male counterparts, are less likely to be full professors, more likely to be instructors, experience longer time periods between promotions, and encounter more negative attitudes regarding their promotion to leadership positions (Association of American Medical Colleges, 2000; Heid, O'Fallon, Schwenk, & Gabriel, 1999; Scadron, Witte, Axelrod, Greenberg, Arem & Meitz (1982); Wallis, Gilder, & Thaler, 1981).

The climate experienced by female physicians may lead to different interaction styles with their patients, who make less money on average, are less likely to be in prestigious fields such as surgery, and are less likely to be in high-status positions. More importantly, both differing interaction styles and experience of professional climate may

be indicative of a larger system of patriarchy which insists on different standards of behavior for men and women.

Likewise, this system of patriarchy could conceivably affect the behaviors of patients in a multitude of ways. For example, currently socially-constructed mandates for gendered behavior may encourage men to remain reticent about pain and other symptoms. Status differentials based on gender may influence the likelihood that a woman will feel entitled to quality health care.

The possible effects of the larger system of patriarchy are seldom recognized in the literature on physician-patient communication. Rather, gender is often treated as an essential trait inherent in both physicians and patients. Rather than viewing gender as another independent variable, the current study attempts to better understand how gender, as a process, is accomplished in the medical encounter.

Current Study

Although previous research has provided evidence that gender differences in both physician and patient behavior may exist, there has been less effort to examine why these differences exist. As Candace West (1993) has pointed out, much of the past research on the medical encounter has conceived of gender differences, “as the explanation, rather than the analytic starting point” (p. 58). West further concludes, “...if we view gender as an individual characteristic, we cannot see how it structures distinct domains of experience” (p. 58). Therefore, the first goal of the current study was to investigate the ways in which women’s recollections reflect gendered behavior in their encounters with physicians. As evidenced in the previous sections, past research has addressed the effects

of both physician gender and patient gender on certain aspects of the physician-patient encounter. Some notable gender differences in behavior on the part of both physicians and patients have been observed in these investigations. An analysis of patients' experiences with physicians' could be very helpful in uncovering how gender is accomplished in the medical encounter, and may provide evidence of the effects that this gendering process has on those involved in the encounter. Analyses associated with this goal include examining women's experiences of information sharing, decision making and disclosure of social and emotional information.

Information Sharing and Decision Making

As previously discussed in the section entitled "Patient Gender," the concept of information sharing may be very important to our understanding of physician-patient interactions. Quantitative analyses suggest that information sharing may be associated with both patient satisfaction and patient adherence (Hall, et al., 1988).

Qualitative research has also found the processes of information sharing and decision-making to be important to understanding physician-patient relationships. Previous qualitative studies have found that information sharing and the decision-making process are factors that women may find to be of special relevance to their medical experiences. Women often report that they prefer physicians who are willing to provide information and engage in a mutual decision-making process (Brown, Carroll, Boon & Marmoreo, 2002; Ellingson & Buzzanell, 1999; McWilliam, Brown & Stewart, 2000; O'Malley, Forrest & O'Malley, 2000; Richter, Kenzig, Greaney, McKeown, Saunders & Corwin, 2002; Zadoroznyj, 2001).

Quantitative analyses of actual encounters have found that female patients tend to receive more information from their physicians than males do (Hall, Roter, & Katz, 1988; Hooper, Comstock, Goodwin, & Goodwin, 1982; Meeuwesen, et al., 1991; Pendleton & Bochner, 1980; Waitzkin, 1985; Wallen, et al., 1979). Although women may *receive* more information from their physician, there is evidence that women may be “silenced” during encounters. It has been noted in previous research that patients’ voices², and perhaps especially women patients’ voices, are eclipsed by the voice of institutional medicine in the medical encounter (Barry, Stevenson, Britten, Barber & Bradley, 2001; Mishler, 1984). Whereas the patient may want to discuss her contextually-grounded experiences and problems, her physician may prefer to speak in technical and scientific terms.

Women’s explanations of symptoms and problems may be deemed less important than information gleaned from examinations and tests. Grace (1995) interviewed women who had used health services for chronic pelvic pain. Results showed that her participants were often disempowered during medical encounters. Physicians were often patronizing, dismissive, and unwilling to provide information, such as the possible side effects of prescribed medications and alternatives to surgery. Women’s own words and experiences were often discarded or ignored in favor of “objective” knowledge gained through technological examination.

Therefore, although women may receive more information from their physicians, they may be silenced or ignored when providing their physicians with information

² “Voices” in this context refers the philosophical concept of voice, the ability and power to express oneself, rather than the literal vocal utterances of patients.

relevant to their own lives and experiences. Information sharing and decision making are factors that illuminate the distribution of power in the physician-patient relationship (Fisher, 1984). Therefore, these elements are analyzed in the current study.

Emotion and Context

Data regarding patients' expressions of emotion in the medical encounter was also assessed. There is mixed evidence as to whether, compared to men patients, there is more (or less) attention given to women's expressions of emotion in medical encounters. Some evidence suggests that the emotions of female patients may be better attended to than those of male patients (Wallen, et al., 1979; Stewart, 1983). However, there is also evidence that women's emotional and social problems are ignored in the medical encounter. In a qualitative analysis of verbatim transcripts between physicians and female patients, Borges & Waitzkin (1995) investigated the ways that women patients attempted to discuss social and emotional problems with their physicians and how the physicians responded to these attempts. Their findings indicated that physicians (whether male or female) rarely attended to the social and emotional problems of their female patients and often discouraged discussion of these problems if patients initiated such a dialogue. They suggest that the results of a dismissal are the perpetuation of patriarchal ideology and the medicalization of non-medical problems.

The clinical treatment implications of attention to emotion during physician visits remain uncertain. Physicians have increasingly endorsed a biopsychosocial model of health. Therefore, evidence that women's emotions are receiving more attention could be interpreted as a greater tendency for physicians to recognize the social and psychological

contexts of women's lives. However, it could also be hypothesized that women's emotions are given more attention because women are stereotypically considered to be more prone to emotionality. Or, it could be hypothesized that women's emotions are attended to more often because there is a greater suspicion that women's symptoms are best explained by psychological problems.

This denial of women's social and emotional problems could indicate a lack of acknowledgment of the effects that the context of women's lives may have on their health and well-being. The silencing of women's emotional and social concerns may operate to mask macro-level societal problems, perpetuate patriarchal ideology and encourage the medicalization of non-medical problems. Therefore, data regarding women's expression of emotional and social problems will be noted and analyzed and compared to the conflicting evidence discussed above.

Gender and Women's Expectations

The second goal of the current project was to investigate the ways in which women's expectations, including assumptions and scripts, regarding the medical encounter may reflect gendered relations that permeate society in general. Much of the previous research in the domain of physician-patient interaction has concentrated on what happens between physicians and patients *during* actual medical encounters and has focused on such things as how many questions are asked by physicians or by patients, the level of technicality in physicians' answers, and how much time physicians spend with patients. Less attention has been paid to the *precursors* of the meeting between patient and physician.

Recently, there has been a call for more understanding of the expected scripts and assumptions patients bring to their encounters with physicians and how these expectations and assumptions affect the encounter. For example, Rimal (2001) has urged researchers to investigate what scripts patients might rely on when communicating with their physicians. Vanderford, Jenks & Sharf (1997) have encouraged researchers to conceive of patients as “active interpreters, managers, and creators of meaning of their health and illness” who bring with them preconceived notions and realities, rather than conceiving of patients as “recipients of and reactors to the messages of others” (p. 14). Kreps (2001) has advised researchers to “resist the tendency to glorify provider’s communication” and to better acknowledge the perspective of the patient (p. 599). According to Cline (2003), the importance of understanding patients’ perspectives, knowledge, and world views will increase as patients become increasingly bombarded with information from sources such as internet web sites and direct-to-consumer drug advertising.

A number of qualitative studies have attempted to assess such precursors as the patient’s understanding of an illness (de Zwart, van Kerkoff & Sandfort, 1998; Grande, Hyland, Walter & Kinmonth, 2002; Kleinman, 1988). For example, Shefer, et al. (2002) found through analysis of transcribed focus group discussions with Black South Africans that there were many incongruities between their understandings and explanations of sexually transmitted infections and accepted medical knowledge regarding this health issue. Examples of this incongruity included a popular belief that only women could spread sexually transmitted diseases. The relevance of this study to the current project is two-fold. First, it demonstrates the importance of understanding something that pre-dates

the actual medical encounter—the patients’ preconceived notions. In this case, patients’ belief that only women can spread sexually transmitted diseases can potentially have a devastating impact on the health of these patients and on the health of patients’ sexual partners. Secondly, this study provides an example of how cultural scripts and understandings of gender may be re-created within a medical framework. The belief that only women can spread illness is compatible with and reflects historic cultural beliefs that female sexuality is dangerous and hidden.

Karasz & Anderson (2003) provide another example of the importance of understanding the explanatory models of patients. Karasz & Anderson (2003) utilized grounded theory techniques to investigate the experiential dimensions of women’s diagnosis of vaginitis or vaginal conditions. Participants were asked to discuss “their interpretations and explanations of their illness, their accounts of its impact on their lives, their experiences with treatment, and the role of vaginal symptoms in communicating stress and anger” (p. 1014). Results indicated that many women’s understanding of vaginitis differed from and often blatantly contradicted the current medical model described in the literature on vaginitis.

The authors asserted that, although their study did not examine physician-patient communications directly, their data did suggest that there was a conflict between the conventional disease model espoused by physicians and the lay models of patients (Karasz & Anderson, 2003). This conflict may adversely impact the effectiveness of communication between physicians and patients and could have serious effects on the quality of patient care. This conflict may also provide an example of how cultural

dictates of appropriate behavior of women, namely the propriety of women becoming knowledgeable about their own sexual anatomy, may affect the medical encounter.

Although studies have assessed patients' conceptualizations of their illnesses, few qualitative studies have assessed patients' conceptualizations of their interactions and relationships with physicians. As stated previously, a goal of the current research project was to assess the expectations, assumptions, and scripts that mold and organize women's understandings of their interactions with physicians. Without an understanding of the interpretive repertoires on which patients rely when conceptualizing their interactions and relationships with physicians, we will be left with an incomplete picture of the physician-patient relationship. Analysis in the current study included examining women's assumptions and scripts that may be employed in visits with physicians and will consider women's expectations about how the gender of a physician will affect interactions with their doctor.

Assumptions and Scripts. Data was assessed for detection of scripts that may be enacted during the medical encounter. Social scripts are schemas, or organized sets of cognitions, that we hold about events that are common and well-known to all of us. They dictate standard sequences of behavior in particular situations and we rely upon them to interpret situations in our environment (Abelson, 1976). Scripts dictate not only what is said and by whom, but also indicate the appropriate sequence for these utterances. These dictates encoded in scripts may be especially revealing of gendered power relations and the "doing" of gender (Rose & Frieze, 1989). Despite the revealing nature of scripts, they have largely been neglected in past study of physician-patient communication.

Some studies have attempted to create a taxonomy of types of talk in the medical encounter. For example, Roter & Hall (1993) have conceptualized talk between physicians and patients as falling within the categories of information giving, information seeking, social talk, positive talk, negative talk, and partnership building statements. However, these taxonomies do not provide information regarding the sequencing of exchanges or illuminate the ways that conversations are directed and controlled by each party.

There are also studies that have examined patterns of communication and decision-making during the medical encounter. For example, Sue Fisher (1984) conducted an ethnographic investigation of communications between resident physicians and female patients who had discussed whether a pap smear would be performed during office visits. Fisher coupled her analysis of audio- and video-taped medical encounters with information gathered from patients' files and with knowledge gained from discussions with the resident physicians. Fisher's analysis resulted in the uncovering of patterns of negotiation during different phases of the encounter—opening, medical history, physical examination, and closing. These patterns were indicative of a system whereby physicians were in control and patients were relegated to a position of near-blind trust. Fisher concluded that this power asymmetry structures physician-patient interactions and influences treatment outcomes in ways that were not always beneficial to the patient, especially to the female patient.

Although research that examines in-vivo exchanges between patient and physician has informed the understanding of power in the medical encounter, this methodology does not adequately consider patients' pre-existing scripts or expectations

about how such exchanges should progress. This information could be imperative for understanding communication problems in medical encounters. For example, if patients assume that they will be given ample time to discuss their symptoms, yet encounter a physician who asks only closed-ended questions, they may experience frustration with the exchange. Although actual encounters are not the focus of the current study, it is believed that participants' responses could indicate their understandings of scripts that may be utilized in the medical encounter, as well as their acceptance or rejection of these scripts and their perceptions of who directs and controls the encounter.

Expectations of Gendered Physician Behavior. Previous research suggests that some women and adolescent females may prefer female physicians (Kappahn, Wilson & Klein, 1999; Levinson, McCollum & Kutner, 1985). This preference may be especially notable under certain circumstances, such as when having a gynecological exam performed (Ahmad, Gupta, Rawlins & Stewart, 2002; Alexander & McCullough, 1983; Waller, 1988), or when discussing emotional problems (Ahmad, Gupta, Rawlins & Stewart, 2002).

