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9:00 - 13:00 | **I NUOVI OBIETTIVI DELLA SALUTE DI GENERE**

RES **4.0** crediti ECM
Singola sessione

Ore 9:00-10:30 I SESSIONE **Il sesso-genere in Medicina Legale**

Coordina — ***Monica Bettoni*** — *Comitato Scientifico Forum Risk Management in Sanità*

Saluto Istituzionale
Rocco Palese*
Assessore Sanità Regione Puglia

Introduce
Flavia Franconi ●
Coordinatore Laboratorio Nazionale Medicina e Farmacologia di Genere

Intervengono
Emanuela Turillazzi — *Professore Ordinario Medicina Legale Università di Pisa*
Vincenza Palermo ● — *Presidente COMLAS*
Francesco Introna, Sara Sablone — *Società Italiana di Medicina legale e delle Assicurazioni*

Ore 10.30-11.30 II SESSIONE **Quali cambiamenti del Sistema Sanitario per la tutela della salute ed una medicina basata sul sesso-genere**

Coordina — ***Monica Bettoni*** — *Comitato Scientifico Forum Risk Management in Sanità*

Intervengono
Flavia Franconi ● — *Coordinatore Laboratorio Nazionale Medicina e Farmacologia di Genere*
Gianfranco Costanzo — *Direttore Sanitario INMP*
Mojgan Azadegan — *Coord. Regionale del Centro di Salute e Medicina di Genere Regione Toscana*

Ore 11.30-12.15 III SESSIONE **La cultura della prevenzione**

Coordina — ***Francesco Albergo*** — *Direttore Area Sanità, Università LUM*

Intervengono
Michela Iacobellis — *Direttore Laboratorio HPV ASL Bari*
Vincenzo Gigantelli — *Direttore Distretto Socio Sanitario 14 di Putignano*

Ore 12.15-13.30 IV SESSIONE **Scenari e nuove prospettive in Medicina di Genere**

Coordinano — ***Anna Maria Moretti*** — *Presidente Nazionale GISEG Gruppo Italiano Salute e Genere*
Franco Lavalle — *Rappresentante FNOMCeO*

Medicina di genere nelle prospettive istituzionali
Roberta Maselli — *Istituto Superiore di Sanità*
La formazione in medicina di genere
Teresita Mazzei — *Responsabile Medicina di Genere FNOMCeO*
Differenze di genere in epoca neonatale
Alessandra Foglianese — *UOC Neonatologia e terapia intensiva neonatale universitaria Policlinico di Bari*
Alimentazione e differenze di genere
Giovanni De Pergola — *Università di Bari*

Ore 13:00 Chiusura lavori mattina

Emanuela Turillazzi

Dipartimento di Patologia Chirurgica, Medica, Molecolare e dell'Area Critica

Università di Pisa

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PARTE I: Inquadramento generale della Medicina di Genere

Cos'è la Medicina di Genere

Il concetto di **Medicina di Genere** nasce dall'idea che le differenze tra uomini e donne in termini di salute siano legate non solo alla loro caratterizzazione biologica e alla funzione riproduttiva, ma anche a fattori ambientali, sociali, culturali e relazionali definiti dal termine "**genere**". L'Organizzazione Mondiale della Sanità (OMS) definisce il **"genere"** come il risultato di criteri costruiti su parametri sociali circa il comportamento, le azioni e i ruoli attribuiti ad un sesso e come elemento portante per la promozione della salute. Le **diversità nei generi** si manifestano:

- **nei comportamenti**, negli stili di vita così come nel vissuto individuale e nel diverso ruolo sociale
- **nello stato di salute**, nell'incidenza di molteplici patologie, croniche o infettive, nella tossicità ambientale e farmacologica, nelle patologie lavoro correlate, salute mentale e disabilità, in tutte le fasce di età (infanzia, adolescenza, anziani) e in sottogruppi di popolazione svantaggiati
- **nel ricorso ai servizi sanitari** per prevenzione (screening e vaccinazioni), diagnosi, ricovero, medicina d'urgenza, uso di farmaci e dispositivi medici
- **nel vissuto di salute,** atteggiamento nei confronti della malattia, percezione del dolore, etc.

