Physician Gender and Patient Communication

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Abstract

An analysis of literature on gender differences in communication styles between male and female physicians suggests that female doctors are more patient-centered. They are more attentive, they promote the sharing of information and encourage their patients to ask questions, and in general, are more likely to communicate with patients about psychosocial issues. Research on gender differences in non-clinical environments is consistent with these findings. Women are typically more emotionally expressive, nurturing, supportive and self-revealing, whereas men are perceived to be more aggressive, controlling and insensitive to the feelings of others. Although these differences are often exaggerated, gender socialization theorists on the whole agree that some differences exist in the interpersonal styles of men and women. Because the physician-patient relationship has the potential to influence patient satisfaction and outcomes, it seems natural that the medical community would want to do everything in its power to enhance physician-patient interactions. If the research is correct and women do have a perceptible advantage in terms of communication skills, it would seem reasonable to suggest that certain principles of feminism and feminist therapy could be utilized in training all physicians to adopt a more patient-centered style of medicine.

Introduction

A review of literature on physician gender and patient communication in medical encounters reveals identifiable differences between the interactional styles of male and female physicians. More broadly, there has been significant research and debate concerning differences in the communication style of women compared with that of men. Women, it is argued, are generally more responsive, tactful, supportive and emotional,
while men tend to be more aggressive, direct, insensitive and emotionally unexpressive. It is plausible to suggest that these differences extend to the physician-patient relationship and typically female physicians would tend to be more patient-centered. In particular, the different socialization of males and females is a common philosophy that is used to explain differences in communication styles. Several theories have been proposed: Social Constructionist Theory, Social Role Theory, Social Learning Theory, Standpoint Theory and Symbolic Interactionism. These theories highlight at least some aspect of the socialization process as a potential source of gender differences in communication. However, regardless of the origins of gender differences it seems logical that it would be in the best interest of health care to advocate an environment that fosters trust, empathy, openness and an egalitarian exchange. Therefore, it is suggested that the implementation of certain principles of feminism and Feminist Therapy in physician education and training programs would facilitate a more patient-centered approach to medicine.

**Sex and Gender**

In everyday speech and in scholarly writing the terms sex and gender are often used interchangeably, however, these concepts have very distinct meanings. Sex is classified according to genetic and biological characteristics such as external genitalia and internal sex organs. Each individual is labeled either male or female at birth based on these physical characteristics. The assumption is that most individuals are clearly one sex or the other. Gender, on the other hand, is a more complex concept than sex. It is a social, symbolic category that reflects the meanings a society or culture confers on biological sex. In other words, gender is something individuals learn, yet it is more than an individual quality because it is constructed by cultures or society; it is a social
construction corresponding to masculine and feminine. The meanings of masculinity and femininity are communicated through social institutions and cultural practices that serve to perpetuate and sustain certain values. They are not assigned at birth, but rather are achieved and reflected in behavior. Socially endorsed views of masculine and feminine behavior are taught to individuals from birth through a variety of means. Because social definitions of gender permeate private and public life, they are viewed as universal and normal. It is difficult to imagine that masculinity and femininity could be defined differently because the practices and structures that comprise social life constantly represent men and women in particular ways (Arliss, 1991:6, 7; Wood, 1999: 20-30). Thus, when gender is mapped onto sex, as is commonly the case, there is an implicit assumption that socially determined differences between men and women are inevitable and natural (Talbot, 1998: 9).

**Gender Differences and Sex Stereotypes**

Researchers disagree over the origins of gender and gender differences nevertheless, they do agree that gender plays a significant role in how people see themselves, how they act and how they view others (Wharton, 2005: 9). Biological models assume that biological sex determines gender and that innate biological differences lead to behavioral differences (Kimmel, 2000: 52). These models usually take an essentialist position that attempts to define what it means to be a woman or a man in core objective physiological terms. Gender identity, behavior, and cognitive and personality traits are sex-linked to physical characteristics of the body. Furthermore, essentialist models portray gender in terms of fundamental attributes that are conceived of as internal, inherent, persistent and generally separate from the on-going experience of
social interaction within daily contexts of one’s life (Gergen & Davis, 1997: 33). Wood (1999: 22) presents a contrary view and she suggests that despite the influence of biology, it seldom, if ever determines behavior. She claims there is general consensus among researchers that environment is at least as significant an influence on human development as biology; a majority of researchers perceive environment as the stronger of the two factors in influencing behavior.

According to Wood (quoted from Canary & Dindia, 1998: 20, 21), gender differences are cultivated by the distinct conditions and contexts of the lives of women and men as groups. Social ideologies prescribe specific experiences, roles, personal appearances and professional options based on sex, and consequently, men and women typically conform to these often polarized circumstances. To the extent that we hold stereotyped beliefs about men and women, these perceptions can lead us to form different expectations about what men and women are like and how they should behave. For example, men are described by a cluster of instrumental traits: as leaders, aggressive, dominant, independent, rational, objective and competitive. Women are described by a collection of affective traits: as emotional, subjective, tactful, nurturing, sympathetic and acutely aware of the feelings of others. Similarly, we hold stereotypes about men and women as communicators. Male speakers are believed to be loud, aggressive, forceful, authoritarian, direct and blunt, whereas women are perceived to be gentle, friendly, receptive, self-revealing, emotional, polite and expressive in their concern for the listener. Despite the considerable changes that have occurred in the status of women in society, gender stereotypes have continued to persist. Research suggests that people continue to
hold stereotyped beliefs about the personalities, speech, interaction and communication styles of men and women (Aries, 1996: 163, 164, 167).

Sex stereotyping is one of the many consequences resulting from gender construction. Sex stereotypes are socially shared beliefs that certain qualities can be assigned to individuals depending on their biological sex. They divide people into two groups: male or female and correspondingly, masculine or feminine. An implication of stereotyping these two groups as polar opposites is that any movement away from the stereotype of one group is a movement toward that of the other group (Lips, 1997: 2, 3). Webster (1996: 5) maintains that gender divisions are central in allocating men and women to particular jobs, in creating sex-typed work, in restricting access to technological expertise and in allocating value to men’s and women’s respective activities. Therefore, if women are perceived as passive, physically weak and technologically inept, it may be seen as inappropriate for them to participate in areas that require physical strength, aggressiveness and technological know-how (Hopkins, 1998: 6). Moreover, it is not uncommon for women to internalize these perceived inadequacies and consequently, this will limit opportunities that would otherwise be available to them. Women come to believe that chosen standards of femininity are normal, natural or inherent. Additionally, the pressure to conform to these standards of behavior stifles any potential that women may have in areas that are considered to be traditionally male.