However, research regarding why these preferences exist is lacking. Women's preferences for a female physician could indicate a difference in expectations of male and female physicians' behavior. Therefore, data regarding women's differing expectations about male and female physicians will be analyzed. These data will be compared to evidence of gender differences in physician behavior (see above). It has been suggested that gender differences in physician behavior may be due, in part, to patients'

expectations that female and male physicians will interact differently with them (Hall, 2003). However, researchers have neglected to investigate these expectations. Therefore, whether women's expectations differ for male and female physicians and, if differences exist, how these expectations differ will be assessed.

CHAPTER 2

METHOD

The current study employed qualitative analytic techniques, including discourse analytic and grounded theory techniques, in the examination of transcribed interviews between myself as the interviewer and female participants, who were asked to describe their experiences with and expectations of their relationships and interactions with physicians. Although the physician-patient relationship was not observed directly in this study, it is believed that a better understanding of women's experiences with and expectations for medical encounters may add significantly to previous research in this area.

Participants

Previous qualitative studies of women's experiences of the physician-patient relationship have focused on special populations, such as breast cancer survivors (e.g., Ellingson & Buzzanell, 1999) or women considering hysterectomy (Richter, et al., 2002). However, communication between physicians and patients with life-threatening illnesses may not be representative of communications between most women and their physicians. Therefore, the current study does not focus on women who have received a single, common diagnosis or who have experienced a particular course of treatment. It is hypothesized that the cultural assumptions, expectations, and belief systems regarding gender and the physician-patient relationship will be readily expressed by women in their description of typical office visits. Nevertheless, results from the current study may

provide a basis for comparison of results of previous studies involving more specific populations. Comparison with findings from previous studies, such as those reporting the importance of information sharing and decision making in the experiences of women diagnosed with breast cancer, may provide a better understanding of the generalizability of findings from both types of studies.

A total of 17 women participated in the study. The majority of these participants were recruited for participation from a population of students taking psychology courses at a large, Southeastern university. A purposive sampling design, combined with a snowball sampling technique, was employed. Participants were initially recruited from undergraduate psychology courses and received extra credit in their respective psychology courses for participating in the study. Other participants were recruited from a population of graduate students taking psychology courses.

As part of the snowball sampling technique, all participants were encouraged post-interview to tell others of the study. Four of the 17 participants were recruited via this technique. As part of the purposive sampling design, participants were especially encouraged to pass on information about the study to those who might add diversity to the existing sample. Suggestions included asking those who were ethnic or racial minorities, and those who were older than the traditional college-aged student. Recruitment of participants ceased when it was determined that sufficient saturation had been reached. Saturation was indicated by a noticeable repetition of themes in interviewees' responses.

Twelve of the 17 participants were undergraduate students (one sophomore, four juniors, and seven seniors), four were graduate students, and one was not a student. Two

of the graduate students were also employed full-time, one as an Assistant Professor of Psychology, the other as a Mental Health Associate. The non-student was a High School Teacher who had learned of the study through her husband, a graduate student. The ages of participants ranged from 19-50, with a median age of 24. Thirteen participants were Caucasian, two were Asian, one was Middle-Eastern, and one was Multi-Racial. Seven participants reported experiencing chronic illnesses, including systemic lupus erythematosus, lyme disease, polycystic ovarian syndrome, recurrent pleurisy, polymyositis, depression, and bipolar mood disorder. Participants reported using a number of health care delivery systems, including preferred provider organizations and health maintenance organizations, private insurance, and free or subsidized walk-in clinics. Six of the participants reported having used more than one health care delivery system within the past year.

All participants reported that they had seen a physician within the past year. The number of visits per year ranged from one to 15, but a majority of participants (nine of seventeen) reported that they had visited a physician four or fewer times in the past year. All but one participant reported that they visited specialists (most often gynecologists/obstetricians, but also dermatologists, ophthalmologists, orthopedic surgeons, and psychiatrists) as well as general practitioners, although some considered their gynecologists/obstetricians to be their primary care providers. All participants had been to both male and female physicians, but only five reported currently having a female primary care physician. Three participants reported currently seeing both male and female primary care physicians. Four participants reported currently seeing a female

specialist physician, while four reported seeing both male and female specialist physicians.

Procedures

Participants were given a brief description of the study, then provided with a consent form for participation in the study. Upon signing the consent document (see Appendix A), participants took part in a semi-structured interview (see Appendix B). The interview schedule consisted of eight primary questions with probes. The first question asked participants to recount their expectations of what happens when they go to the doctor, including what questions they expected to be asked, whether they asked questions of the physician, and what they expected the physician to do for them during the visit. The second question asked participants to describe what they looked for in a doctor, including what was most important to them in a doctor, what qualities they would want to avoid in a doctor, and what was ideal in terms of how a doctor related to them. The third question prompted participants to discuss their preferences for a male or a female physician and to explain their preference or lack thereof. The fourth question prompted participants to describe an actual doctor's visit that they thought had been positive, while the fifth question prompted them to recount a negative experience in going to the doctor. The sixth question asked participants to consider what could have been changed about their negative scenario in order for the visit to have been positive. The seventh question asked participants to describe how they and their doctors made decisions, including how courses of action were brought up for consideration, how information was shared, and who made the final decision. The eighth question

encouraged participants to discuss their expectations of the study and how they would modify or enrich the interview schedule. Upon completion of the interview, a brief written questionnaire requesting demographic characteristics and other background information (see Appendix C) was administered.

Interviews were audio recorded and transcribed for analysis (see Appendix D for transcription conventions). Transcription preserved the accuracy of participants' speech when at all possible and focused on the language of the participant rather than paralanguage (voice tone, volume, etc.), with the exception of pauses in participants' speech. Pauses of more than two or three seconds were included, because they are considered relevant to the aims of discourse analysis.

Interviews lasted between approximately 30 and 90 minutes. Single-spaced transcriptions were between nine and 21 pages long, with an average length of approximately 15 pages. With very few exceptions, participants seemed relaxed, comfortable, and forthcoming with information, sometimes of a very personal nature. Several participants seemed eager to describe their experiences with going to the doctor, and some indicated that they were pleased that I had undertaken this topic as a focus of my research. I found most of the interviews enjoyable, and I felt grateful for my participants' willingness to share their thoughts and experiences with me.

Analysis

Analysis in the current study was aided by a number of theoretical perspectives and methodologies, including feminist theory, discourse analysis, grounded theory and

script theory. These approaches were borrowed from and blended together to produce a novel approach to data analysis. Each of these perspectives will be discussed in turn.

Feminist Theory

A feminist theoretical framework was crucial in the analysis of the current data. Several goals of feminist theory were considered in the current study, including the acknowledgement of the power of social and political forces to shape human behavior. According to Crawford & Unger (2000), feminists are “sensitive to the ways that social contexts and forces shape people’s behavior and limit human potential” (p. 20). White, Russo & Travis (2001) assert that: “Many features of gender and gendered-related behavior thought to be located within personal traits essential to male or female gender are instead located in a changeable social context” (p. 272). It is recognized in the current study that relations within the medical encounter may be influenced by the socially constructed concepts of masculinity, femininity, and gender roles.

Another goal of feminist theory is to uncover hidden processes of power and privilege (White, et al., 2001). According to White and colleagues, the dynamics of power operate as “ubiquitous features of daily life and become reflected in customs, norms and laws” (p. 273). One way to better understand these ubiquitous, and often silenced, features of daily life is to give a voice to marginalized groups. According to Ellingson & Buzzanell (1999), women’s experiences, concerns, and language have largely been missing from research on the physician-patient relationship. The current study is guided by the feminist notion of giving voice to those who have been ignored or marginalized in previous research in an effort to uncover possible power differentials.

Discourse Analysis

Discourse analytic methods, in the tradition of Potter & Wetherell (1987), were applied to the study data. Discourse analysis may involve fine-grained examination below the level of the sentence and alternatively may focus on broad cultural themes and concepts. Broad discourses, the focus of this study, may be reflected in various forms, including metaphors, stereotypes, expectations, or aphorisms, as well as more personalized accounts and anecdotes. Special attention was focused on issues of information sharing, decision-making, the discussion of social and emotional problems, and assumptions regarding scripts and gendered physician behavior. Interviews also were analyzed for broad discourses related to the doing of gender, as expressed in women's experiences and expectations of interactions with their physicians.

Discourses can be thought of as expressions of belief systems, worldviews, or canons that emerge from one's culture. Hepworth & Griffin (1995) refer to discourses as the "ideological baggage" that becomes associated with certain terminology, such as "female" or "patient" (p. 81). It is through participation in the social world that people gain knowledge of "discourses" (also referred to as "interpretive repertoires"), or sets of meanings that may operate independently of the conscious awareness of individual speakers or writers. The aim of discourse analysis is to discern the underlying societal and cultural belief systems and worldviews employed in the written or spoken language (Ballinger & Payne, 2000; Banister, Burman, Parker, Taylor & Tindall, 1994; Burman & Parker, 1993; Edwards & Potter, 1992; Kroger & Wood, 1998; Potter & Edwards, 1992).

Discourses include values, expectations, and stereotypes that have emerged from and are consistent with the ideals of a culture. Expressions of ideas that are consistent

with these values, expectations, and stereotypes are typically unexamined, are readily comprehended by others, and often are conveyed in shorthand, telescopic fashion with little loss of meaning for the audience. Discourses are often thought of as “common sense” views of the world and everyday life. What people say and how they say it is not strictly an expression of isolated ideas internal to the speaker, but rather is a function of culture and social context. This perspective compliments the goals of feminist theory discussed above, namely the goal to uncover hidden assumptions regarding what it is to be “male” and “female.”

Grounded Theory

The current analysis was also aided by grounded theory techniques for inductive analysis. Since discourse analysis employs no single method or technique, grounded theory techniques, which have a relatively long tradition within qualitative research, were used as a guide to the analytic procedure (Banister, Burman, Parker, Taylor, & Tindall, 1994; Glaser & Strauss, 1967; Goetz & LeCompte, 1981). Transcribed interviews were assessed through a constant comparative method, which entails combining the coding and the analysis of data so that each unit of coded data is compared with other examples within the coding category (Glaser & Strauss, 1967). The constant comparison method requires that, as the phenomena at hand are being recorded and classified, they are also being compared across categories. As new excerpts are considered and compared, categories may be added, changed and become more refined (Goetz & LeCompte, 1981).

Processes of open and axial coding involve first classifying data into categories, then refining the categories, and establishing patterns and connections between categories

(Glaser & Strauss, 1967; Banister, Burman, Parker, Taylor, & Tindall, 1994). Interview questions served as a basic framework for open coding. Initial categories, therefore, included general expectations, “good doctor” qualities, preferences regarding physician gender, good experiences, bad experiences, and decision-making experiences. Although the interview questions served as a basic framework for open coding, participants often discussed certain topics, such as good and bad doctor’s visits, outside the context of their replies to direct questions about these topics. Therefore, effort was made to include all relevant information in appropriate categories. During the process of axial coding, excerpts were examined with respect to the topics of information sharing and decision making, emotion and context, scripts, and expectations of gendered physician behavior. Findings associated with each topic were considered. For example, one finding was the overall significance and weight that participants accorded their experience with respect to information sharing.

Script Theory

The current study was also guided by script theory, a theory most closely associated with cognitive psychology (Charlin, Tardif & Boshuizen, 2000). As described in the previous chapter, scripts are schemas, or organized sets of cognitions, that we hold for routine events, such as eating at a restaurant. According to script theory, in order to interpret and find meaning in new situations, individuals must rely on prior knowledge. Prior knowledge includes information about similar previous situations and characteristics of the situation, as well as information regarding the appropriate sequencing of events. These prior knowledge structures are referred to as *scripts* (Abelson, 1976; Schallert, 1982; Johnson & Hasher, 1987).

Script theory has been widely applied to the topic of human sexual interaction (e.g., Simon & Gagnon, 1986). For example, Rose & Frieze (1989), found strong evidence of a script for the first date. There was strong agreement amongst their participants regarding the content and sequence of actions typically undertaken during the first date. Rose & Frieze also found that the scripts for women and for men differed significantly, with men more likely to be described as initiators (e.g., ask for the date, initiate sexual contact) and women more likely to be described as passive (e.g., wait for date to arrive). Therefore, this study revealed evidence of a script for first dates, as well as provided evidence of the ability of scripts to reveal power structures within relationships.

According to Rimal (2001), the framework of script theory may be quite applicable to our understanding of the physician-patient relationship. Rimal suggests that, since medical visits are common experiences for many, it is likely that individuals have internalized scripts for this event. Rimal further suggests that our understanding of scripts within the medical encounter may inform our understanding of the negotiation of power and control between physician and patient. The current study, therefore, will be guided by an understanding of script theory in order to better understand the ritualized aspects of the medical encounter and the implications of these scripts on women's experiences and expectations. Script theory is relevant to the goals of discourse analysis, since both perspectives recognize the largely unacknowledged frameworks on which individuals rely in order to anticipate, interpret and remember situations. Both perspectives also recognize the significance of missing elements of these frameworks and the consequences of these missing discourses and script elements on human interaction.

Assessment of Rigor

Open coding by the author identified a variety of types of text, including segments that seemed notable or striking (e.g., vehement statements of opinion or emotion) as well as text that appeared to reiterate a common theme. These were grouped and conceptualized as discourses during axial coding. Descriptions of these initial categories were formulated, and segments of individually coded text were assigned to these categories. Descriptions allowed for some overlap in categorization of coded material. For example, a given section of text depicting a participants' negative experience might reveal information pertinent to decision-making as well as to scripted behavior. However, overlap among categories was minimal. Overlap was most likely to occur between the categories of "information sharing and decision making" and "emotion and context" and relatively unlikely to occur among the other categories. Coding was not exhaustive, as many segments of text were not considered pertinent to the research questions of the present study. For example, one participant detailed a scenario where she had been unable to find a solution to her problem—a tattoo that she wished removed. Although she reported that this was a negative experience, she did not indicate that she was unhappy with any aspect of the physician-patient interaction; rather, she was simply disappointed that she would not be able to have her tattoo removed.