Pertanto, in base all'indicazione dell'OMS, si definisce **Medicina di Genere** lo studio dell'influenza delle differenze biologiche (definite dal sesso) e socio-economiche e culturali (definite dal genere) sullo stato di salute e di malattia di ogni persona. Infatti, molte malattie comuni a uomini e donne presentano molto spesso differente incidenza, sintomatologia e gravità. Uomini e donne possono presentare inoltre una diversa risposta alle terapie e reazioni avverse ai farmaci. Anche l'accesso alle cure presenta rilevanti diseguaglianze legate al genere.

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31-1-2018 GAZZETTA UFFICIALE DEI

LEGGE 11 gennaio 2018, n. 3.

Delega al Governo in materia di sperimentazione clinica di medicinali nonché disposizioni per il riordino delle professioni sanitarie e per la dirigenza sanitaria del Ministero della salute.

La Camera dei deputati ed il Senato della Repubblica hanno approvato;

IL PRESIDENTE DELLA REPUBBLICA

- ***Applicazione e diffusione della medicina di genere nel Servizio sanitario nazionale***

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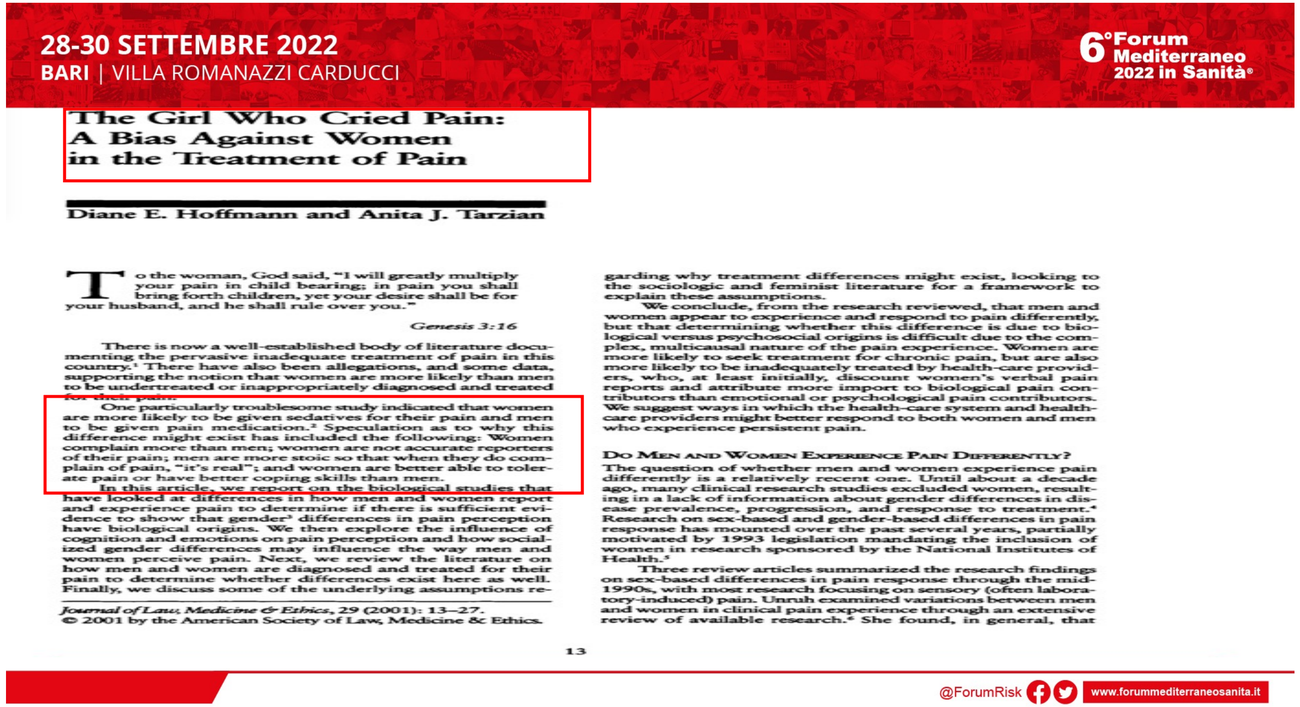
- 1. Il Ministro della salute … predispone, con proprio decreto, un piano volto alla diffusione della medicina di genere mediante divulgazione, formazione e indicazione di pratiche sanitarie che nella ricerca, nella prevenzione, nella diagnosi e nella cura tengano conto delle differenze derivanti dal genere, al fine di garantire la qualità e l'appropriatezza delle prestazioni erogate dal Servizio sanitario nazionale in modo omogeneo sul territorio nazionale.
- 2. Il decreto di cui al comma 1 è adottato nel rispetto dei seguenti princìpi:
- a) previsione di un approccio interdisciplinare tra le diverse aree mediche e le scienze umane che tenga conto delle differenze derivanti dal genere, ***al fine di garantire l'appropriatezza della ricerca, della prevenzione, della diagnosi e della cura;***
- b) promozione e sostegno della ricerca biomedica, farmacologica e psico-sociale basata sulle differenze di genere;
- c) promozione e sostegno dell'insegnamento della medicina di genere, garantendo adeguati livelli di formazione e di aggiornamento del personale medico e sanitario;
- d) promozione e sostegno dell'informazione pubblica sulla salute e sulla gestione delle malattie, in un'ottica di differenza di genere.
- 3. Il Ministro della salute emana apposite raccomandazioni destinate agli Ordini e ai Collegi delle professioni sanitarie, alle società scientifiche e alle associazioni di operatori sanitari non iscritti a Ordini o Collegi, volte a promuovere l'applicazione della medicina di genere su tutto il territorio nazionale.