A related development in the sociology of gender is the discipline’s increased emphasis on the relations between gender and other bases of distinctions and stratification, such as race or ethnicity, age or social class. Theory and research exploring the intersections between ethnicity, age, and social class for example, has demonstrated
the ways these categories, acting together, shape how people experience the world. While they may be analytically separate, as elements of lived experience, they are also highly intertwined. In this light, we need to be cautious about the dangers of overgeneralization; this occurs when one assumes that conclusions based on one group of men or women are automatically extended to all men or women (Wharton, 2005: 5, 6). For instance, Cotter et al. (1999: 453) assert that white women are economically disadvantaged relative to white men because they are women. However, white women’s earnings are higher than those of African American and Hispanic women due to the benefits that accrue to white women from their membership in the dominant racial/ethnic group; they are penalized for being both female and nonwhite. Johnson (2005: 155) maintains that male gender and white race dominate social life to such an extent that they become socially invisible. Unlike the invisibility of women and people of color, this narrow perspective allows men and whites to exist with relatively little awareness of the causes or consequences of male and white privilege as well as the social oppression they create. Shachar (2001: 23) reaffirms this idea and suggests that difference-blind institutions which “purport to be neutral among different groups…are in fact implicitly titled towards the needs, interests, and identities of the majority group; and this creates a range of burdens, barriers, stigmatizations, and exclusions for members of minority groups.” For this reason, studying the texts and lived experiences of marginalized people is necessary in order to construct a more accurate understanding of the social world in which we live (Moya: 2002: 3).
Gender Socialization

Gender socialization refers to the processes through which individuals acquire gender qualities and characteristics as well as a sense of self. Through socialization people learn what is expected of them as males or females, that is, they will be judged, in part, on the basis of whether they exhibit appropriate masculine or feminine behavior.

There are two sides to gender socialization processes: On one side is the target of socialization, for instance, the newborn who encounters the social world through interaction with parents, relatives and caretakers; on the other side of socialization processes are the agents of socialization, such as the individuals, groups and organizations who pass on cultural knowledge and norms of behavior (Wharton, 2005: 31). Aries (1996:194) proposes that gender can be explained to some degree by examining the construction of gendered personalities through socialization. She acknowledges that gender is acquired early in life. In fact, children acquire gender identity and categorize themselves as males or females by the age of two or three.

Young children learn the cultural expectations for appropriate behaviors and roles for members of their sex and similarly, they learn the consequences for deviating from those prescriptions of behavior. Kimmel (2000: 3) reinforces the effects of socialization processes and argues that men and women are different because they are taught to be different. From the moment of birth females and males are treated differently and gradually, they acquire the traits, behaviors and attitudes that our culture defines as masculine or feminine. Various gender theories, taken together, provide a number of explanations for gender development and they complement one another by exposing the
different ways in which socialization, language, communication, gender and culture not only interact, but are also interrelated (Wood, 1999: 42).

Research has found that children are socialized into stereotypical gender roles from the moment of birth, when the parents find out the sex of the baby. Taking this a step further, Smith (2005: 49, 51, 52), an educational researcher schooled in Women’s Studies and socialized gender roles, explores the idea that gender socialization begins in utero. Her paper, presented as a case study in narrative form, documents her verbal expressions as well as the feelings that were transmitted to her unborn child both before and after an ultrasound identifying the sex. Her goal was to more fully understand the gender socialization process taking place prenatally. Her findings concluded that in this case, prenatal socialization occurred as soon as the ultrasound identified the sex of the baby. In particular, the labeling of a sex not only predetermined the child’s personality for the mother, but it also resulted in the changing of nonverbal behavior, such as the tone of voice. This change in language along with the attaching of sex to personality indicates the beginning of the socialization process. Shocked by the findings, Smith wonders what sex stereotyped signals average mothers send to their babies if she, who is exceptionally conscious and critical of engendered language, labels and socializes a baby in utero, according to gender.

**Gender Socialization Theories**

*Social Constructionist Theory*

Social constructionists view gender differences as created, learned and alterable, with gender role divisions always historically relative and contingent upon cultural and
social expectations. Categories of male, female, man and woman are ideals that are culturally constructed and have the potential to change in meaning and practice over time, and vary cross-culturally (Hopkins, 1998: 8). Kimmel (2000: 88) outlines some elements of the social constructionist perspective on gender: definitions of masculinity and femininity vary from culture to culture as well as in any one culture over historical time; gender definitions vary over the course of one’s life; lastly, definitions of masculinity will vary within any one culture at any one time – by race/ethnicity, class, age, sexuality, and geography. Thus, to explain differences, social constructionists offer an analysis of the plurality of gender definitions.

Central to the social constructionist position is the idea that “facts” are dependent upon the language communities that have created and sustained them, and that all forms are labeling or naming are socially constructed; this includes the biological categories, such as the male-female sex distinction (Gergen & Davis, 1997: 33). Sheldon (quoted from Tannen, 1993: 84) reaffirms the importance of language in contributing to gender differences. She insists that language is part of a culture and an instrument for transmitting and perpetuating principles of social order and systems of belief in the context of defining masculinity and femininity. Gergen & Davis (1997: 33, 39) argue that gender as a construct identifies certain transactions as either appropriate or inappropriate to one sex. Therefore, what it means to label a transaction as masculine or feminine is socially agreed upon and is reproduced, consciously or unconsciously, by the very process of participating in that transaction. In this light, gender is the meaning we have agreed to ascribe to a particular class of transactions between individuals and environmental contexts; it is the term given to a set of behavior-environmental
interactions that we have come to agree represents members of one sex. Enns (1997: 116) suggests that the main feature of social constructionism is that “one does not have gender, one does gender.” “Gender is something we enact, not an inner core or constellation of traits that we express; it is a pattern of social organization that structures the relations, especially the power relations, between women and men.”