Inter-rater reliability was assessed by use of a random selection of coded material across all transcripts. Effort was made to include coded material that did not overlap in multiple categories. Each of two raters (undergraduate research assistants) was individually provided with a set of unlabeled excerpts along with a list of theme headings. Additionally, each rater was given a brief description of the theme and an

exemplar from the coded text. For example, a theme regarding the importance of information sharing was given the theme heading “Information Sharing,” and was accompanied by the following description: “Excerpts that address issues of receiving or providing information. Information may be related to symptoms, medical examinations and procedures, directions for use of medications, etc.” The following exemplar was also provided: “I want them to take their time and to explain things to me. That’s, my gynecologist is that way. She’ll sit in there with me and explain things to me and tell me every single side effect, and, you know, just exactly what’s gonna happen and what I need to do.”

Raters were asked to assign each unlabeled excerpt to a coding category. Raters were also instructed to indicate if they believed an excerpt could belong to more than one category by assigning it to a primary category and noting any possible secondary categories. Concordance was assessed between the author’s original designations and designations made by each of the two raters.

Two kappa coefficients were calculated, one comparing my designations to those of each of the two raters. Kappa coefficients measure the amount of agreement between two raters and have been utilized in the assessment of rigor in qualitative analysis (Buchanan, Villagran & Ragan, 2001; Cohen, 1960; Cohen, 1968). Kappa coefficients range from 0 to 1.0, 0 indicating agreement no better than chance, and 1.0 indicating perfect agreement. It was established that general kappa coefficients across all categories would reach .75 before the analysis continued. Kappa coefficients of .83 and .80 were obtained in the initial iteration. Therefore, the coded data was retained in the original categories and no segments were dropped from the analysis. Although both raters

indicated that some material might have been appropriately assigned to more than one category, kappa coefficients were sufficiently high to indicate primary designations were significantly similar.

After interviews and analyses were completed, select participants were asked to participate in a phone interview. Participants were selected on the basis of their interest in being contacted at a later date as well as the level of participation exhibited during the interview. Participants who had been more engaged in the interview process were more likely to be contacted. During this brief interview, preliminary observations based on combined responses from many respondents were presented to the participant. The participant was asked for her feedback on these observations and given an opportunity to clarify her previous statements. Participants were encouraged to comment on their feelings and thoughts about these observations and to discuss the relevance of these observations to their own experiences. These interviews provided an opportunity to alleviate the power differential inherent in the methodology of discourse analysis, as well as contributed to the rigor of the study. It also provided another opportunity for the author to examine her own values, assumptions, characteristics, and motivations, and how these may have affected the interpretation of the data.

CHAPTER 3

RESULTS

The analysis of transcribed interviews focused on women's experiences with and expectations of the physician-patient relationship. The analysis focused on information sharing, decision making, and disclosure of emotional and contextual information, as well as participants' understandings of the scripts that physicians and patients might employ in the encounter. Themes associated with each of these topics are discussed below under the heading "Women's Experiences and Expectations." Discussion of these major topics is followed by a description of themes related to the enactment of gender, found under the heading "Doing Gender."

Women's Experiences and Expectations

Participants discussed both good and bad experiences during medical encounters, what they considered to be desirable qualities in their physicians, as well as their general expectations and scripts for medical visits. Topics related to experiences and expectations included information sharing, decision making, and emotional context.

Information Sharing: The Importance of Reciprocity

Data regarding information sharing emerged from Participants' responses to several interview questions. Participants spoke about sharing information in response to questions about good and bad doctor visits, questions about what they expected to happen during the typical doctor visit, questions about their description of a "good doctor," and questions about how they typically made decisions about their health.

Participants' responses indicated that information sharing was a very important element of their experience. The major finding to emerge regarding information sharing was that participants wanted to be engaged in a reciprocal process of giving and receiving information. Both imparting information to physicians and receiving information from physicians were deemed important. When participants were not given sufficient information or not allowed to share information, they tended to evaluate their experience and their physician negatively. Conversely, those who were included in the processes of information sharing tended to evaluate their physicians and medical encounters positively. As illustrated below, participants were emphatic about the importance of information sharing, and it was often a feature of notably bad or notably good visits.

In general, participants seemed to appreciate being provided information regarding their health. This appreciation was perhaps most apparent in participants' retelling of their bad and good experiences with physicians. Many of the bad visit scenarios involved the participants being dissatisfied because they did not receive as much information as they would have liked. Anna³, a participant who had been diagnosed with rheumatoid arthritis, recalled her first visit with a rheumatologist at the age of twelve. After the doctor had asked her and her mother a lengthy series of questions, examined her, and drawn her blood, he prescribed daily gold shots, which she would have to give herself. Anna commented that she "... had no idea what he was even talking about" and that, "[he] didn't explain anything to me, just told me, out of the clear blue. I mean, my mom even started crying, my mom didn't even know what in the world

³All participants have been assigned fictitious names to preserve their anonymity.

he was talking about.” Anna recalled that, although there were many reasons she considered the visit to be a negative experience, this element of not understanding was very perplexing for both herself and her mother.

In a bad visit scenario recounted by Barbara, a participant who had recently experienced a problem with hair loss, a dermatologist had failed to provide her with information about her condition: “And the doctor came in and basically, like, pulled out a few of my hairs, came back within, like, a couple of minutes, and was just like, ‘We don’t know what’s wrong.’ ...I was very unhappy with his lack of wanting to do anything else or any explanation.” She asked him what else she could do, and he suggested more blood work, “but he didn’t really elaborate on that or give any further explanations.” As in Anna’s scenario, Barbara’s experience was frustrating for many reasons. However, the lack of information from providers seemed to be pivotal in her evaluation of the encounter.

Rita also described a bad visit scenario where the lack of information provided seemed pivotal to her experience. Rita was pregnant with her second child and had, in the middle of the night, thought that her water had broken. She awoke to a blood-soaked bed. Rita continued to bleed as her husband rushed her to the hospital. She described herself as being “in shock” and feared that she was losing her baby. However, none of the hospital personnel were willing to explain to her why she was bleeding: “the whole time, I’m like, why all this blood? What’s going on? Nobody really had an answer for me, and....I kept asking people and never got an answer.” Rita delivered a healthy son, but she remained perplexed about why there had been so much blood. She later discovered that it was probably not an uncommon occurrence, but she lamented the fact

that she had not been answered when she asked her question: “I wish that somebody would’ve answered my questions instead of putting me off the whole time I was in there. If they knew it was something that just happens once in a while, why didn’t they just say it’s something that happens once in a while, you know, trying to...address my concerns instead of just blowing me off.”

Several good visit scenarios also seemed to reveal an appreciation of a doctor’s willingness to provide information. When asked to tell about a visit that went well, Faith recounted a visit where she was diagnosed with pleurisy: “The doctor ended up, ‘cause I didn’t, I mean, I didn’t have any idea what [pleurisy] was. And he went and got a pamphlet for me, and showed me, you know, this is what’s going on....So it was like he really sat down and explained.” Faith related an account of another visit that she thought went well, this time when she was diagnosed with a stomach ailment. In this visit, she says the doctor, “took his TIME, um, once again, he gave me papers on a newer diet ...and sat down and told me, you know, you maybe should try these things.” She was grateful that the doctor was willing to take the time and explain this information.

Grace, a participant who had recently had her oral contraceptive prescription changed, talked about what she described as the best doctor’s visit that she thought she had ever had. Her gynecologist had asked her to come in so that she could give her the instructions for taking this new prescription:

...the only reason that I even went in there was because she wanted me to come in to make sure that I knew the right way to take those birth control pills....She wanted to make sure that I knew everything about it and how to take them and just the right way to do it and all the side effects and

everything, and she just made sure that I knew.

Grace noted that this particular physician was different from other physicians she had seen, that this physician would often take the time to look up the answers to Grace's questions if the physician did not already know the answer. This willingness to provide information was very important to Grace.

Others appreciated the willingness of physicians to explain procedures. Carrie described her first gynecological exam as a positive experience because the physician told her exactly what was going to happen and what he was doing, which put her at ease. She had previously been very apprehensive about the exam, but she felt that, "he explained it to me better than anyone else could have." She further commented that she thought that this positive experience was probably why she no longer feels apprehensive about going to the gynecologist.

Ivy also described a scenario in which she felt information about what would be taking place during an encounter was important. Ivy had been experiencing symptoms of a bacterial vaginal infection. She remembered having to answer several questions, undergoing an exam, and her physician going in and out of the exam room several times. She said that she felt "vulnerable" and stated that she thought she would have been more comfortable if she had been provided more information about her diagnosis and about the procedures used during her visit:

I think maybe even, um, just sitting down and kind of talking to me more about, oh, this is the—this is something that's, you know, if it's common or not, or, um, I remember just kind of, her walking in and out of the room a couple of times, you know, to go in, if she was looking at things on a

slide, or, you know, she was just getting samples of things or something, um, and I just kind of felt like what was going on, I didn't know what was going on. She wasn't really talking to me to tell me what they were doing, and...what state I was in.

Ivy suggested the following scenario when asked how she would have changed the visit to make it more positive:

Maybe, um, just...kind of letting me know that this, you know, that there was a systematic way...once I told her maybe some of my symptoms, for her to say, okay, well we're going to do this test, and we're going to, you know, it's going to take a little while or something, and, just to have, probably, a little bit of awareness as to what was going on.

Although it was evident from most participants' interviews that they appreciated receiving information from their physicians, it was also evident that many appreciated it when their physicians were willing to receive information. This was evidenced in a preference to have a physician who was willing to listen. A physician's willingness to listen to patients' symptoms, concerns, and even explanations were important to many of the participants. When asked to describe what they thought were the characteristics of a good doctor or what they looked for in a doctor, several of the participants replied that they wanted a doctor who would listen to them. Rita was one of these participants. According to Rita, the only really important qualities that she would look for in a physician were for them to be "competent and [want] to listen to what I have to say."

Rita's recounting of a bad medical encounter reiterated her desire to be listened to. Rita was pregnant with her first child and was only a matter of days away from her

due date. She had gone to the emergency room with symptoms of a urinary tract infection, a condition she had experienced many times prior to her pregnancy. Although she described her symptoms to the physician, he neglected to take the possibility of a urinary tract infection into account. Instead, he admitted her and told her she was in labor. After several hours and the physician breaking her water, she did indeed begin having contractions. Rita became very sick during labor and her son was born with a very high fever and an infection. She believed that the outcome could have been different for both herself and her son had her physician listened to her symptoms and tested her urine to detect whether infection was present.

In another bad visit scenario revealing of the importance of being listened to, Hannah recalled a time when she presented her gynecologist with information she thought relevant to her then-current condition. Hannah, who was being treated for a urinary tract infection, brought a book about homeopathic remedies with her to a visit in order to solicit her gynecologist's opinion. Hannah recalled her gynecologist's reaction: "...she just told me it was a bunch of bull, not to believe it, that medicine is the best thing on the market." Hannah believed that, even if her doctor did not agree with the book, she "should have been, like, you know, well this is...why I don't believe in it, you know, and this is how your body's...made up, and explained...that to me, instead of taking the book, putting it on the table and looking at me and saying this is just not—you don't even need to be reading this, this is crazy." In short, Hannah wished she had been listened to and had her information given serious consideration.

Anna recalled a time when her physician failed to listen to her medical history. Anna, as mentioned above, had been diagnosed with lupus. This condition had precluded

her lifting heavy weights as a part of her physical exercise routine. Anna had been warned by more than one physician that she should use only light weights when weight lifting. Therefore, Anna was surprised when a new physician told her that she really needed to be lifting weights as a part of her work-out routine. She asked him if he had read over the medical history questionnaire that she had filled out previous to their appointment. Anna described his response: "...instead of taking a second to look over my medical records, he proceeded to disapprove of me and to argue with me." Anna found this encounter so frustrating that she left the appointment and never returned to this physician.

One participant in particular, Nancy, was especially critical of doctors' unwillingness to listen to their patients: "...doctors are, like, in and then they're OUT. And they're not LISTENING⁴ to what the patients NEEDS are. And I really feel like that's happened to me, SO many times, like I'm not being listened to."

Barbara commented that she would prefer a physician who would listen to her self-diagnosis: "That they'll listen to what I think it might be,...I think that's important...even if I'm wrong, and then they can tell me why I'm wrong." Anna, who had dealt with several chronic health problems including lupus, said that she wanted a doctor, "who will listen to me and who will...even if I don't follow the textbook lupus, then he'll still listen to me and understand what's going on or try to understand, he or she, should try to understand." Anna confided that physicians had often told her that the symptoms that she had stated were not what most people with lupus experience, which

⁴ All capitals indicate that the participant placed vocal emphasis on the term or phrase.

frustrated her. She felt as though they were telling her how she *should* feel rather than listening to her description of her symptoms and discussing with her the possible significance or relevance of these symptoms to her diagnosis of lupus.