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The Girl Who Cried Pain: A Bias Against Women in the Treatment of Pain

Diane E. Hoffmann and Anita J. Tarzian

To the woman, God said, "I will greatly multiply your pain in child bearing; in pain you shall bring forth children, yet your desire shall be for your husband, and he shall rule over you."

Genesis 3:16

There is now a well-established body of literature documenting the pervasive inadequate treatment of pain in this country.[1] There have also been allegations, and some data, supporting the notion that women are more likely than men to be undertreated or inappropriately diagnosed and treated for their pain.

One particularly troublesome study indicated that women are more likely to be given sedatives for their pain and men to be given pain medication.[2] Speculation as to why this difference might exist has included the following: Women complain more than men; women are not accurate reporters of their pain; men are more stoic so that when they do complain of pain, "it's real"; and women are better able to tolerate pain or have better coping skills than men.

In this article, we report on the biological studies that have looked at differences in how men and women report and experience pain to determine if there is sufficient evidence to show that gender[3] differences in pain perception have biological origins. We then explore the influence of cognition and emotions on pain perception and how socialized gender differences may influence the way men and women perceive pain. Next, we review the literature on how men and women are diagnosed and treated for their pain to determine whether differences exist here as well. Finally, we discuss some of the underlying assumptions regarding why treatment differences might exist, looking to the sociologic and feminist literature for a framework to explain these assumptions.

We conclude, from the research reviewed, that men and women appear to experience and respond to pain differently, but that determining whether this difference is due to biological versus psychosocial origins is difficult due to the complex, multicausal nature of the pain experience. Women are more likely to seek treatment for chronic pain, but are also more likely to be inadequately treated by health-care providers, who, at least initially, discount women's verbal pain reports and attribute more import to biological pain contributors than emotional or psychological pain contributors. We suggest ways in which the health-care system and health-care providers might better respond to both women and men who experience persistent pain.

Do Men and Women Experience Pain Differently?

The question of whether men and women experience pain differently is a relatively recent one. Until about a decade ago, many clinical research studies excluded women, resulting in a lack of information about gender differences in disease prevalence, progression, and response to treatment.[4] Research on sex-based and gender-based differences in pain response has mounted over the past several years, partially motivated by 1993 legislation mandating the inclusion of women in research sponsored by the National Institutes of Health.[5]

Three review articles summarized the research findings on sex-based differences in pain response through the mid-1990s, with most research focusing on sensory (often laboratory-induced) pain. Unruh examined variations between men and women in clinical pain experience through an extensive review of available research.[6] She found, in general, that

Journal of Law, Medicine & Ethics, 29 (2001): 13–27.

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39.2 COLUMBIA JOURNAL OF GENDER AND LAW 91

MISS DIAGNOSIS: GENDERED INJUSTICE IN MEDICAL MALPRACTICE LAW

CECILIA PLAZA*

Abstract

Women patients have experienced a history of discrimination in medical practice. Medical malpractice litigation offers an avenue for patients affected by practitioner negligence to recoup the costs inflicted by their injuries. The present study investigates the impact of patient gender on plaintiffs' recovery amounts in medical malpractice suits alleging delayed, wrongful, or misdiagnosis, as women are more vulnerable to diagnosis-related malpractice. This study also analyzes the impact of contextual factors such as state demographics, state malpractice legislation, and features of each instance of litigation, such as the duration of each case. Using a national database of resolved malpractice cases from 2004 to 2018, this study uses several different statistical models to shed light on the contours of the gender gap in medical malpractice litigation. This study also offers suggestions for future research and potential solutions to address the gender gap and increase equal access to legal recourse after medical injury due to negligence for patients of all genders.