**Social Role Theory**

Some scholars maintain that because men and women are assigned to different roles in work and family life, they acquire different traits and characteristics. For instance, women are believed to be more communal, nurturing, emotionally expressive and concerned with the interpersonal relations between others because domestic roles require these traits. Similarly, men are perceived to be instrumentally competent, task-oriented, independent, controlling and assertive because they fill occupational roles in society that require these skills. The performance of diverse roles in society by men and women leads to differential behavior, which in turn creates stereotypic expectations for men and women. Additionally, in the process of enacting these different roles, men and women acquire sex-typed skills that further contribute to gender stereotypic behavior. According to social role theory, people are expected to behave in a manner consistent with their gender roles; because such behavior is viewed as socially desirable, people tend to conform and comply with prescribed social norms for behavior. Thus, in accounting for gender differences in behavior, social role theorists point to the importance of gender related-expectations in shaping the behavior of men and women (Aries, 1996: 42, 43, 199).
Typically, gender role socialization – teaching the child to be a man or woman - begins as soon as the sexual identity of the child is determined or designated. The parents and grandparents draw upon their culture’s understandings and expectations of what is appropriate for males and females. In Rheingold and Cook’s (1975) study using subjects from Canada and the United States, the authors examined furnishings and toys of boys’ and girls’ bedrooms. They concluded that boys were provided objects that encouraged activities directed away from home – toward sports, cars, animals and the military – while the girls objects encouraged activities toward the home – keeping house and caring for children (Richardson, 1982: 43, 45, 46). In a separate study, researchers analyzing popular books written for children found that the activities of the male and female characters differed. Males in the picture-book world were active; females were passive. Males engaged in exotic adventures, riotous activities and various pursuits requiring independence and competence. In contrast, most of the female characters were passive and remained indoors. In other words, girls performed traditional female sex-typed roles that were associated to passivity, service and dependence; they cooked and cleaned for their fathers and brothers. The activities for the boys, on the contrary, were directly linked to preferable male values of activity, independence and achievement. The prescription is clear. Girls can expect to grow up and become wives, mothers and caretakers, while boys can grow up to do whatever they choose. It is interesting to note that most of the books researched and analyzed were ethnic stories depicting a wide range of cultures. These findings imply that gender messages are prevalent throughout many cultures and not restricted to Western society (Richardson, 1982: 54, 55, 56). Thus, at its core, social role theory addresses the way in which men and women perform different
social roles in the family and in society, which in turn leads to expectations that men and women possess different characteristics suited for the roles they occupy (Aries, 1996: 199).

Clearfield and Nelson’s (2006: 135, 136) more recent study supports previous findings that parents transmit different messages to their male and female infants, both through language and interaction; consequently this may contribute to infants’ gender role development. Participants of this study were native English speakers and English was the primary language spoken in the home, however, mother-infant dyads included Indian American, African American and European Americans. The results indicated that parents talk differently with their daughters and sons, with mothers encouraging and expecting more verbal responses from daughters than from sons. In other words, girls were expected to be more verbally expressive than boys. It is argued that mothers’ speech to their young children reflects our culture’s social traditions with respect to gender and they may, unknowingly, be transmitting those traditions to their children through their language and communication. In addition, mothers also appeared to send gendered messages when playing with their infants. Mothers were actively engaged with their girls more frequently than with their boys, who were encouraged and reinforced for exploring on their own. By being more involved with their girls mothers may be sending the message that girls require a greater amount of attention and are more dependent. On the contrary, by not engaging with their sons to the same extent mothers may be reinforcing a sense of independence in boys that is not reinforced in girls. This differential treatment contributes to contemporary gender norms and stereotypes; boys
are supposed to be independent and strong are girls are expected to be emotional and dependent on others.

Social Learning Theory

Social learning theory contends that gender roles are learned through the positive and negative reinforcements that children receive for engaging in gender-appropriate and gender-inappropriate behavior. Reinforcement is the primary means through which children acquire gender-appropriate behavior (Wharton, 2005: 32). Reinforcement or sanctions can be positive or negative, tangible or intangible, subtle or violent (Arliss, 1991: 130). This is based on B.F. Skinner’s theory of Operant Conditioning which proposes that behavior is determined by an individual’s response to stimuli in the environment. This response leads to consequences which can be either positive or negative. Reinforcement is the key element in Skinner’s theory and a reinforcer is anything that strengthens the desired response. For example, a young child can be verbally praised for playing with her dolls and this praise serves as a positive reinforcer, encouraging the child to continue with this behavior in the future. On the contrary, a reinforcer can also be negative such is the case when a young boy is chastised for playing with dolls. The negative consequences will likely deter him from playing with dolls in the future (Boeree, 2006). The bulk of research concerning social learning has concentrated on the early childhood period and consequently, much of the literature concerning sanctions, observation and modeling have referred to parental interaction with children (Arliss, 1991: 131).

The social learning model is not exclusively behavioristic as many advocates of this theory maintain that imitation and modeling play a crucial role in shaping behavior.
Nevertheless, the concept of reinforcement is also embedded in these other forms of learning (Weitz, 1977: 77). According to Wood (1999:50, 51), individuals learn to be feminine and masculine through observation and communication. Children observe and then imitate the communication they see in parents, relatives, peers, as well as on television. This suggests that others’ communication teaches children what gender behaviors are appropriate. Because it is natural for children to prefer rewards to punishments, they are more likely to conform to what others deem appropriate. Typically, young girls tend to be rewarded when they are deferential, quiet, obedient, considerate and emotionally expressive, all being characteristics associated with femininity. On the other hand, they tend to get less positive responses if they are competitive, boisterous, independent and unconcerned with the well being of others. As parents and other influences reinforce what are considered to be feminine behaviors, they discourage actions and attitudes that are perceived to be masculine. They shape little girls into society’s notion of femininity. Likewise, while external influences communicate approval to boys for behaving in stereotypically masculine ways and curb them for acting feminine, little boys are influenced to become masculine. Finally, social learning theory claims that the reinforcement process is life-long and that men and women are constantly influenced by messages that reinforce femininity in women and masculinity in men.