Involved Decision Making

Participants' responses to several interview questions provided information regarding decision making. In addition to participants' responses to a direct question about how decisions about their health were made, participants talked about making decisions in response to questions about good and bad doctor visits, questions about what they expected to happen during the typical doctor visit, and questions about their description of a "good doctor."

The dominant theme to emerge from participants responses regarding decision making was that it was important to be actively involved in the decision-making process. Although many participants indicated that they did not think it was typical to be involved in the decision-making process during a medical encounter, most participants clearly felt it was desirable.

Involved decision making was characteristic of good visit scenarios. In good visit scenarios, Barbara and Ivy described situations where they had been given some power in making a decision about their treatment plan. Barbara, who was being treated for a sinus infection, recalled that her physician gave her a number of medication samples and a prescription for an antibiotic. He advised her to take the samples first, then get the prescription filled if she did not feel better. When asked how it made her feel to be given the opportunity to make the decision whether or not to take the antibiotic, she replied: "I

feel confident, like I know what goes on in my body.... He kind of made me feel like, okay, you know what your symptoms are, you know what you need to do, and so here's your options."

Ivy recalled, not a specific visit, but visits in general with her dermatologist as being positive because he often gave her options. According to Ivy, "...he has often, you know, given me samples or things, you know, just like, well try this out, tell me what you think about this, and...just to kind of allow...me to be a little bit more in control of... what medications, or what I think works best." Ivy admitted that this physician had poor "social skills," a characteristic she typically liked to avoid in a physician, but she continued to see this physician because he included her in the decision-making process.

When asked directly about their experiences with deciding on things like prescription medications or medical procedures, most of the women described a process whereby their physician presented a number of options and information about each option (e.g., side effects, instructions for usage). Once information was exchanged, a decision was made. Some of these decision-making scenarios involved a decision regarding procedures or surgeries that the participant might undergo, several spoke specifically about the decision to begin taking oral contraceptives, and others described making a decision about treatment options.

Jane, who visited her physician for gynecological complaints, recalled that she was given an option of whether or not to undergo a procedure. She stated that she had three different sessions with her gynecologist to ask questions about this possible procedure. After these sessions, talking to her friends who had undergone the procedure,

and reading about the procedure, Jane “made that decision, you know, sort of, not entirely on [her] own, but pretty much.”

Faith also stated that she had been given the opportunity to make a decision after being given an option by a physician. Faith had been experiencing stomach problems, and her physician gave her the option to have a special procedure that might allow them to better understand her problem. The physician explained the procedure to her, telling her about the possible discomforts. She stated that her doctor then “let [her] basically make that whole decision.”

Some of the women—Carrie, Laura, and Mary—described a similar decision-making process when detailing their decision to begin taking oral contraceptives. According to Carrie, she asked her physician for birth control. Carrie’s doctor gave her the option between taking a shot or taking pills (Carrie had told him “upfront” that she was not interested in a diaphragm) and they discussed the side effects of each. Carrie commented that the final decision was “kind of mutual” because she made the decision to take a pill, but he decided which pill to prescribe.

In contrast, Laura replied to the question of who made the final decision on which birth control pill to take with, “Oh, it was definitely me.” Laura described the decision-making process: “We had to sit down and talk about, like, what would make me fe-feel⁵ more comfortable...whether I wanted to do a shot, patch, pill.” She recalled looking at a poster on the wall, and her physician giving her a “rundown” of each option listed on the poster. She eliminated each option that she felt uncomfortable with and they decided that

⁵ Hyphen indicates stuttering.

she would take a pill. He then suggested she begin taking one of two oral contraceptive pills. He provided information on both, and she then chose one.

Mary had asked her physician for oral contraceptives to control severe menstrual cramps. She recalled that her physician told her that she would need a pill with a higher dose of estrogen in order to control her cramps, and he told her about “a couple different ones” which had this higher dose. He told her about the side effects, effectiveness, and cost of these higher-dose options, and then she decided which one she would take.

Others described being given a number of options for treatment of various ailments. Barbara had been diagnosed with polycystic ovarian syndrome. Her doctor gave her three treatment options: “There was a pill I could take, like three days once a month.... I could get on birth control, or, like, pills, or I could do birth control shots.” Barbara explained that her doctor helped her “talk it out” and decide what would be best for her, but Barbara reported that, “the decision was purely up to me.”

Pamela had sought medical help for a problem with anxiety that she had been experiencing. Her physician told her that there were “several possibilities” for treatment, then described a number of anxiety medications. Pamela shared with her physician her concerns with taking a medication for anxiety, and, knowing these concerns, her physician made a recommendation. Although Pamela initially remarked that her physician had made the final decision, she corrected herself and said that she made the final decision by actually deciding to take the medication.

Anna professed a similar philosophy about who really made the decisions about her health. When asked who made the final decision in the scenario that she had described, she jokingly replied that she did: “...unless my mom or my husband is

sneaking it into my food.” In the decision-making scenario described by Anna, she mentioned being given only one option for treatment. However, Anna and her physician discussed her concerns about the medicine, they discussed the “pros and cons” and she was given the prescription. Anna commented that she felt lucky to have the doctor mentioned in her decision-making scenario because he gave her the opportunity to discuss her treatment plan. She further explained, “Other times...I’ve just been given prescriptions and sent on my way.”

When asked to describe a visit when a decision, such as to take a medication or to have a procedure, was made, a majority of the participants described visits where they had been given some option. Interestingly, however, when asked if they thought this was the typical way that decisions were made, most of these same participants replied that it was not. Many seemed to agree with Anna that, typically, they were simply given a prescription or told to have a procedure. Rita commented that she did not think that she typically discussed with her doctor the medications that she was prescribed: “...they just write a prescription, or they give me samples or whatever, and I just take whatever they give me.” Faith compared her experience with deciding whether to have a procedure to diagnose her stomach ailment with her experience in consulting with her doctor about her diagnosis of pleurisy: “I mean, like with the pleurisy thing,...they had to take x-rays and stuff, so, I mean, he was like okay we’re gonna take x-rays.” She believed that this latter scenario was the more typical scenario.

Emotion and Context

In addition to information sharing about biomedical factors, participants talked about information sharing with respect to emotional and social contexts. Participants had varying experiences of and opinions about sharing social and emotional information during medical visits; some endorsed the relevance and beneficial effects of incorporating these elements, while others expressed disapproval about it. Information regarding emotion and context emerged from participants' comments about both good and bad visit scenarios. Participants' comments about what they expected to occur between physician and patient during a typical office visit was also relevant to the topic of emotion and context.

Participants generally perceived it necessary to provide physicians only minimal information regarding their emotional states or other contextual variables within their lives. When participants were asked what they expected to happen when they went to the doctor, few anticipated a need to tell their doctors what was going on in their lives, other than to describe what physical symptoms were bothering them and to answer perfunctory questions such as, "How's school?" However, many participants' stories of both bad and good visits indicated a preference for some acknowledgement of their contextually-grounded experiences and emotional concerns.

Some bad visit scenarios involved a lack of attention to the context of the patient's life or to the emotional concerns of the patient. For instance, Olivia described an experience with a physician whom she consulted after feeling symptoms of depression. At the time of the visit, Olivia was finishing her undergraduate degree, her father was dying of cancer, she was about to start a summer job, and she was preparing to

begin graduate school within a few months. She was having trouble getting out of bed in the morning, and often felt as though she were having an “anxiety attack.” She described her experience with her symptoms and with her doctor:

...I went there [her physician’s office] several times and they ran tests and they never really came up with any conclusions, and the final visit, I said, “Well, what’s wrong with me?” And she said, “Well,” she said, “I don’t know what’s wrong with you.” She said it might be, you know, depression or psychological, but, “I wouldn’t necessarily suggest that you go to a therapist.”

When asked what questions her physician asked her during these visits, Olivia responded that the doctor asked, “Is there anything going on in your life?”. In reply, Olivia told her all of the many stressors that Olivia had been experiencing: “I listed all these things, and she goes, ‘Well, how are you dealing with that?’ And, in my mind, I thought I was doing okay.” When asked what she would have changed about the visit, Olivia intimated that she would have liked for the doctor to have spent more time with her and for her physician to have been more empathic with her. Olivia continued to experience symptoms until she talked with an acquaintance who had had a similar experience and who had been helped by psychotherapy. Olivia eventually consulted a counselor, and her symptoms abated. Although the physician in this bad visit scenario did ask questions regarding the context of the patient’s life, it seems that these contextual issues were not explored to the degree Olivia had hoped.

Eve also recounted a doctor’s visit where she had complained of symptoms of depression. Eve commented that she had been given a bag of medication samples with

the instructions to try them and return if they did not bring her relief. Eve later came to resent these instructions when she was unable to discontinue use of the medication without negative side effects. Although this scenario may indicate an irritation due to a lack of information sharing, Eve's responses to follow-up questions indicated that the source of the problem was more specifically that she was not given information about alternatives such as talk therapy. When asked what she would rather have happened in the scenario, she replied that she wished they had referred her to someone she could talk to. Eve did not comment on whether or not she had been asked about the context of her life, but her wish for someone to talk to may indicate that she did not receive adequate attention during her office visit.

Another negative experience may demonstrate a lack of attention to a patient's contextual information. Rita was expecting her first child. She had explained to her two obstetricians on several occasions that her husband was an officer in the United States Army and was stationed in Iraq (during the Persian Gulf War). However, she recounted one visit where her doctor had forgotten this information. According to Rita, her obstetrician asked her what her husband thought about some decision. When she replied that she had not been able to talk to her husband for some time, the doctor continued to question her about her ability to get in contact with her husband. This made Rita all the more aware of her situation, which was far from ideal in her mind. She finally began crying, which, she recounted, elicited an awkward apology from her physician. Perhaps had her physician been more attentive to her difficult situation, there would not have been any need for awkward apologies.

Nancy described an experience that she found to be “completely devastating,” an experience that may have been remedied had more sensitivity been applied to the contextual factors of her visit. Nancy was visiting her primary care facility for her annual gynecological exam. Although she had requested a female physician, she found that there was not one available when she arrived at her appointment. Nancy explained to the staff that she was a survivor of childhood sexual abuse, and, therefore, it was very difficult for her to be examined by a male physician. According to Nancy, “There was just a HUGE run-around.... I felt that the staff handled the situation so horribly.” Had Nancy’s history of sexual abuse been taken more seriously, perhaps she would not have found the experience to be so emotionally devastating.

Although the importance of understanding and acknowledging the context of women’s lives was most prominent in the depictions of visits that did not go well, some good visits also demonstrated this point. Hannah described an interaction with her gynecologist that she remembered being very positive. The night previous to Hannah’s interaction with her doctor, she had visited a hospital emergency room for symptoms of a urinary tract infection. The emergency room experience had been very scary for Hannah. Therefore, the actions of her gynecologist were more than welcomed. According to Hannah, her gynecologist called her and told her that she was sorry that Hannah had gone through such a bad experience. Her gynecologist asked her if she needed to talk and offered to see her. The next day, Hannah did see her gynecologist, who continued to question her about her emergency room experience and how it had made her feel. Hannah commented that she had been very lucky to have this physician who was interested in how she felt emotionally as well as physically.

Expected Scripts for the Medical Encounter

Excerpts regarding scripts for the medical encounter came primarily from responses to a direct question about what was expected to happen during a doctor's visit. Responses to this question typically indicated the existence of a normative script, i.e., women had very similar accounts of what would happen during a typical encounter. Omissions from the normative script are discussed later in this section under "Missing Elements: Asking Questions and Negotiating Disagreement."

The Normative Script. Most participants had no difficulty in describing a standard sequence of behaviors to be undertaken by both physician and patient (as well as by other players, such as receptionists and physicians' assistants). Participants described a process whereby they provided some information to a receptionist, waited for a period in a waiting room, were taken to an examination room by someone other than the physician (most referred to a nurse or a physician's assistant), were asked a number of questions by this person (such as what was the cause of their visit), and had their blood pressure and/or temperature measured. After this interaction, they would wait for another period in the examination room. When the physician arrived, he or she would ask the patient more questions (often repeating questions already asked by the nurse or physician's assistant), and, depending on the reason for the visit, some form of physical examination would occur. The physician would then make some recommendation, perhaps write a prescription or provide the patient with medication samples. The patient would then exit the examination room and make any necessary arrangements for payment with the receptionist before departing from the office. Although some mentioned more

steps than others (e.g., only one participant reported being asked to give a urine sample), there were no disagreements regarding the basic sequence of events.

Carrie described her expectations regarding the sequential order of steps to be taken in an office visit as thus:

I go and I check in and write a little note saying what time I got here and what insurance I have and then I sit in the waiting room for however long, it just depends on the day. And then a nurse calls, comes gets me and, um, usually they don't weigh me or anything but sometimes they do. And then they put me in a room; they take me, like they take the prereq. stuff, like why are you here and what the symptoms are. And then they write that down and then they go get, they leave, put the chart in the door and then the doctor comes. And then if he needs to go get free samples, he'll leave the room, go get them and then come back. And then I just go and check out, and if I have to pay anything I pay it and I leave.

Many of the participants, like Carrie, had to be prompted to describe the typical interactions that they had with their physicians. All participants reported that the physician typically talked first. Many reported that he or she would enter the room and greet them by asking them how they were doing. The physician would then ask more specific questions, such as "How long have you been experiencing these symptoms?"

Missing Elements: Asking Questions and Negotiating Disagreement.