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2007

Maryland Tort Damages: A Form of Sex-Based Discrimination

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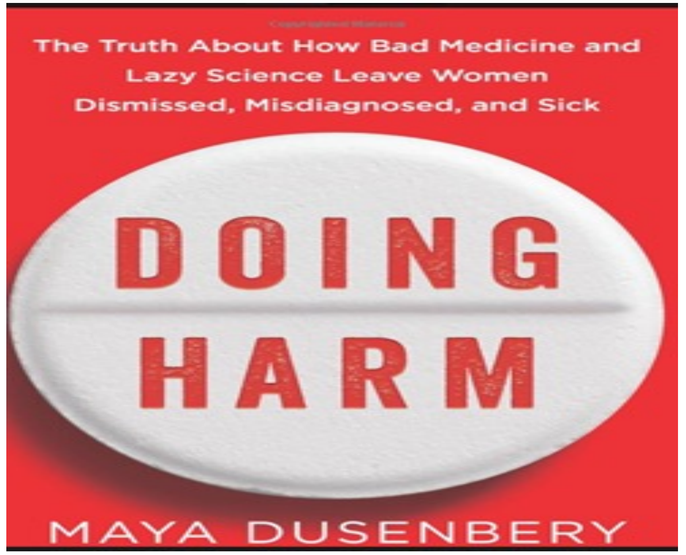
diagnosis at all.[2] Women are more likely to face misdiagnosis than men.[3] This can be attributed to two main factors: the dearth of medical scientific knowledge about women's health[4] and the widespread distrust among health professionals of their women patients relative to male patients.[5] The combination of the "knowledge gap"—the medical community's lack of knowledge about women's health due to women's historical underrepresentation in medical research—and the trust gap—the medical profession's history of distrusting or downplaying women's reports of their own symptoms—creates an increased risk of missed, delayed, and incorrect diagnoses for women.[6]



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The knowledge gap

A. The Knowledge Gap

There is less information available about women's health than about men's health.[9] In other words, there is a knowledge gap between the medical profession's understanding of men's health and women's health. This is a natural consequence of women's historical underrepresentation in biomedical studies and the relative neglect of diseases that predominantly affect women in medical research, both of which continue to this day despite patient advocacy efforts.[10] The resulting knowledge gap affects the quality of medical care that women patients receive.

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The trust gap

The trust gap is the increased distrust that medical professionals have historically had and still have of women patients as compared to men. In general, medical professionals are more likely to discount women patient's symptoms in favor of their own knowledge about what illnesses 'typically' affect women.[37] Professionals are also more likely to discount women's symptoms altogether and label them as psychological in origin.[38] This leads to a pervasive distrust between women and their medical practitioners: Professionals do not trust women patients as reliable reporters of their own symptoms and, as women patients feel discounted and distrusted, they in turn distrust their medical professionals.

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The impact

C. The Impact of Knowledge and Trust Gaps on Women's Quality of Care

When women's symptoms are not taken seriously and when women patients are subjected to often incorrect psychogenic explanations of their symptoms,[64] women patients as a group are left vulnerable to misdiagnosis, under-diagnosis, and to being stereotyped as mentally ill, making them less likely to ever receive a correct diagnosis.[65] Women patients are thus more likely to experience missed, delayed, or wrongful diagnoses, which are legally redressable claims under medical malpractice laws.