Anderson and Robson (2006: 1, 2, 4) studied childhood influences on adult male behavior in the domestic sphere using subjects born in Great Britain. Informed by social learning theory, they concluded that in families where parents hold traditional sex-role attitudes toward housework, boys learned how to “do” masculinity by watching and
assisting their fathers engage in stereotypical, male sex-typed activities such as cutting
the lawn or taking out the garbage. Moreover, boys were positively rewarded for
engaging in such activities. Similarly, girls learned how to be feminine by identifying
with and observing their mothers participating in female-dominated activities and
domestic behavior. Ultimately, it was found that in families where fathers participated in
more than average amounts of female-typed housework, children were more likely to
believe that men should contribute to household tasks. Thus, it is argued that parental
attitudes and behaviors influence the sex-based division of household chores and
children’s performance of these sex-typed tasks, which in turn reflects the social
reproduction of gender and the gendered division of domestic labor.

*Standpoint theory*

Advocates of standpoint theory insist that the social, symbolic and material world
of women and men are different in fundamental ways and that their disparate
circumstances promote distinctive and unique identities, perspectives, priorities, views of
social life and ways of interaction. Research on male and female communication cultures
does not suggest that there are innate, essential differences between the sexes, nor does it
imply that early socialization absolutely and forever determines behavior. Rather, much
like social learning theory, standpoint theory claims that women and men learn rules,
meanings and norms of communication through interaction with others in specific
contexts; these communication cultures inculcate distinctive styles of being, knowing and
communicating. For instance, research findings indicate that masculine communication
cultures highlight instrumental goals, individualistic orientations and competitive forms
of speech. Conversely, feminine communication cultures generally prioritize expressive
goals, collective or communal orientations and interactive, cooperative forms of speech. Thus, the tendency for sex segregation in childhood means that boys and girls are socialized into relatively distinct contexts that emphasize different goals, rules and meanings of communication (Wood, quoted from Canary & Dindia, 1998: 29).

Symbolic Interactionism – A Cultural Approach

Many theorists assert that gender is best understood through a cultural perspective. Scholars in this field do not dispute biological and psychological influences on gender, rather, they assume these reflect the larger influence of culture. Culture refers to structures and practices, particularly those relating to communication, through which a society announces, sustains and perpetuates its values. In Western society, gender is clearly a significant issue and consequently, there are numerous structures and practices that serve to reinforce society’s prescriptions for men’s and women’s behaviors (Wood, 1999: 36, 53). Symbolic interactionism concentrates on how cultural values and norms are transmitted to individuals so that most people adopt the identities our culture designates as appropriate for our gender. Herbert Mead, referred to as “the father of symbolic interactionism,” developed a broad theory which incorporates socialization and how we learn gender through interacting with others. Mead insists that awareness of personal identity arises out of communication with others, who pass on society’s values and expectations. From the moment of birth, we engage in interaction with others who tell us who we are, what is appropriate for us and what is unacceptable; this occurs both on a conscious and unconscious level. Research has shown that views of gender are expressed by parents through their responses to children, through play activities with peers, and through teachers’ interactions with students. Finally, symbolic interactionism
accentuates the fact that gender is socially created and sustained through communication that teaches us to define ourselves as gendered and to internalize and adopt the roles that any given society prescribes for us (Wood, 1999: 53, 55, 58).

Some researchers have argued that boys and girls are socialized within different speech communities. This implies that the origin of gender-related cultural differences can be traced to the ways in which boys and girls learn to use communication as they interact and relate with others – most commonly in sex-segregated groups. Typically, the world of boys is hierarchically organized and competitive, with dominant and assertive behavior being valued and praised. In contrast, the world of girls is non-hierarchically organized and cooperative, thus promoting values of equality and emotional closeness. These distinctive features of social relationships lead to and sustain well-defined patterns of language use, which encourages boys to use self-assertion, boasting, factual reports and impersonal language, whereas girls are urged to express and respond to the feelings of others, share personal perspectives and to create a relationships of intimacy and caring. These patterns extend to adulthood in which men’s friendships tend to be defined by storytelling and verbal aggressiveness, while women’s interaction with friends tends to be characterized by the sharing of feelings, expressions of emotional support and intimacy. Ultimately, each culture is believed to instill in its members a different set of assumptions concerning the functions of communication in relationships (Kunkel and Burleson, quoted from Canary & Davis, 1998: 105).

In her examination of three different cultures in New Guinea, Margaret Mead hoped to show the enormous cultural variation possible in definitions of masculinity and femininity. Additionally, by comparing American culture with other cultures, Mead
defied critics to maintain the fiction that what we observe in the United States is natural and inherent, and therefore cannot be changed. In two of the tribes studied, Mead revealed evidence of gender flexibility to such an extent that gender differences were virtually nonexistent. Men and women were not perceived as “opposite sexes,” rather, they shared all of the activities related to child rearing; both were maternal and both discouraged aggressiveness among boys and girls. According to the symbolic interactionist tradition, if meanings vary across cultures, over historical time, among men and women within any one culture, and over the life course, we cannot label masculinity and femininity as though each is a constant, singular, universal essence. Essentially, definitions of gender are informed, shaped, and modified by their interactions with other differences, such as race/ethnicity, class, sexuality, age and region (Kimmel, 2000: 49, 89).

**Gendered Styles of Communication**

There is a tradition of sex/gender difference research that continues today and there have been hundreds of personality characteristics, capabilities and behavioral orientations examined, as researchers attempt to identify differences between men and women. However, it is important to note that there are virtually no traits or behaviors that consistently distinguish all men from all women, and when variations are found they are a matter of degree rather than absolute differences (Tannen, 1994: 14; Wharton, 2005: 25). Nevertheless, Dindia (quoted from Canary & Dindia, 1998: 35, 36) contends that gender scholars mostly agree that differences exist in the communication styles of men and women, which they attribute primarily to cultural and social influences; they are not in any way essential or unalterable. Wood (1999: 121, 122, 123, 133) reaffirms the idea
that women and men are socialized into distinct speech communities and as a result, they
learn different rules for interacting. For instance, boy’s games tend to be competitive,
have clear goals, and they are organized by rules that specify how the games are to be
played. Communicating in this environment is used to assert yourself and your ideas, to
attract and maintain an audience, and to become the center of attention. These rules of
communication are consistent with other aspects of masculine socialization that
emphasize individuality, competition and dominance. By contrast, quite different
patterns exist in girls’ games. Extensive discussions, cooperation, collaboration, lack of
goals and rules, and sensitivity to others’ feelings are typical characteristics of girls’ play.