Interestingly, the normative script did not include question-asking by the patients, and most participants had to be further prompted to describe any questions that they might ask the doctor. Mary's reply to the question of whether or not she tended to ask questions

of her doctor was similar in sentiment to many of the other participants' responses: "Um, only if you're concerned, I mean, [I] usually expect the doctor to know what they're talking about. You expect them to ask the right questions." And Barbara succinctly replied, "Not really. I just trust him."

Not all participants indicated a tendency towards reticence with physicians. For example, Anna explained that she often kept a notebook to keep track of her lupus symptoms and to record the questions that she wanted to ask her physician. She would take the notebook to her office visits and refer to it to ensure that she does not forget to ask any questions. She reported that she often asks questions about alternative medications, side effects of medications, and whether or not there were any lifestyle changes that could be undertaken to alleviate a particular symptom or set of symptoms. Anna, however, was a member of a very small minority of the participants in regard to her preference for preparing and asking questions. Most of the participants reported that they did nothing to prepare for their doctor's visits, other than showering or procuring funds for the payment of fees.

Another apparent missing component of the normative script pertained to negotiating a disagreement with a physician. Participants seldom discussed visits where there had been specific disagreements, and no consensus emerged in regard to how disagreements between physicians and patients might be negotiated and resolved. The response to disagreement often was to leave the field rather than negotiate.

Many participants plainly stated that they had never really disagreed with a physician, while others said that they had disagreed, but had not confronted the doctor. For example, Eve reported that she thought that the directions for use for her oral

contraceptive were inaccurate. However, she did not ask her physician any questions; she simply began taking the oral contraceptives in a manner most convenient for her. Anna described two different situations where she disagreed with two respective physicians. She resolved these disagreements by not returning to their practices, but reported that she did not feel that the matters were ever completely resolved and that situations where she disagrees with physicians generally “don’t go well.”

Kara described a visit with her obstetrician where she felt that his warnings about not gaining enough weight were unwarranted: “We did kinda...disagree there on a few occasions, so, um, but, I mean, you know, he kinda got a little testy with me a couple of times as far as that was concerned, just kind of emphasizing how important [gaining weight] was and the reasons why and everything.” She reported that she tried to explain to him why she believed she was not gaining much weight and why she did not think that he should be concerned, but he did not want to hear her explanations. She also reported, however, that she never left her doctor “on bad terms” because she knew that she had to return to see him. The situation was resolved by her eventual weight gain.

One participant, Jane, related a story about a time that a disagreement with a physician resulted in a positive outcome. Jane had been experiencing some debilitating symptoms of an illness that had not been diagnosed. Jane’s internist had suggested she take a medication that she was opposed to taking. Jane consulted her rheumatologist and discussed an alternative medication that she had found while researching her illness. Jane and both of her physicians decided that she should try the alternative medication she had proposed to take. She reported that, although she thought that her internist still wanted her to take the medication to which she was opposed to taking, he “gave up on that” and

agreed that she should take the medication she proposed. After taking the medication for several weeks, her symptoms abated. Jane reported that she did not feel very comfortable in the situation where she proposed taking a different medication. However, Jane reported that she felt “pretty excited” about having the opportunity to share information with her doctor. Jane further commented: “I sort of discovered then that you have to take charge of your own health, in a lot of ways. You can’t just be totally trusting of the doctors.”

Jane was the sole participant who was able to recount a scenario in which she was able to confront a doctor with whom she disagreed and which resulted in a positive outcome. As stated above, most participants were unable to recall a time when they had disagreed with a physician. Those who could recall such a scenario often reported that they did not directly confront the physician. Some participants were asked to report how they thought they would react if they, some time in the future, were to disagree with a physician. Mary replied to this question by saying that, if she were given a prescription that she did not want to take, she would simply not take it. However, she then mentioned that this would not be a good solution because she might actually want to be given some other medication. Mary tenuously concluded that she would be able to confront a physician if she disagreed on matters other than prescription medications.

The reluctance to directly confront a physician was explained by some of the participants. Barbara explained that she had never disagreed with a physician because of her “lack of knowledge about medical things,” and that she tended to, “take their word for a lot of stuff.” As another example, Hannah explained what her parents had taught her about questioning physicians:

I think I was really gullible when I was younger, because they were supposed to be like someone that I looked up to, you know, someone who's supposed to, like, take care of me, you know. I think my parents, any time I would question anything, they were like, "You can't question that." You know? ... "They-they know what's best for you."

This participant explained that she no longer believed this about physicians, but admitted that she still felt uncomfortable disagreeing with a physician. This uncomfortable feeling could, in part, be due to a lack of a known, regimented way to confront a physician with a disagreement.

Doing Gender

Gender appeared to be enacted in a variety of ways within medical encounters. The subordinate status of women typical of society in general was often evidenced in women's recounting of medical encounters. This was most notable in women's experiences of information sharing and decision making. Aspects of gender characteristic of society in general were also reflected in general expectations regarding medical encounters.

Ignored, Dismissed and Disempowered

As evidenced in previous sections, the women in the present sample were able to recount many instances where their requests for information had been ignored, where their concerns had been dismissed and where their experiences had resulted in a sense of disempowerment. Participants' responses also provided information about women's perceptions of how their gender may affect their experiences with physicians.

Subsequent to their accounts of being silenced and ignored, some participants were asked if they believed they would have been treated differently if they had been male.

Some participants hypothesized that they might have been treated differently in their bad visit scenarios if they had been male. For example, Barbara, who had recounted her experience of having her questions ignored by a dermatologist, suggested that her doctor would have reacted more positively to her questions had she been male. Anna also suggested that physicians would have treated her differently if she had been male. She believed this because she had noticed that, when her husband went with her to her physician visits, the physician tended to talk to her husband rather than her. For this reason, Anna explained, she no longer takes her husband with her to her visits.

Rita also indicated that she thought that she might receive different treatment from physicians if she were male. Rita confided that she had felt the physicians she had encountered in the past had often been condescending towards her. She believed that, had she been male, she would not have received at least some of these condescending comments.

Resistance to the Doing of Gender

The doing of gender was evidenced in some participants' attitudes toward providing information about the emotional and social contexts of their lives. Although many participants indicated that it was important for their social contexts and emotional lives to be acknowledged during the medical visit, others expressed apprehension when physicians focused extensively on what the woman felt to be non-medical aspects of her problem. In a society where women are often stereotyped as overly-emotional and may

be at risk for having her medical problems dismissed as an emotional problem, this apprehension may be well-founded. Limiting the amount of focus accorded social-emotional factors may be a way to resist the traditional doing of gender.

A number of participants indicated that they were uncomfortable discussing their personal lives with physicians. For example, Eve mentioned that she felt that physicians sometimes crossed boundaries by asking questions about family:

Just, like, sometimes with your family life, they really don't need to know that. Like, sometimes, they'll get into your family life.... My mom's doctor sometimes asks about how my brother's doing, how my family's doing sometimes. Really, that's—he shouldn't ask that, because he's dealing with one patient, and you shouldn't have to ask what the FAMILY, if he knows there's problems going on, that's kind of being nosey.

Eve further explained that it is preferable to have a physician who is “personal, but not too personal.”

Rita, also, discussed how her ideal relationship with a physician would involve a certain amount of distance. When I asked Rita if she was typically asked questions about what was going on in her life, she replied that she was asked once about anxiety when she was experiencing chest pain, but that it was not a typical question to be asked. When asked if she thought physicians should ask questions about patients' lives more often, she replied:

I personally do not like it when doctors, um, are more personal, I like them to be impersonal, I don't like them to, to get involved

in that, and that's probably, that's probably not the norm, I mean, I prefer it to stay, you know, doctor-patient. I-I-I'm not sure why, but I just prefer that distance, and, um, so I don't like when they ask questions like that.

Neither Eve nor Rita was able to explain her need for a less personal physician-patient relationship. However, responses from other participants indicated that some participants were aware of possible stereotypes that they might encounter. For example, Nancy recounted a story of an encounter with a nurse whom she had contacted when her daughter had a high fever. Nancy's daughter had previously experienced a seizure due to a high fever, and, therefore, Nancy's concern for her daughter's well-being was perhaps heightened. She reported that she felt as though the nurse responded to her concerns as though she were a "hypochondriac." Nancy reported that she understood that nurses and physicians receive many calls from mothers who are concerned about the welfare of their children. However, she also stated that she believed that nurses' and physicians' reactions to worried, anxious mothers were an indication of their willingness to subscribe to gender stereotypes of overly-emotional females. Evidently, being perceived as "stereotypically female" might be a concern for some women when they are interacting with their physicians.

Different Scripts for Different Genders

Participants were asked what they thought the ideal relationship with a physician would be like, and then were asked if this ideal differed for men and women. Some participants believed that there would not be a different ideal for male and female

patients. For example, Olivia thought that the ideal physician-patient relationship was “very personal to every individual.” However, the majority stated that they thought there would be a difference in ideal physician-patient relationships for male and female patients. Many of the responses indicated that a differing ideal would impact the understood script of the medical encounter.

Many participants commented that male patients would require less time with their physicians, for a variety of reasons. For example, Debbie responded that she thought doctors would treat male patients differently than female patients because a doctor:

“...might think that, you know, just like the male stereotype is, kind of, not, you know, they’re not scared going to the doctor or something, or, you know, they just want to, you know, quickly in and out, like they don’t want to interact, they don’t, you know, they may not want to talk or interact with the doctor or anything.”

Eve replied that men are less emotional than women, and that this would affect how their physicians would treat them:

“So, I guess, when [male patients] go to the doctor, they just go in there and get it out, get over it and leave, you know? They don’t care which doctor they have, but women, I think, they’re more emotional with their doctors, I think.”

Eve further elaborated: “Women have a lot more doctors than men do in the first place.

You have to ask questions. You have to know what’s going on. You kind of have to

have a close relationship with your doctor.” According to Eve, men would seemingly not need as much time with and attention from their physicians.

Faith, Grace, and Ivy also expressed beliefs that men would spend less time with their physicians. Faith responded that male patients would be “short and sweet with it.” She postulated that this might be because women are “more on, like, communicating, they want to know that, I guess, they understand the doctor and the doctor understands them.” Grace expressed a belief that males really “didn’t care to have things explained to them.” Grace also suggested that females would require more time with their doctors than male patients would: “I think that a female, that’s just how females are, I mean, females are gonna take more time with anybody.” Ivy explained why she thought that men might not take as much time with their physicians:

If [male patients] have a problem, then they want to get that resolved, because it’s taking up their time, not because it’s necessarily affecting so many other things.... Maybe with women, going to their doctors is more than just resolving the illness, or something like that, but it’s also, you know, maybe they feel that, um, maybe if their doctor is-is a part of their whole world, their whole life, you know. They have their family, they have their friends, they have their doctor, they have their church, or just whatever, these kinds of things make up their social realm.

Hannah stated that she believed women would want to spend more time with their physicians because women tended to focus more on relationships than men did. She stated that male patients might consider a doctor’s appointment to be a “time constraint” and might not desire “any attachment with their doctors.” Nancy also articulated a belief

that male and female patients are different, and therefore would require different interactions with physicians. She noted that her husband did not get as upset as she when a doctor neglected to ask a question and that this was because: “Men don’t make as much of an emotional connection with their practitioner.”

Pamela stated that there would be a different ideal for male and female patients “because men and women are so different, and I feel as though women’s health care is so much more out there than it is for men.” She believed, since women seemingly had more health concerns than men, that physicians should ask women more questions.

A majority of participants expressed a belief that male and female patients are different, and, therefore, require a different level of involvement with their physicians. This understanding of men and women as essentially different was also revealed in the participants’ responses to questions about how a physician’s gender might affect the physician-patient interaction.

Expectations Based on Physician Gender

Participants were asked whether or not they had a preference for a male or a female physician. This question was followed-up by several questions, such as: “Are there certain circumstances under which you would prefer to have a female physician or prefer to have a male physician?” Four of the seventeen participants replied that they did not have a preference for either a male or female physician. For example, Carrie stated that she had thought at one time that she would want a female physician, but when logistical circumstances required her to go to a male, she was not particularly disturbed. She did not believe that a physician’s gender would coincide with any differences in their

behavior, so she did not consider it a factor when choosing a doctor. Two participants stated they preferred to go to male physicians for their gynecological care. However, a majority of the participants either preferred female physicians, in general, or preferred a female physician particularly for gynecological and/or obstetrical visits.

Participants were encouraged to explain why they had such preferences.

Responses tended to indicate a belief that either women physicians were superior because they have more knowledge of women's bodies, or that women physicians were more likely to possess a number of desirable characteristics and skills, such being more caring or better able to connect emotionally with their patients. These themes will be discussed in the following sections.

Women Know Women Better. Several participants expressed the sentiment that female physicians were preferable because women physicians have more knowledge of the female body. Hannah explained her preference for female physician by stating, "Females know female bodies better than males do." And Pamela stated that she preferred a female gynecologist because: "A woman knows a woman's body better than a man."