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4. Intersectionality and Impact

It is important to note that gender interacts with other factors like race, socioeconomic status, age, and weight, among others. For instance, that healthcare professionals tend to underestimate black patients' pain is widely documented.[97] Women who are able to get diagnoses for illnesses such as chronic pain conditions, which are difficult to diagnose and which present with symptoms that healthcare professionals are especially likely to dismiss as trivial or psychosomatic, tend to be white and of higher socioeconomic status, having the resources to find a specialist who can diagnose their condition.[98] Many treatable conditions like Alzheimer's, which is more prevalent in women, are often diagnosed late because symptoms are too casually dismissed as 'normal' signs of aging.[99] Women are also more likely than men to be wrongfully told their symptoms are a result of being overweight; women are more likely to be advised to lose weight by their physicians[100] and are advised to do so at smaller amounts of

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BMJ. 2008 Apr 5; 336(7647): 731–732.
doi: 10.1136/bmj.39526.359630.BE
PMCID: PMC2287223
PMID: 18390498

Effects of gender on performance in medicine

Jenny Firth-Cozens, professor

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Unwin et al. BMC Medicine (2015) 13:172
DOI 10.1186/s12916-015-0413-5

BMC Medicine

RESEARCH ARTICLE Open Access

Sex differences in medico-legal action against doctors: a systematic review and meta-analysis

Emily Unwin[1*], Katherine Woolf[1], Clare Wadlow[1], Henry W. W. Potts[2] and Jane Dacre[3]

Abstract

Background: The relationship between male sex and poor performance in doctors remains unclear, with high profile studies showing conflicting results. Nevertheless, it is an important first step towards understanding the causes of poor performance in doctors. This article aims to establish the robustness of the association between male sex and poor performance in doctors, internationally and over time.

Methods: The electronic databases MEDLINE, EMBASE, and PsycINFO were searched from inception to January 2015. Backward and forward citation searching was performed. Journals that yielded the majority of the eligible articles and journals in the medical education field were electronically searched, along with the conference and poster abstracts from two of the largest international medical education conferences. Studies reporting original data, written in English or French, examining the association between sex and medico-legal action against doctors were included. Two reviewers independently extracted study characteristics and outcome data from the full texts of the studies meeting the eligibility criteria. Study quality was assessed using the Newcastle-Ottawa scale. A random effect meta-analysis model was used to summarize and assess the effect of doctors' sex on medico-legal action. Extracted outcomes included disciplinary action by a medical regulatory board, malpractice experience, referral to a medical regulatory body, complaints received by a healthcare complaints body, criminal cases, and medico-legal matter with a medical defence organisation.

Results: Overall, 32 reports examining the association between doctors' sex and medico-legal action were included in the systematic review (n=4,054,551), of which 27 found that male doctors were more likely to have experienced medico-legal action. 19 reports were included in the meta-analysis (n=3,794,486, including 20,666 cases). Results showed male doctors had nearly two and a half times the odds of being subject to medico-legal action than female doctors. Heterogeneity was present in all meta-analyses.

Conclusion: Male doctors are more likely to have had experienced medico-legal actions compared to female doctors. This finding is robust internationally, across outcomes of varying severity, and over time.

Keywords: Disciplinary action, Malpractice, Medical education, Medical regulatory boards, Meta-analysis, Systematic review

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other did not provide any inferential statistics.

Summary of findings

Overall, 27/32 studies found that male doctors were more likely to have had experienced at least one medico-legal action [5–7, 13, 14, 16–19, 21–23, 25–28, 30, 32–39], although 4/27 studies did not calculate inferential statistics and did not provide sufficient data to enable the calculation of any effect size [13, 18, 32, 38]. Of the studies that provided an effect size or where it was possible to calculate an effect size from the data reported, 22/23 demonstrated that male doctors were statistically significantly more likely to have had experienced a medico-legal action ($P \leq 0.05$) [5–7, 14, 16, 17, 19–23, 25–28, 30, 31, 33–37, 39]. The remaining study examined doctors at two separate time intervals finding a significant association at the early time point only [31].

Finally, 5/32 studies found no statistically significant difference between male and female doctors [8, 9, 15, 24, 29].

Conclusions

This is the first systematic review and meta-analysis examining the association between doctors' sex and experience of a medico-legal action. It demonstrates that male doctors are more likely to have had experience of a medico-legal action when compared to female doctors. This effect was demonstrated over a number of years, across a range of study designs, across different countries, and with a wide definition of outcome types, and therefore seems robust. The demonstration of a consistent effect size, present in the main analysis, as well as in the subgroup analyses, highlights that there is likely to be a fundamental reason to explain why male doctors are at over two times the odds of experiencing a medico-legal action.

More detailed information is needed to understand the reasons why male doctors are more likely to experience a medico-legal action. The causes are likely to be complex and multi-factorial, but the first step is to recognise that there is a difference, and this study shows that robustly. Medical schools, medical regulatory authorities, and researchers now need to work together to try to further understand the difference between the sexes that could explain the difference in experience of medico-legal action, with the aim of better supporting our doctors and improving patient safety.