There are a number of communication-related differences between men and
women that have been reported and analyzed by researchers. For example, male
childhood and adolescent communication involves more interruptions, challenges, strong
assertions and direct judgments than their female counterparts; women rely on verbal
communication, including personal disclosures to build and maintain relationships,
whereas men tend to rely on shared activities and doing things for others to build, sustain
and express intimacy; and lastly, women seem to be more sensitive to and perceptive
over others’ nonverbal cues than men. It is suggested that the differences between these
communication styles is a matter of degree rather than dichotomy and that they are
generalizations as opposed to essential differences (Wood, quoted from Canary & Dindia,
communication styles of men and women and postulate that research on gender and
conversation emphasizes women’s strategies for cooperative, supportive talk and
promoting intimacy and solidarity. This style has been contrasted with a male style that
is perceived to be competitive rather than cooperative, and men are usually seen as most interested in establishing their independence and autonomy from others. Lerner and Steinberg (2004: 249) point out that hundreds of studies of gender differences in verbal and nonverbal behaviors of male and female adults, and some involving children, show that males and females behave differently in some dimensions. In particular, they assert that women more frequently ask questions, smile and laugh, and maintain eye contact with their partners, whereas men interrupt more often, they spend more time speaking, and they are more likely to offer factual information. Arliss (1991: 16, 25) argues that prevailing gender stereotypes continue to influence perceptions of masculinity and femininity and these generalizations are inextricably linked to differences in male and female styles of interaction. Consequently, traits such as tactfulness, sensitivity, gentleness, submissiveness, compassion and empathy are perceived to be feminine qualities that most women embrace, while the majority of men are believed to be assertive, insensitive, direct and dominating.

The Communication Styles of Female Physicians

Meeuwesen et al. (1991: 1148) report that gender-specific socialization processes influence both the behavior of patients as well as physicians. Research indicates that differences between the communication styles of female and male physicians correspond with gender differences that are documented in non-clinical populations. In other words, it is reasonable to assume that the communication styles of male and female physicians resemble the patterns expressed outside of the medical context, in the larger social world (Byland & Makoul, 2002: 208; Roter et al., 2002). Hall & Roter (1998: 39, 40) reveal that there are behavioral gender differences in verbal and non-verbal communication
patterns between physicians and patients during the medical visit. For instance, it has been said that female physicians more frequently make statements of encouragement and approval, as well as more statements reflecting partnership values; they ask more questions concerning both biomedical and psychosocial topics, encouraging the patient to expand on issues; they engage in more in-depth discussion of psychosocial topics; and they engage in more talk about emotional experiences. In addition, female physicians use more positive nonverbal behaviors, such as smiling, nodding and eye contact.

Altogether, the image of the female physician’s communication style suggests a higher degree of expression and concerned engagement with the patient, a more egalitarian approach to the relationship, and more attention to quality of life issues that extend beyond biomedical problems; in particular, psychosocial and emotional issues. These differences correspond with gender differences reported in sociological and psychological research writings.

Kiss (2004: 78) reaffirms the differences in interactional styles of male and female doctors based on 29 publications that were reviewed for physician gender effects in medical communication. The conclusion was that female primary care physicians engaged in significantly more active partnership behaviors, more emotionally focused talk, more positive talk, more psychosocial counseling, as well as more psychosocial question asking. As well, female physicians were inclined to create a more positive atmosphere through verbal behaviors such as encouragement, agreements and reassurances. They let their patients speak more frequently, they interrupted less and in general, asked more questions. Meeuwesen et al. (1991:1148) support this conclusion and agree that female physicians tend to be more egalitarian and interactionally-oriented; they
pay more attention to the overall relationship including the psychosocial factors of the
complaints, while at the same time dealing with the medical-technical aspects.

Hall et al. (1994: 385, 389) highlight nonverbal behavioral differences between
male and female physicians. They propose that there are variations in smiling, facial
expressiveness, gazing, interpersonal distance, eye contact and touching, and in each case
female physicians show a pattern of behavior that suggests more openness, friendliness
and receptiveness. Additionally, they emit more back-channel responses (e.g., nods and
the use of *uh-huh, I see* and *yes*), which is a sign of showing interest, but it also
encourages patients to speak more freely. As with some of the other studies, female
doctors made more positive statements, used more partnership language, asked more
questions – medical and psychosocial - and in general, smiled and nodded more. It
appears that female physicians are good listeners and they also attempt to create a
positive interpersonal climate, just as women do in non-clinical contexts.

**Patient Expectations and Gender**

Roter and Hall (2004: 510) contend that patients of female physicians talk more
overall, make more positive statements, discuss more psychosocial issues and express
more partnership building than patients of male doctors. This high degree of personal
disclosure could be attributed to the fact that female physicians ask more open-ended
questions of a psychosocial nature and that they more actively facilitate egalitarian
relationships. Because female physicians ask more psychosocial questions than their
male counterparts, it may be likely that this type of questioning stimulates more patient
disclosure. In addition, female physicians spend more time with their patients and this
too can foster an environment in which patients feel comfortable revealing their
biomedical and psychosocial issues. Patient expectations may play a role as well. Sex role socialization could result in patients bringing traditional role expectations or stereotypes to the medical encounter and interaction with physicians may be based on these perceptions. For example, patients might expect female physicians to be compassionate, nurturing, empathetic, more expressive and genuinely concerned, whereas male physicians are often presumed to be less demonstrative, more direct and disconnected from emotional concerns and issues. Consequently, the more person-centered approach fosters an environment of openness, ease and comfort (Weisman & Teitelbaum, 1985: 1120). Kiss (2004: 79) also affirms that patients’ stereotypes are incorporated into the medical encounter. In particular, he refers to research that suggests patients are more assertive with female physicians and they tend to interrupt them more. This is consistent with the literature on gender and social status where women are accorded a lower status. Overall, the conclusion is that patients often hold different expectations of male and female physicians and this in turn impacts communication aspects of the medical visit (Weisman & Teitelbaum, 1985: 1125).