Statements made by other participants reflected Hannah's and Pamela's sentiments. For example, Anna stated that she had a preference for female physicians. When asked to explain why, she responded by relating a story of how, when she was quite young, she had been hospitalized for an infection. The antibiotics that she had been administered to fight the infection had induced a vaginal yeast infection. She explained that the treatment for this yeast infection was a vaginal suppository. The suppository had been inserted by a male healthcare professional. Anna found the encounter to be quite

traumatic. She thought that it had been “unfortunate” that a male had administered the suppository, indicating that she thought the encounter would not have been as frightening had it involved a female medical professional. According to Anna, female physicians are more likely to understand what is meant when a female patient says she is experiencing pain: “If I say it hurts, she knows what I mean when I think it hurts. Where, if I say it hurts, I don’t think a guy can understand that.”

Nancy preferred to see female practitioners for her gynecological and obstetrical care. She explained that, although she held this preference, she did not think that male physicians were not “good people,” but she believed that, “...if you want to be seen about your body parts, you’re gonna want to be seen by somebody else who has the same body parts.” And in regards to male obstetricians, Nancy expressed the following attitude: “I mean, how the hell is [a male obstetrician] gonna know about BIRTHING A BABY when he’s not, he’s a man, he *probably* hasn’t done it before!”

Other participants expressed a belief that, not only do women understand women’s anatomy and physiology better than men do, they can also relate to women better. For example, Hannah conceded that male physicians might have just as much medical knowledge, but she expressed her belief that female physicians, “really understand and feel what you’re going through more so than a male would.”

Kara also indicated that a female physician would be more likely to empathize with her female patients’ concerns:

I want to say...female doctors are probably, when it comes to females... seem to be more sensitive towards female patients’ concerns.... Male doctors, you know, CAN be concerned, but, um, since they’re not, you

know, a female, then they may not necessarily understand some of the things that you may have concerns about or complain about AS a female. Grace believed that, because she was a female, she could “identify” with a female physician more readily, and Ivy discussed how she felt it would be easier for her to explain to a female physician her concerns about acne and other dermatological complaints because a female would be more likely to understand the extent of importance that appearance has for women.

Many of the participants indicated that they preferred a female physician, and many indicated that this was because they believed women physicians to be more knowledgeable about the female body. This belief led some to conclude that women would be better able to understand or empathize with her female patients. Other participants believed that female physicians were more likely to exhibit a number of desirable traits, like being good listeners, showing more concern and being better able to “connect” with their patients.

Female Doctors Listen, Care, and Comfort. Several participants indicated that they believed that female physicians would be more likely to listen, show that they were caring, and make the patient comfortable. Although some believed that this was because women understand women better, many were unable to explain why they believed they were more likely to encounter these characteristics and skills in a female physician.

For example, Debbie believed that she could “connect and interact” with a female physician better, and that it seemed that she could “open up to females more and just be more laid back.” In addition, she thought that, with a female physician, she could, “talk about anything.”

Connecting and interacting were important to Anna, too, who indicated that she preferred female physicians because female physicians were more likely to listen to her. Anna described several situations where she believed her experiences might have been different had she seen a female physician. For example, she did not expect a female physician to talk to her or listen to her with her eyes closed, as one male physician did routinely during their visits. Anna believed that female doctors were “actually interested in what you have to say, um, more so than men.”

Grace also indicated that listening and demonstrating care for a patient were important characteristics that were more likely to be found in female physicians. Grace commented, “I think that maybe female doctors, I think they do take their time a little more than males do, and I think that they are more caring.” She continued, “A female, in my opinion, I don’t know how other females are, but I guess other female doctors would want things explained to them or want time taken with them, maybe that’s why they do it, I don’t know.” Grace especially preferred a female gynecologist because, “in that environment, I would just rather have a female, just because I would really, I really need things explained to me in that sense of the caring, and, um, just taking your time and everything.”

Ivy saw women doctors as being more “attentive” and concerned than male doctors. According to Ivy, female doctors

listen more to just, you know, maybe asking me questions and wanting to get more feedback, rather than just, um, kind of going off of the notes that maybe the nurse had taken, or-or, something like that, maybe just actually asking me again those questions,

um, and, I think, just a slower process of, of the actual interaction with the doctor. I think it would be a little bit longer than it would be with, like, a male doctor.

It is possible that the participants' expectations of gendered physician behavior were based on their actual experiences with physicians who demonstrated these gender differences. However, some participants expressed a belief in gender differences in physician behavior, even though, in their own experiences, they had not encountered these differences. For example, Mary admitted that she had not had any negative experiences with male physicians and would not hesitate to go to a male physician. However, she expressed a belief that female physicians might be preferable: "Just, I guess, in a, in a way, I think it's easier to talk to a female, especially in just, as far as your health, um, just basic prescriptions, you know...just in general, I think it's easier to talk to female doctors."

Many of the participants indicated that they felt more comfortable with female physicians. Some explained that they thought this was due to their belief that women are better able to understand other women, and, thus, they were more at ease when communicating with female physicians. However, some comments indicated that perhaps more was at play in participants' acknowledgement of female physicians' propensity to be more comforting.

None of the participants indicated that physicians had abused them. However, several indicated that possible sexual abuse by male physicians was a concern. For example, Debbie repeatedly referred to male gynecologists as "creepy." She volunteered: "Like nothing ever happened. I've never been, like abused or anything, but, I'd just

rather have, like, my boyfriend touch me, and not any other males.” Anna also explained that she had not been abused by a male practitioner, that he had not done anything “unethical,” but that he still made her feel uncomfortable.

Ivy explained that her mother had once seen a physician who, according to Ivy, was not a “good physician.” She explained how she came to understand why he had not been a “good physician”:

...it’s always kind of bothered me a little bit, because I heard, um, [my parents] talking about it once about he was, this doctor, you know, probably was taking advantage of the female patients just with, you know, touching them more than he needed to and things, and so, I’ve always been a little bit, just hearing probably when I was in late middle school or something, I’ve always, um, a little bit more concerned as when I saw male doctors to know if this is normal. Is he doing something that is procedural? Or is he going beyond? I never have felt like, like they’ve done anything, you know, that was over-over the edge, but...if it’s a male doctor, ... is this the way that they go about this?

Hannah also indicated that her attitudes toward male physicians could be affected by her knowledge of sexual abuse cases:

...this could be in the back of my mind, embedded that I don’t even know about, but, you, just hearing so many, um, freakish, um, circumstances where, like, the men have taken advantage of women in a situation like that or abused them in some way.... I know that

my boyfriend's mom knew someone who that happened to. And it's just, and it's scary, you know? ... If a nurse isn't in the room, I get scared, you know?

Participant responses suggest that many of the participants held some expectations of physician behavior that depended on the gender of the physician. The implications of these findings, as well as other findings elucidated within this chapter, will be discussed in the following chapter.

CHAPTER 4

DISCUSSION

Past research on gender and the medical encounter has tended to focus on gender differences in behavior of both patients and physicians. However, it has been pointed out that this line of research often views evidence of gender differences as an ending point in the analysis—it is simply acknowledged that men and women act differently. Less effort has been expended in assessing how gender shapes and structures the experience of the medical encounter (West, 1993). The present study aimed to provide insight into aspects of the medical encounter from the perspectives of women patients themselves and to offer insight into the ways gender emerges and is enacted in the medical encounter. To this end, female participants recruited from a population of undergraduate and graduate students participated in a semi-structured interview involving questions about their experiences with and expectations of their relationships with physicians. The analysis focused on women's experiences with information sharing, decision making, disclosure of social and emotional information, and on their expectations about scripted behavior in the medical encounter and about how physician gender might affect their interactions with their doctor.

Several themes emerged with respect to aspects of the medical encounter that were significant for the women themselves. Participants indicated that it was very important to be involved in the information-sharing process and appreciated both giving and receiving information. Participants also showed a preference to be actively involved in the decision-making process. Participants indicated that it was necessary in some

circumstances to provide information about the social and emotional contexts of their lives. There was a normative script for an office visit, but, notably, some elements were missing in the script, namely, how to ask a physician questions and a how to negotiate disagreement with a physician.

Participants' accounts provided evidence that many aspects of their encounters were gendered and effectively reproduced traditional gender roles common to society in general. Several of the participants recounted stories of being ignored, dismissed and disempowered during their medical encounters. Some of these participants indicated that they thought they would have been treated more respectfully (i.e., would have been allowed to become involved in information sharing and decision making) had they been male patients. Participants' responses also revealed that some were reluctant to share emotional and contextual information with their physicians, and some indicated that they were reluctant to do this because of the likelihood of being labeled as overly-emotional females. Participants' comments also demonstrated a belief that male patients would differ in their preferences as patients. Many of the participants believed that most men would prefer to have briefer medical visits with more succinct verbal interactions.

Participants also shared their thoughts on how physician gender may affect the medical encounter. Many participants expressed a preference to see a female physician. Reasons for this preference tended to fall within two themes: women physicians know women patients better, and women physicians are better listeners and more caring and comforting. Interestingly, although no participants provided personal accounts of sexual abuse or assault by a physician, a few participants did mention generalized concerns about potential sexualizing and inappropriate behaviors by male physicians. Therefore, it

is possible that women who have not been personally affected by physician sexual misconduct may nonetheless be influenced by the potential of such behavior and may limit their behavior accordingly.

The current findings regarding the importance of information sharing and decision making support past research with female patients. For example, Ellingson & Buzzanell (1999) found that their sample of female breast cancer survivors preferred physicians who would treat them as intelligent and autonomous individuals. This respect was conveyed partially by physicians' willingness to provide information in a straightforward, but tactful, manner. Respect was also conveyed in a physicians' willingness to share control in decision making, thus allowing patients a sense of integrity and empowerment.

In another study of women who had experienced breast cancer, McWilliam, et al. (2000) found that positive experiences of physician-patient communication began with the physician's sensitivity and responsiveness to the vulnerability felt by their patients. This sensitivity and responsiveness was conveyed by a physician's willingness to take their time, listen to their patients, and provide "just the right type and amount of information...to create an experience of actually *sharing* information" (p. 194). When information was not shared, or shared in a manner that was frightening or belittling, participants felt that their control over decisions made about their lives was undermined.

The current study supports the generalizability of results from previous studies of special populations of female patients. In a series of studies, Brown, et al. (2002) investigated the health care decisions of three populations of female patients. These three populations were women who had faced decisions about prenatal genetic screening, hormone replacement therapy, or breast cancer. In all three groups, information sharing

was seen as integral to the decision-making process. Participants described the optimal information-sharing process as involving a physician who would listen and be open to a mutual discussion. The current study provides evidence that a desire for mutual information sharing and decision making may be experienced by many women, not only those who have experienced a life-threatening illness or a specific course of treatment.

Women's demonstrated preference for mutual information sharing may account for findings from previous quantitative studies of actual encounters that indicate women receive more information from their physicians (Hall, et al., 1988; Hooper, et al., 1982; Meeuwesen, et al., 1991; Pendleton & Bochner, 1980; Waitzkin, 1985; Wallen, et al., 1979). Female patients may be more likely, because of this preference, to make efforts, such as showing attentiveness, to engage the physician in the information-sharing process.

Participants in the current study were able to recount experiences of being silenced when attempting to engage in a dialogic process of information sharing and decision making. Participants in the current study related many instances of having their concerns ignored, of being denied explanations, and of being disempowered during times of decision making. These experiences occurred during visits for health and wellness issues as varied as childbirth, hair loss, and lupus. Past research has found similar results. For example, Grace (1995), in her study of women who had experienced chronic pelvic pain, found that her participants were able to recount many stories of not being given adequate information about their diagnoses and prescribed information. Participants also reported that they felt as though they were not being taken seriously by their physicians (Grace, 1995).

Analysis in the current study also focused on a special type of information sharing—the sharing of information about a woman’s social-emotional context of her life. Participants indicated that it was sometimes helpful if physicians were attentive to the context of their lives. Participants were most likely to indicate the importance of attention to their emotional and social well-being when their recent circumstances had been especially stressful (such as having been recently informed that a loved one had cancer), or when the woman had some history (such as childhood sexual abuse) that made medical procedures difficult or distressing.

Past research has provided evidence that physicians pay more attention to the disclosure of information regarding emotions when the patient is female (Stewart, 1983; Wallen, et al., 1979). However, the present study provided little evidence that participants expected physicians to pay heed to information about their lives and emotions. In fact, most comments on the importance of physicians’ receptiveness to such information came from participants’ narratives of medical visits that had not gone well. In these examples, participants recounted stories about bad visits where some aspect of their life’s context had been ignored by the physician. There were few instances of visits that had gone well because some contextual aspect of a participant’s life had been attended to by a physician.

Although some participants reported that it was important for physicians to consider information other than their physical symptoms, some participants also expressed a reluctance to share information about the contexts of their lives. Not all participants were able to explain why they were reluctant, although some indicated that a reluctance to share personal information may be due to stereotype threat. Stereotype

threat is the intimidation that stereotyped groups may feel when in situations where a stereotype is particularly salient, such as when a woman discusses her emotional health (Steele & Aronson, 1995). Some participants in the current study expressed that they felt they might be stereotyped as overly-emotional women, whose physical symptoms and concerns could be discounted and attributed to their emotional problems. This sense is likely not unfounded, as previous research has demonstrated that women are more likely than men to be prescribed mood-modifying medications (Armitage, et al., 1979; Cooperstock, 1971; Hartigan, 2001; Martin & Lemos, 2002).

Participants in the current study were asked questions about their expectations of physicians and medical encounters as well as questions about their past experiences. Although there are many examples of studies that have examined precursors to the medical encounter, such as patient's understandings of specific illnesses (e.g., Grande, et al., 2002), there is a dearth of research on patients' understandings of what will likely transpire during the medical encounter. Nevertheless, patients' understandings have the potential of affecting dynamic processes within the physician-patient interaction as well as the patient's evaluation of the encounter. These factors could have implications for the efficiency and effectiveness of medical visits and on the course of health and illness.