Kiss (2004:79) asserts that the communication styles of male and female patients will be shaped according to their respective male and female gender identities. For example, when it comes to discussing psychological problems, male patients are more likely to be reserved and apprehensive in expressing their concerns. Using depression as an example, Kiss reveals that when men finally open up about the subject, they tend to present themselves as stressed rather than depressed, since depression questions fundamental notions of male gender identity. Conversely, female patients usually initiate discussions about depression with their physicians. Furthermore, despite the limited
amount of research dealing with patient gender, the available research suggests that female patients receive more information than male patients. Studies have attributed this difference to female patients’ more numerous requests for information, as well as their receptivity towards open and intimate dialogue (Hall et al., 1994: 385). Recent literature reiterates these findings and reports that when with their physicians, women ask for more information and they talk more overall. Additionally, female patients use more emotionally concerned statements, disagreements, and positive statements as compared to their male counterparts. Furthermore, Brink-Muinen et al. (2000) conclude that female patients consider talking about psychosocial issues to be an important aspect of the medical visit while at the same time, they communicate more openly with physicians, particularly female doctors, about psychosocial issues. Male patients on the contrary, attach more importance to biomedical issues and are more likely to bring up these types of issues. Lastly, regardless of gender, patients will likely become more involved when their physicians are more patient-centered in their communication (Street, 2002: 204).

**Physician Interactional Styles and Patient Satisfaction**

Studies have shown that when physicians optimize their communication skills it is beneficial for both the patient and physician alike. For instance, improved patient health outcomes, improved patient satisfaction and increased patient compliance with recommended medical treatment are just some of the advantages documented when physicians optimize their communication skills. In particular, several studies have indicated that patients who felt they had adequate time to tell their physician about their illness and also felt that their physician listened intently with genuine interest were more satisfied and had higher rates of compliance (Renchko, 2005). Pittman (1999: 398)
reaffirms this idea and argues that different types of communication styles have been associated with variables such as patient satisfaction, ability to recall information during the medical visit, as well as rates of adherence to treatment.

Roter & Hall’s (1992: 136) reviews of doctor-patient interaction studies reveal that the social climate established in the medical visit appears to be a major determinant of satisfaction. They conclude that satisfaction is enhanced when physicians treat patients in a more partner-like and egalitarian manner: when positively toned words are spoken, such as statements of approval and agreement; when fewer negative words are spoken, such as criticisms; when more social conversation takes place, particularly non-medical talk; and when the physician treats the patient in a warmer manner, such as sitting closer, gently touching the arm of the patient or engaging in more eye contact. In addition to these behaviors, the patient-centered interviewing style of communication in which the point of view of the patient is actively sought through expressions of concern and question asking, is positively associated with patient satisfaction. Similarly, communication behaviors that establish and maintain a positive relationship between doctor and patient, such as friendliness, interest, empathy, compassion and a nonjudgmental attitude, are more likely to result in patient satisfaction as compared with a more dominant style of communication. In light of this information, it could be argued that patient satisfaction may be influenced by the gender of the provider (Bertakis & Azari, 2003: 69). Roter et al. (2002: 218) determined that female physicians, because of their communication behaviors, create a more favorable therapeutic environment than their male counterparts; this seems to positively impact on patient satisfaction and clinical outcomes. Nevertheless, it also must be recognized that patient satisfaction as an
outcome does not supercede health outcomes, which ultimately validate the quality of health care delivery (Bertakis et al., 2003: 74).

**Patient-Centered Communication and Female Physicians**

As stated previously, gender is a characteristic that is associated with variation in communication style. Differences in the interpersonal styles of women as compared with men are well documented in routine conversations. Women disclose more information about themselves, they have a more engaged style of nonverbal communication, and they encourage and facilitate others to express themselves in a more intimate and open fashion. It also appears that women are more accurate in judging and assessing others’ feelings both verbally and nonverbally. On the basis of these gender-linked conversational differences, researchers have speculated that female physicians may find it easier to engage in communication that can be considered patient-centered (Roter & Hall, 2004: 498, 499). This is in contrast to their male counterparts who are often deemed more suited for the biomedical approach to medicine which embraces objectivity and detachment from patients and their life contexts.

The dominant model in medical practice has been labeled ‘the conventional medical model’ or ‘the biomedical model’. This model explains sickness in terms of pathophysiology: abnormal structure and function of tissues and organs, and ultimately, it reduces sickness to disease. The primary focus is on the body, not the person. The primary task of the physician is to make a diagnosis and there is little or no room for the social, psychological, and behavioral dimensions of illness; the disease is dealt with as an entity separate from psychosocial issues (Stewart et al., 2003: 7, 8, 36). Stewart & Roter (1989: 22, 27, 29) insist that the world of the patient comprises a complex web of
personality, culture, relationships and living situations, all of which impact and define the illness experience. The biomedical model does not aim to understand the meaning of the illness for the patient, nor does it place it in the context of the patients’ life experiences or culture. For this reason, these authors maintain that the clinical method should be transformed into a patient-centered method, an approach that enables the physician to enter the world of the patient.

Patient-centered care is beginning to play a central role in heath care. This model of care is comprised of the following conditions: the physician explores patients’ main reason for the visit, concerns and need for information; the practitioner seeks an integrated understanding of the patient’s world – their whole person, including social, emotional and psychological needs, as well as life issues; the physician-patient relationship should seek to find common ground in terms of the problem, but also in relation to achieving a mutually agreed upon management approach; the relationship should be one in which prevention and health promotion is a primary goal; and finally, the physician must not only empower the patient but also share the power, allowing the patient to actively participate and contribute to discussions and decisions (Stewart et al., 2003: 3, 4, 5, 6). Stewart & Roter (1989: 252) are convinced that better communication between physician and patient is central to the task of achieving patient-centered care.

In their study on the patient-physician relationship and verbal communication, Meeuwesen et al. (1991: 1148) concluded that female physicians met the criteria of a patient-centered approach more often than their male colleagues. Similarly, in her study on the role of gender in health care communication, Brink-Muinen (2002: 199) postulates that there is a heightened level of comfort, engagement, disclosure and empowerment on
the part of male and female patients in their interactions with female doctors. Moreover, there appears to be more affectiveness and sensitivity of female physicians to the patients’ needs. Thus, the review of literature on physician gender and communication suggests that patients have a strong desire for a patient-centered approach to health care and that female physicians are more likely to practice this style of medicine.