The current study found evidence that participants do indeed have preconceived notions of how patients and physicians interact during a routine medical visit, and most related very similar elements of a medical encounter script. This normative script, as reported by participants, included arriving at the physician's office, signing in with a receptionist, being taken to an examination room by a nurse or physician's assistant, being asked questions by this person, then being left alone to wait for the physician.

According to most participants, the physician would, after some time, enter the examination room, greet them, ask them a number of questions, perhaps perform an examination, then make some suggestion or provide a prescription. Interaction with the physician ended at this point, and participants would then return to the receptionist to pay for their visit.

As discussed above, participants found it very important to both provide and receive information during their medical encounters. However, upon inspection of the script that most participants enumerated, it was quite evident that participants did not expect to ask their physicians questions. This suggested that, although participants espoused a bi-directional information-sharing process, they did not expect to initiate this process. This is perhaps not surprising, given past research which indicates that the physician-patient interaction often demonstrates power asymmetry, with physicians more often controlling conversation and negotiation patterns (Fisher, 1984).

This power asymmetry may also explain why participants were unable to describe a common way of negotiating disagreements with physicians. Indeed, many participants said that they had never disagreed with a physician. If asked to consider a hypothetical situation in which they did disagree with a physician, they were unable to explain how they would settle this difference. Some participants stated that they would likely not return to the physician, although they also acknowledged that this might not be the most productive way of settling a difference.

As discussed previously, participants expressed a preference to be involved in the decision-making process. However, this lack of a script for the negotiation of disagreements may lead one to wonder how participative the decision-making process

really is if one does not know how to tell a physician that they disagree with a treatment plan or other suggestion. Therefore, the current study provides more conflicting evidence from participants in regards to their wishes and expectations. They may wish to participate in making decisions about their health, yet they may have difficulties initiating this active participation.

Participants indicated that there may be differences in the script for male patients. When asked whether they thought there were different ideals for male and female patients, many participants indicated that they thought there were. Many indicated that they believed that male patients would need less time with their physicians. Participants also expressed the belief that male patients would have less need than female patients to share information with their physicians or to develop relationships with their physicians. This may be an indication that male patients, in the view of these female participants, require a different normative script.

This finding is interesting when compared to analyses of actual medical encounters which have found that female patients, on average, ask their physicians more questions (Pendleton & Bochner, 1980; Waitzkin, 1985; Wallen, et al., 1979) and have longer physician visits (Bensing, et al., 1993; Blanchard, et al., 1983; Waitzkin, 1985; Wallen, et al., 1979) as compared to male patients. Thus, participants' beliefs about differing ideals for male and female patients may be grounded in knowledge about typical experiences of male and female patients. Perhaps these findings from past research may be explained by male patients' preference for shorter medical encounters with less involved physician-patient communication. Alternatively, participants' beliefs may also be indicative of shared assumptions between patients and physicians regarding

appropriate behavior towards male patients. Perhaps physicians, too, are influenced by men's likely preference for a more distant physician-patient relationship and more concise interactions and, consequently, treat their male patients accordingly.

There was also evidence that participants held different expectations of physician behavior based on the physician's gender. Many participants indicated that they expected male and female physicians to act differently. These differences fell within two themes, one indicating that female physicians are better able to understand the minds and bodies of female patients, and another indicating that female physicians are better able to provide important elements of care, such as listening, expressing care and concern, and offering comfort. Past scholars have hypothesized that female patients would be best served by female physicians (e.g., Waller, 1988). Some went so far as to suggest that only women should be admitted into the specialty practices of obstetrics and gynecology (Seaman, 1975). Along with these earlier proponents, many women in the present study offered the same reasons for increasing the number of female physicians, such as the belief that only women would be able to empathize with biological processes experienced only by women.

Many participants in the current study stated that they preferred a female physician, especially when they were receiving gynecological or obstetrical care. Some participants also stated that they preferred female physicians because they felt more comfortable sharing information with female physicians, whom they expected to be more concerned and compassionate. Previous studies have found similar results, indicating that some women may prefer to see female physicians (Kappahn, et al., 1999; Levinson, et al., 1985), especially for gynecological examinations (Ahmad, et al., 2002;

Alexander & McCullough, 1983; Waller, 1988) and when discussing emotional problems (Ahmad, et al., 2002).

Although expectations may shape experience, experience may also shape expectation. Previous studies of actual medical encounters have found that female physicians, on average, spend more time interacting with their patients (Hall, et al., 1994a; Roter, et al., 1991), and are more warm and engaging with their patients (Bertakis, et al., 1995; Hall, et al., 1994a; Scully, 1980; Wasserman, et al., 1984) as compared to their male counterparts. Therefore, participants may have been expecting different behaviors from male and female physicians because they had experienced these types of differences in the past.

Limitations of the Study

The current study was limited in its scope of participants included. Although measures were taken to include a wide range of participants (i.e., multiple sampling techniques), the population from which participants were pooled was limited largely to undergraduate and graduate students attending one particular university. Extended efforts may be needed to assess the generalizability of the present findings to less homogenous populations.

The current study was also limited in its self-report approach to the problem of the physician-patient interaction. The focus of the research was on the individual's subjective experience of the physician-patient relationship. However, it may be argued that such a focus allows the results to be influenced by errors in participant memory.

Future research may attempt to address this issue by combining interviewing and more objective measures, such as video-taped medical encounters.

Social desirability may also have influenced participants' responses to study questions. For example, one participant prefaced her comments regarding her preference for a female physician with an explanation that she was not sexist. Although this was but one participant, it is conceivable that other participants may have been reluctant to admit to opinions that may have been perceived as sexist, such as a belief that male physicians are more qualified.

Any heightened concern on the part of participants about being perceived as sexist may have been due, in part, to the location of the study interviews. All interviews in the current study were conducted in an office within the university's women's studies department. Participants were recruited from psychology courses and were informed that they were participating in a study whose primary investigator was a graduate student in the psychology department. However, it is plausible that, given the knowledge that the study interviews were to be scheduled within the women's studies offices, participants may have anticipated an emphasis on the gendered aspects of the physician-patient relationship. This anticipation may have influenced their own mental preparation for the study as well as their answers to the study questions. Effort may be necessary in future research to conduct interviews in a more neutral atmosphere.

Future efforts may also heed the necessity of combining the dual goals of assessing both experience and expectation. Although interview questions were devised to assess experience and expectation separately, the difference between these two concepts was often blurred in participants' responses. For example, when asked if she expected

male and female physicians to behave differently, one participant replied with two narratives—one in which she had seen a female physician and one in which she had seen a male physician. These narratives may have demonstrated *why* she held differing expectations for male and female physicians.

Perhaps the most notable limitation of the study was the lack of a comparison group of male participants. The scope of the current study made the inclusion of such a group impossible. However, it is acknowledged that the inclusion of such a group would have been beneficial to the interpretation of the current results. Without knowledge of men's experiences with and expectations of their relationships with their physicians, it was not possible to assess the potential effects of patient gender on the physician-patient relationship. For example, it is plausible that male patients have been disempowered in their relationships with their physicians. As noted by other researchers in the field (e.g., Mishler, 1984), the physician-patient relationship is inherently hierarchical in nature—the physician is the knower and the patient the known. Therefore, instances where patients are silenced or disempowered in interactions may be quite frequent in populations of both male and female patients.

Conclusions and Directions for Future Research

Findings of the current study indicate that gender may be enacted in several ways during the medical encounter. Many participants indicated that they had experienced being disempowered and blocked from full participation in information sharing and decision making, and some of these women attributed their frustrating experiences to their being female. Some participants indicated that stereotypes about women might

affect their actions within the medical encounter, such as when they were reluctant to reveal information about their lives that might make them seem like “overly-emotional” females. Interestingly, participants’ responses also indicated a willingness to stereotype male patients, as many expressed a belief that interactions between male patients and their physicians would be quite succinct due to men’s apparent preference for less involvement in the medical encounter. Participants’ responses also revealed their ideas about how male and female physicians would differ, including the belief that female physicians are better able to understand the female body and better able to provide care and comfort. Other interesting findings included evidence of a normative script employed in medical encounters, as well as evidence that very important elements of the script—being able to ask physicians questions and being able to negotiate disagreements with physicians—were missing.

The quality of physician-patient communication has been indicated as an important predictor of several outcomes, including overall quality of patient care, patient satisfaction, patient adherence to recommended treatment plans, and the likelihood that a physician may be sued for medical malpractice (Roter & Hall, 1993; du Pré, 2000). Given the possible effects of physician-patient communication on such important outcomes, it is perhaps not surprising that such a large body of literature regarding physician-patient communication exists. One theme within this literature is the importance of understanding how gender, both physician gender and patient gender, may affect interaction during the medical encounter.

The present study provides evidence that gender may be enacted within the context of the medical encounter in a number of ways. Women’s experiences with

physicians indicated that, although they preferred being involved in the information-sharing and decision-making processes, they were often barred from full participation in the medical encounter. Past research has shown that women may be at special risk for dismissal by physicians (e.g., Barry, et al., 2001), presumably because they experience a double-minority status, that of woman and of patient. Smith (1996) asserts that male and female patients may be viewed differently when they ask their physicians questions. According to Smith, a female patient “may be taken as hostile, uncooperative, and confrontative, whereas a male patient might be viewed as rational and actively involved in his own treatment” (p. 194).

Interestingly, one finding from the present study was that most participants did not expect to ask their doctors questions. Paradoxically, the same participants expressed a desire to be actively involved in the information-sharing process. One might expect that women who wanted to be involved in information sharing would anticipate asking their physicians questions. Future research in this area might prove fruitful. If women wish to be actively involved in information sharing and decision making, how might they go about initiating this in a practical manner during the medical encounter? Are there possible scripts for questioning and negotiation that were perhaps untapped in the present sample? These and other questions could be addressed in future research involving larger, more diverse samples.

The present study also found that women may experience some reluctance when conveying information of an emotional or contextual nature to their physician. This reluctance may be best understood when considering previous research which has found that female patients may be more likely than male patients to be referred to psychologists

rather than cardiologists when they present with symptoms of both heart disease and anxiety (Chiaramonte & Friend, 1997, as cited in Watkins & Whaley, 2000). Watkins, Nock, Champion and Lidren (1996) found evidence that female patients presenting with symptoms of panic disorder rarely received sufficient information about their diagnosis, but were likely to receive pharmacological treatment. Previous research also indicates that women experiencing disturbances within their social contexts, such as abuse by a partner, are likely to receive psychiatric diagnoses and psychotropic medication (Russo, Denious, Keita & Koss, 1997). These studies provide evidence that, when a woman has a health problem, but mentions additional symptoms of emotional disturbances, her health problem may be ignored. If she indicates that she has only an emotional disturbance, she may be dismissed and medicated. Indeed, she may even be medicated if she indicates she has a problem within her environment.

Participants in the current study also expressed beliefs about how gender might be enacted within the medical encounter. Participants expressed a belief that male patients would probably require a different type of interaction with their physicians, one in which communication between physician and patient was minimal. Likewise, participants indicated that they expected their physicians to behave according to their appropriate gender roles. Participants expected female physicians to be more caring and nurturing than male physicians and to be more willing to listen to and comfort their patients.

Although the current study provided further evidence that gender is a process that may be enacted within the context of the medical encounter, future studies might also consider other factors that potentially influence outcomes within the medical encounter. As discussed above, the scope of the present study limited the number of participants

included. Thus, the effects of other status variables, such as race and socioeconomic status, on experiences of the physician-patient relationship were not able to be assessed. Watkins & Whaley (2000) urged researchers to acknowledge the dynamic nature of gender and the intersections of gender, class, race, sexuality and ability. For example, women of color may have different experiences and expectations as compared to Caucasian women.

Another factor that might be considered is the influence of chronic and/or serious illness on a person's perception of the physician-patient relationship. As discussed previously, much of the qualitative research on women's experiences with healthcare practitioners have focused on specific populations of women, such as those who have had breast cancer. Although the present study did not focus on a population with a specific diagnosis, a few of the participants indicated that they had experienced either a chronic or a serious illness. Although most participants expressed a desire to be involved in decisions made about their health, participants who had experienced a chronic or serious illness tended to be more adamant about this desire. This was reflected in their greater willingness to, for instance, take notes about their conditions or write down questions for their doctors prior to their visits. Since many chronic illnesses, such as lupus and fibromyalgia, affect a disproportionate number of female patients, it might be important to further consider the possible effects of chronic and serious conditions on patients', especially female patients', experiences with and expectations of physicians.

Future research might focus on another special population of women—women who have given birth. Four women in the present study discussed their experiences with pregnancy, labor and/or delivery. Of these four, three of the women discussed their

experiences within the context of their “bad visit” narratives. Experiences included having their questions and concerns ignored, their input disregarded, and their wishes dismissed. Childbirth has long been of great concern to advocates for better women’s healthcare. It has been noted that pregnancy and childbirth are natural processes that have been especially vulnerable to the process of medicalization (Eagan, 1994; Norsigian, 1996). Historical personal accounts (e.g., Hirsch, 1972; Rich, 1977) present evidence that women have, in the past, often felt disempowered during the birthing process. The present study provides some evidence that this might still be true today. Future research, including larger-scaled studies, is required to better investigate this possibility.