At present, there is a growing trend away from the doctor-centered traditional biomedical model towards a more patient-centered approach. The patient-centered style highlights the social relationship that exists between physician and patient, and talk plays a central role (Wang, 2005). Roter & Hall (1992: 3) assert that communication is the main ingredient in medical care and that it is the fundamental instrument through which the physician-patient relationship is defined and established. What these authors have found is that the characteristics observed in female physicians and in women generally, are needed in all physician-patient relationships. That is to say, female physicians show a greater affinity for collaboration, they spend more time with their patients, they are more likely to engage their patients in discussions involving social and psychological issues, and they deal more often with feelings and emotions. Furthermore, female physicians tend to facilitate partnership and patient participation in the medical encounter, more effectively than do male physicians (Roter & Hall, 1998: 1093, 1094). With this in mind, it seems reasonable to suggest that the medical community ought to do everything in its power to enhance physician-patient interactions. Research on the effectiveness of communication skills training is encouraging. There is evidence to suggest that education and training is associated with improvement in skills, and in many cases, these improvements are long lasting (Roter & Hall, 2004: 512). Roter & Hall (1998: 1097)
claim that practicing physicians of both genders can be effectively trained to utilize a more patient-centered approach and once trained, these skills become integrated into their routine practice. Because women seem to have an advantage in terms of their interactional skills, it might be beneficial to explore certain principles of feminism and feminist therapy as an approach to enhancing the communication skills of physicians.

**Feminism and Feminist Criticism**

Lerner (1986: 212, 213, 214, 220) maintains that patriarchy is a historic creation by men and women, in which the basic unit of organization is the patriarchal family. Gender, which involves roles and behavior appropriate to the sexes, is a central issue embedded in this doctrine. These roles and behavior were and continue to be expressed in values, customs and laws. Men as a group had rights that women as a group did not have. In every known society it was women of conquered tribes who were first enslaved; the enslavement of women also preceded the formation of the class system as well as class oppression. The first gender-defined social role for women involved those who were exchanged in marriage transactions. Although some aspects within Western civilization are more egalitarian, male dominance in the public realm, in institutions and in governments, prevails. According to Eckert & McConnell-Ginet (2003: 9), gender is so thoroughly embedded in our institutions, our actions, our beliefs and desires that it appears to be completely natural. Harding (quoted from Wharton, 2005: 6) reaffirms this notion and insists that gender remains a central organizing principle of modern life: “In virtually every culture, gender difference is a pivotal way in which humans identify themselves as persons, organize social relations, and symbolize meaningful natural and social events and processes.” Feminism and feminist criticism is a specific kind of
political discourse that is committed to the struggles against patriarchy and sexism, including problems such as gender inequality. Although there are diverse viewpoints within feminist discourse, the main task of critics and feminist theorists is to expose the ways in which male dominance constitutes what Kate Millett describes as ‘perhaps the most pervasive ideology of our culture’ (Belsey & Moore: 1989: 117, 188, 189). Within feminist discourse, woman is the primary object of study and she is also the central subject. Feminist scholars seek not only to locate and identify women in social life, but also to discover how that life appears to women. Feminist theorists apply their intellectual tools by enhancing knowledge of women’s oppression and based on this knowledge, to developing strategies for resisting subordination and improving women’s lives (McCan & Kim, 2003: 1).

Many people assume that feminist theory provides a singular and unified framework for analysis, however, this is not quite the case. All feminist theories posit gender as a significant characteristic that interacts with other elements such as race/ethnicity and class, to structure relationships within society as a whole. Nonetheless, the use of gender to view the world results in a number of diverse theories of feminism, including liberal, radical, Marxist/Socialist and Postmodern feminism, to name but a few: Liberal feminism proposes that women are oppressed in contemporary society because they suffer unjust discrimination; they seek no special privileges for women and they insist that everyone receive equal consideration without discrimination on the basis of sex. Advocates argue that women and men are alike in important respects and therefore, women are entitled to equal rights and opportunities (Rosser, 1998; Wood, 1999: 72); Perhaps the most important outcome of the radical feminist movement was its
identification of the structural basis of gender differences and opportunities. The link
between women’s individual situations and social practices was captured in the
movement’s declaration that “the personal is political” (Wood, 1999: 72);
Marxist/Socialist feminists offer an alternative view to Western and capitalist versions of
feminism. These perspectives assume that economic and material conditions are very
powerful sources of oppression. Moreover, both assume that capitalism plays a central
role in creating and perpetuating the sexual division of labor and the resulting political
and economic inequities between men and women (Wood, 1999:75); finally, postmodern
feminists counter the idea that women speak in a unified voice or that they can be
addressed universally. Proponents insist that race, class, nationality, sexual orientation,
as well as other factors, prevent the universalization of women. In this context, feminist
postmodern theorists maintain that no one solution or approach can benefit all women
world-wide (Rosser, 1998).

**Feminist Therapy and the Physician-Patient Relationship**

Feminist therapy and counseling is one aspect of contemporary feminist action
concerned with women’s emotional wellbeing. Much like feminism, feminist therapy
involves a wide range of theoretical and counseling approaches, all of which are
compatible within a feminist framework (Enns, 1997:6; McLeod, 1994:1). The principles
of feminist therapy remain unchanged to date and involve a commitment to political,
economic and social equality for women and men, as well as a commitment to an
egalitarian relationship between client and therapist. An essential element in both
feminism and feminist therapy is the idea that “the personal is political,” and this has
been emphasized in order to create a foundation for comprehending and explaining the
oppression of all women (Rosewater et al., 1985: xx, 1). Feminist critics have a history of exposing sexist biases and abuses in traditional medicine and psychotherapy, and central to all feminist tenets is attention to power and the egalitarian relationship. Feminist therapists translate their beliefs into practice by modeling communication skills such as genuineness, compassion and self-disclosure, all in an attempt to establish equal relationships (Rader & Gilbert: 2005). Pivato (2004: 89) maintains that feminist therapy is more a description of a therapist’s value system and in this context, it is grounded in a number of core principles: a valuing of diversity; an egalitarian therapeutic relationship; paying attention to both social and intrapsychic forces that comprise an individual’s life; the need to rely on feminist research for information and directions for treatment; the need to view women as equal to men, not complementary to men; and finally, empowerment of the client rather than adjustment to unequal social relations.