Directions for future research also include broadening the category of “physician” to include other health care practitioners. Today, patients encounter a number of healthcare practitioners, including registered nurses, nurse practitioners, and occupational and physical therapists. In fact, participants in the current study often mentioned interactions with practitioners other than physicians in their narratives of past experiences with medical encounters. Future researchers may take heed of this observation and acknowledge the medical establishment’s growing reliance on the services provided by these practitioners. Future researchers may consider, for example, the differences in professional culture between physicians and nurse practitioners, who often provide the same services to patients.

It may also be advisable for future research to consider the other roles that individuals may play in the medical encounter. For example, it is perhaps not unusual for patients to bring an advocate to their medical visit. In this capacity, women may gain

even more experience communicating with medical professionals. Women may be more likely than men to take on the role of health-care provider within the family, and, thus, accompany their children, parents, or spouse to their physician encounters.

Further consideration of the perspectives of practitioners may also be advisable. A large body of research and theory regarding academic models of the physician-patient relationship exists. These models include the paternalistic model, consumeristic model, and mutuality model. The paternalistic model, considered to be the “traditional” model, involves a patient who passively complies with the recommendations of an expert physician (Charles, Gafni & Whelan, 1997; Parsons, 1951; Roter & Hall, 1993). The consumeristic model acknowledges the power of the patient in their role as consumer of medical services (Haug & Sussman, 1969; Reeder, 1972; Roter & Hall, 1993). Somewhere between these two models is the mutuality model, which espouses power symmetry within the physician-patient relationship. In this model, patients actively participate in information sharing and decision making and are acknowledged as experts on their own bodies and experiences (Quill, 1983; Szasz & Hollender, 1956).

The current study, as well as past research, indicates that female patients may be disempowered in their encounters with physicians. This finding, however, may be a reflection of a physician’s espousal of a paternalistic model, a model that he or she may adopt with both male and female patients. Alternatively, physicians may prefer to enact different models with different patients. For example, physicians may envision themselves in a paternalistic role with young patients, but not with older patients, or with female patients, but not male patients. Future studies may investigate this possibility by

questioning physicians about *their* expectations regarding interaction in the medical encounter, including how they conceptualize their relationships with patients.

Despite what remains unknown about the physician-patient relationship, great strides have been made within this research domain. It is hoped that the current study adds to this body of knowledge and helps to answer some of the questions previously posed regarding the enactment of gender within the medical encounter. Future researchers may consider the analytic approach used in the current study, an approach that attempted to fuse several different theories and frameworks. The analysis of the current data was aided by feminist theory, discourse analytic theory, grounded theory and script theory. Although such an approach may require more effort and attention than when applying only one framework, the effort may well be worth it. Without this eclectic approach, some results may not have emerged. For instance, if grounded theory alone had been utilized, evidence of a script may not have been as readily noticeable. If discourse analysis alone had been employed, themes regarding the importance of information sharing may not have been deemed as relevant to study goals. Although an eclectic approach may be advisable, some goals of the current study seemed to be more amenable to the interview approach than others. For example, research on scripts may be better aided by a procedure that would allow larger sample sizes, such as the use of surveys.

Ultimately, it is hoped that this and related research will help to inform healthcare practitioners. As urged by Hartigan (2001), research regarding gender and quality of health services should be utilized in training health professionals, who should be given

opportunities to better understand how gender influences their own lives and their work. Perhaps an increased awareness may help healthcare professionals provide more equitable services to male and female patients, patients who may become more satisfied and healthy.

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APPENDICES

APPENDIX A

INFORMED CONSENT STATEMENT

Women's Experiences with Physicians

You are invited to participate in a research study. The purpose of this study is to examine women's experiences with their physicians.

Researcher: Jill Compton, Department of Psychology, 1912 Terrace Avenue,
jcompto2@utk.edu

Advisor: Dr. Cheryl Travis, Department of Psychology, Austin Peay 303C,
ctravis@utk.edu

INFORMATION

Participants will be interviewed regarding their experiences communicating with their physicians. Participants' answers will be audio-recorded. This interview will last for approximately 60-90 minutes. Participants will also fill out a brief demographics and background questionnaire.

RISKS

There are no experimental treatments, manipulations, deceptions, or physical risks involved in this study. A debriefing and study information sheet will explain the purpose of all data collected and its use.

BENEFITS

Students participating in the study may receive extra credit in their respective classes. Amount and use of extra credit is determined by class instructors.

CONFIDENTIALITY

The information in the study records will be kept confidential. Data will be securely stored and will be made available only to the principle investigators and supervised research assistants unless you specifically give permission in writing to do so otherwise. No reference will be made in oral or written reports that could link you to the study. Identifying information contained on the consent form will be kept separately from all data collected and the participants' identity will not be associated with the data. Consent forms will be stored for three years after the completion of the project and then will be

destroyed. Data (with no identifying information) may be kept indefinitely for archival purposes.

CONTACT

If you have questions at any time about the study or its procedures, please contact **Jill Compton at 1912 Terrace Avenue, by phone at 865-974-2409, or by e-mail at jcompto2@utk.edu**. If you have questions about your rights as a participant, contact the Compliance Section of the Office of Research at (865) 974-3466.

PARTICIPATION

Your participation in this study is voluntary. You may decline to participate without penalty. If you decide to participate, you may withdraw from the study at any time without penalty and without loss of benefits to which you are otherwise entitled. If you withdraw from the study before data collection is completed, your data will be returned to you or destroyed.

CONSENT

I volunteer to participate in the investigation conducted by Jill Compton, Department of Psychology. I read the description of the study, have had all my questions answered, and have received a copy of this form. I agree to participate in this study.

Participant's Signature _____ Date _____

Investigator's Signature _____ Date _____

FOLLOW-UP QUESTIONS

The researcher would like to contact select participants at a later date (approximately early March) in order to share with them the results of the study and to ask them for their thoughts on these results. This discussion will take place during a brief (approximately 20-minute) phone call. If you would consent to being contacted at a later date, please sign below and provide your contact information.

Participant's Signature _____ Date _____

Participant's Contact Information: Phone _____

Investigator's Signature _____ Date _____

APPENDIX B

INTERVIEW GUIDE

WOMEN'S EXPERIENCES AND EXPECTATIONS OF THE PHYSICIAN-PATIENT RELATIONSHIP

Introduction: Thank you for taking the time to talk with me today. I'm going to ask you a few questions about what you think about doctors and about your visits with doctors. Relax and feel free to take your time and think about the questions. You may want to think about recent visits you've had with doctors, or about visits that you've had in the past that stick out in your mind. Please feel free to elaborate, don't feel like you have to just answer 'yes' or 'no'. If you'd like, you can also tell me about the experiences of others you know, for instance, if you think that something that happened to a female relative might be relevant, please feel free to mention that, too.

1. What do you expect to happen when you visit your physician?

- Probes:
- Can you tell me, step by step, why typically happens during a doctor's visit?
 - Who usually speaks first?
 - What do you expect the doctor to ask you?
 - Do you expect the doctor to ask you questions about what's going on in your life?
 - Do you ask your doctor questions? If so, what kinds of questions?
 - What do you expect to need to tell your physician? Your symptoms? Your problems?
 - What do you expect your doctor to do after you've told them this information?
 - What do you usually think a physician will do for you during a visit?
 - What, if anything, do you do to prepare for a visit with your doctor?
 - Do you usually feel good about your visits afterward? Why or why not?

2. Overall, what do you look for in a good doctor?

- Probes:
- How do you go about looking for a doctor?
 - How did you choose your doctor?
 - Is the sex or gender of the physician a factor when you decide on a doctor?
 - What things are most important to you in a doctor?
 - What characteristics in a physician would you like to avoid?

What would be ideal in terms of how doctors relate to you? To women in general? Do you think this ideal is different for men?

3. Do you have a preference for a male or a female doctor? Why or why not?

Probes: Have you been to both male and female physicians?
Have you noticed whether the doctor being male or female has affected your visit?
Do you expect male and female physicians to act the same or differently?
Are there certain circumstances under which you would prefer to have a female physician or prefer to have a male physician?

4. Tell me about a doctor's visit that you thought went really well.

Probes: Was it something that the doctor did that made the visit a good one?
How did you feel when s/he said (or did) that?
How did you respond to that?
What happened next?
What specifically did you like/dislike about the way s/he talked, touched you, looked at you, etc.?
Did you want to say something at that point? Why did/didn't you?
How did you feel when you left the office?
How was this visit similar or different from a typical visit?
Did you expect this to happen?

5. Tell me about a visit to a doctor that did not go well.

Probes: (See #4 above.)

Do you think a man would have received different treatment?

6. Now, think about what would have to change in order for that visit to have been a positive experience, while still keeping the diagnosis, news, facts received the same.

Probes: What would you change about the way the doctor acted?
What would you change about the way you acted?
What would you change about the atmosphere or surroundings of the visit?
Why would you change [whatever aspect the participant mentioned]?
Tell me how you feel going home after this created visit.

7. How do you and your doctor make decisions about your course of treatment?

- Probes:
- Can you think of a time when you discussed with your doctor some medicine that you might take, or a test you might have run?
 - Who brought up the possibility of this course of action?
 - Did you and your physician discuss what would happen?
 - If so, what was that discussion like?
 - Did you ask your doctor questions? If so, did you feel comfortable doing so?
 - What kinds of questions did you ask, or do you ask routinely?
 - How did your doctor react to your asking questions?
 - Do you feel more comfortable asking a female or male doctor questions, or do you think that matters to you?
 - Who made the final decision?
 - In your experience, is this the way that decisions are typically made?
 - Have you and your doctor ever disagreed? If so, how was the disagreement resolved?

8. Thank you for sharing so much helpful information with me. I have just a few more questions. Were these the questions you expected to be asked during this interview? Is there anything you would add that I did not ask? Do you know someone who might be interested in participating in this study?

APPENDIX C

DEMOGRAPHICS AND BACKGROUND QUESTIONNAIRE

DEMOGRAPHICS

Your Ethnicity: Asian Black -- African-American
 Hispanic White -- Caucasian
 Other _____

Your Age: _____ years old

Your Year In School: FRESHMAN

[for students only] SOPHOMORE
 JUNIOR
 SENIOR

Your Occupation: _____

Have you been diagnosed with a chronic illness or illnesses? _____

If yes, what have you been diagnosed with? _____

If yes, when did you receive this diagnosis? _____

How often have you visited a physician in the past year? _____

**Do you usually see a primary care physician, or do you also see specialists?
(explain)**

Is your primary physician a male or female? _____

If you see any specialists, are they male or female? _____

Have you seen both male and female physicians in the past? (Circle One):

Yes No

What kind of health care delivery system do you use?

- Private/Group Practice**
- Health Maintenance Organization**
- Preferred Provider Network**
- Walk-in Clinic**
- Other** _____

APPENDIX D

TRANSCRIPTION CONVENTIONS AND GUIDELINES

Instructions to transcriptionists: Make each interview a separate document. Name the document the participant identification number (example: SS001). [The id will be written on the outside of the tape, on the participant's folder and on all the documents inside the folder.] Margins should be 1" on all sides. Single space within each turn, double space between turns (i.e., double space between where I talk and where the participant talks).

Conventions:

1. Speaker Interviewer's words indicated by italics. Participants responses should be in regular font.
2. Turn/Utterance Each new turn, or the beginning of an utterance by speakers in a series generally starts at the beginning of a line in the transcript. Overlaps are indicated by appropriate markers.
3. Overlap [
If a speaker begins to talk while the other is still talking, the point of beginning overlap is marked by a bracket between the lines.
4. Silence ... (34)
Silences within the speaker utterances and between speakers are marked by a series of dots; each dot represents one second. Long pauses are denoted by number of seconds in parentheses. These silences are assigned to the previous speaker if they occur between speakers, that is, they are given the meaning of a post-utterance pause.
5. Lack of Clarity (cold)/(...)
Where word(s) is (are) heard but remains unclear, it is included in parentheses; if there are speaking sounds that are unintelligible, this is noted as dots within parentheses. Make sure to denote where in the tape (according to the counter) this is. I can then go back to it, listen, and maybe fill in the blanks.
6. Speech Features ? / .
Punctuation marks are used when intonation clearly marks the utterance as a question or as the end of a sentence.
:
If a word is stretched, this is marked by a colon as in "Wel:l".
-

If a speaker breaks off in the middle of a word or phrase, this is marked by a hyphen, as in “haven’t felt like-”.

((softly))

Double parentheses enclose descriptions, not transcribed utterances.

___ or CAPS

Underlining or capital letters are used if there is a marked increase in loudness and/or emphasis.

7. Names

--- (blanks)

To protect confidentiality, blanks substitute for proper names.

VITA

Jill Denise Compton was born in Farmington, Missouri on October 28, 1976. She attended public schools in Frankclay, Missouri and Leadwood, Missouri. Jill graduated *summa cum laude* from Maryville University of Saint Louis where she received a Bachelor of Arts degree in Psychology and Liberal Studies. After working briefly as a research assistant at Unity Sleep Medicine and Research Center in Chesterfield, Missouri, Jill entered into the doctoral program in Experimental Psychology at the University of Tennessee, Knoxville in the fall of 1999. Jill has served as an Instructor at MacMurray College in Jacksonville, Illinois since the fall of 2004.