Meryn (1998) contends that the most common complaint by patients and the public in terms of their physicians is related to problems of communication and in particular, the notion that doctors do not listen to them. Numerous studies have documented that doctors and patients have different views on what makes communication good and effective; these differences influence and impact the quality of interactions between patients and doctors. If the research is correct and people prefer a more patient-centered model of medicine, it seems reasonable to propose that elements of feminist therapy can also be applied to the physician-patient relationship in an effort to improve communication between the clinician and patient. While the idea that communication is an essential aspect of medicine is not new, more recently, communication skills teaching and patient-centered care have become more visible in
medical education (Makoul, 2003). Wear (1994: 43) maintains that the powerful social institution of medicine in the United States is still under patriarchal control and consequently, most feminist debate has been framed to keep women on the defensive, working within the existing educational framework.

**Feminist Criticism, Communication Skills and Medical Education**

Feminist scholars have taken modern medical institutions and practice to task for their complicity in some aspects of the oppression of women and gender discrimination: from institutional structures to its insistence on authoritarian patterns of control; from its differential treatment of male and female patients to its obsessive interest in the reproductive functions of women. Feminist critics insist that it all begins in a system of medical training that imitates and reflects some of the most profound socialization found in any profession, a socialization that “often forces those in training to absorb the values of the dominant group” (Wear, 1994: 45, 46). From the first day of training, medical students are indoctrinated into a rigid hierarchy of power and authority, with the mostly male physicians at the top and medical students at the bottom. In addition, gender differences are diminished as students experience the “intense and homogenizing effects of professional socialization” (Wear, 1994: 46). Medical students are usually quick to incorporate these medical doctrines into their already acquired cultural views, which typically involve unexamined sexist beliefs. In this context, it could be argued that collaboration, cooperation and nonhierarchical relationships between and among health care professionals, doctors and patients based on mutuality, collegiality and egalitarianism – components of feminist theory and therapy - could easily be espoused theoretically in medical training (Wear, 1994: 46). Just as patient-centered care and
communication skills training are gradually being introduced into medical education, so too can the principles of feminism and feminist therapy, which to a large degree emphasize and reinforce the value of communication and enhancing interaction.

In medical education there has been a strong emphasis on scientific knowledge as the foundation for understanding other forms of human discourse and consequently, technical skills are considered fundamental, while interactive skills and emotional (affective) aspects of human experience are distanced and diminished. In addition, the learning process in medical school favors the development of detachment, objectivity, wariness as well as the distrust of emotions (Coulehan & Williams, quoted from Delese & Bickel, 2000: 56, 57). However, it is now widely accepted that effective interpersonal communication plays a pivotal role in the quality of health care delivery and that current standards in medicine need to be improved (Hargie et al., 1998). Klass (quoted from Wear, 1996: 87, 94) suggests that many of the techniques traditionally used by male physicians tend not to work for women and as a result, many female doctors have found themselves evolving new ways of interacting with patients, nurses, and peers. In fact, many female physicians believe that women practice medicine differently and that there are advantages to the way they approach their patients. In this light, Wear (1996: 105) recommends that feminist criticism become an alternative framework for teaching medical students whereby students and teachers engage in critically exclusionary or oppressive practices, norms and standards, enacted overtly or subtly, in both the larger culture as well as in the medical culture.

It is important to recognize the barriers confronting the implementation of feminist thought and communication skills training into the medical curriculum. The first
argument involves the notion that intelligent medical students do not need to learn how to communicate. Any deficiencies in this area, it is argued, will develop in students from the exposure they get in the traditional curriculum. Nonetheless, the body of evidence produced from various studies has proved otherwise. Secondly, because many of the instructors are older and male, resistance to change may be very difficult to overcome. Thirdly, there is usually an attitude of skepticism towards any “soft” science from the more traditionally oriented faculty members. This hostility is attributed to the fact that feminist critique and communication skills training originate from groups outside of the medical profession, who are seen as undermining its status and diminishing its exclusive role in education and training (Hargie et al., 1998). An extension of this argument can be applied to primary care physicians. Barriers to patient-centered care and effective communication between physician and patient have been identified: time constraints, lack of training, and emotional inhibition on the part of both patients and physicians can interfere with effective communication (Creed, quoted from White, 2005: 217).

Despite these obstacles, the teaching of feminist principles and communication skills in the medical academy will force students to confront the taken-for-granted assumptions and stereotypes inherent in medical practice. Yedidia et al (2003) concluded that the implementation of communications curricula significantly improved third-year students’ overall communications competence as well as their skills in building relationships, organization and time management, patient assessment, negotiation and shared decision-making – tasks that have been linked to positive patient outcomes. Hargie et al (1998) identified specific features of communication which are problematic in physician-patient medical encounters: gathering adequate and accurate information;
providing sufficient, comprehensible information in a sensitive and compassionate manner; failing to listen to patients’ concerns; being negligent of patients’ psychosocial needs; and finally, failing to engage effectively in the relationship to the detriment of the establishment of mutually acceptable interpersonal associations with patients. Because feminism and feminist therapy tend to highlight the importance of these very issues, it seems reasonable to suggest that elements of this discipline should be integrated into the medical school curriculum, as well as programs of continuing medical education (Meryn, 1998). According to Travaline et al. (2005), simple choices in words, speech patterns, body position and facial expression can greatly affect the quality of one-on-one communication between physician and patient. To a large degree, these are conscious choices that can be learned and implemented into physicians’ practice style when dealing with patients. Avoiding pitfalls of communication and enhancing basic communication skills can ultimately help strengthen the patient-physician bond.

**Conclusion**

In summary, physician gender and patient communication in medical consultations has received significant attention within the research community. It has been suggested that female physicians are more effective communicators than their male counterparts, and this is also consistent with the literature on gender differences between men and women in non-clinical contexts. There is some debate as to the origins of these differences, however, advocates of socialization research have proposed a variety of theories, most of which point to external influences such as parental and peer influences, sex role stereotypes and cultural values and norms, to name but a few. Regardless of the origins, research indicates that there is a preference for patient-centered care. Because
women appear to have an advantage in terms of interpersonal style, it seems logical to suggest that certain aspects of feminism and feminist therapy, which highlight communication skills and patient-centeredness, could be used as a tool for enhancing the physician-patient relationship.
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