Additional file

Additional file 1: Table S1. Search terms used for electronic database search. **Table S2.** Names of journals and conference abstracts searched electronically. **Figure S1.** Funnel plot of effect size by inverse standard error.

Abbreviations

CI: Confidence interval; GMC: General Medical Council; OR: Odds ratio; UK: United Kingdom.

Competing interests

Professor Dacre and Dr Unwin, Dr Woolf, and Dr Wadlow declare that they have no competing interests. Dr Potts reports grants from the General Medical Council.

Authors' contributions

EU, KW, and JD conceived and designed the study. EU collected the data. EU, CW, and KW were involved with data analysis and data interpretation. EU wrote the first draft of the manuscript. KW, JD, CW, and HP critically reviewed the manuscript for important intellectual content. All authors read and approved the final manuscript. The study was supervised by KW, JD, and HP.

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2017

AMA AMERICAN MEDICAL ASSOCIATION

Policy Research Perspectives

Medical Liability Claim Frequency Among U.S. Physicians

By José R. Guardado, PhD

Introduction

Medical liability claims impose costs to society—monetary and non-monetary—so examining their prevalence is important. Using new data from the American Medical Association's (AMA) 2016 Physician Practice Benchmark Survey, this paper presents estimates of claim frequency for all physicians and explores whether the likelihood of claims varies by age, gender, specialty, practice type and ownership status.

The 2016 Benchmark Survey offers a unique opportunity to shed light on physicians' risk of liability. Other data sources provide measures of claim frequency, but they lack the total number of physicians which is needed to calculate the *relative* frequency (or risk) of getting sued. For example, while the PIAA—a trade association of medical liability insurance companies—has very good data on the number of closed claims, it does not report the number of physicians that are insured.[1] Schaffer et al. (2017) use data on the number of lawsuits from the National Practitioner Data Bank (NPDB). However, because the NPDB data do not report the number of physicians, they have to rely on the AMA Masterfile data to obtain it. In contrast, our data allows us to ask questions such as: out of a nationally representative sample of physicians, how many of *those* physicians have been sued?

As a preview, we find that liability claims against physicians is not a rare event. Thirty-four percent of physicians have had a claim filed against them at some point in their careers. We also find that claim frequency varies by certain factors, particularly age, specialty and gender. Older physicians had a higher incidence of claims than did younger ones. There was also wide variation in claim incidence by specialty. General surgeons and obstetricians/gynecologists (OB/GYN) were the physicians most likely to be sued.

There is also variation in claim frequency by gender. Female physicians were less likely to be sued than their male counterparts. Almost 40 percent of male physicians have been sued over the course of their careers, compared to 22.8 percent of women. While 20.4 percent of male physicians had at least two claims filed against them, 9.7 percent of female physicians did. On average, women had about half the number of claims filed against them (41 per 100) than did male physicians (82 per 100). As with age, however, there was little variation by gender in the likelihood of getting sued recently. The percentage of both men and women who were sued in the last year was just above 2 percent.

There are a number of apparent reasons why women are less likely to get sued than male physicians, such as differences in age and specialty.[6] In separate analyses, we find that women physicians tend to be younger than their male counterparts so they have been in practice for a shorter period of time and thus have had less exposure to liability risk.[7] Thus, lower age is one explanation for part of the gender differential in claim frequency. We also find that with one exception (OB/GYN), women tend to practice in lower risk specialties than their male counterparts. In short, just controlling for age and specialty largely reduces the gender differential in claim incidence.

Table 2 also shows wide variation in claim frequency by specialty. Psychiatrists and pediatricians were the least likely among the specialties to be sued. Sixteen percent of psychiatrists and 17.8 percent of pediatricians have been sued, and about 6 percent of physicians in those specialties have been sued two or more times. At the other end of the distribution, general surgeons and OB/GYNs

[5] This last statistic is simply the average number of claims per physician multiplied by 100.
[6] See the AMA's *Physician Characteristics and Distribution in the US, 2015 Edition*, which reports physician distribution by gender, age and specialty.
[7] Results not shown.

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Table 1. Medical Liability Claim Frequency by Physician Age and Gender, 2016

	Percentage of Physicians			Number of Claims per 100 Physicians
	Ever Sued	Sued 2+ Times	Sued in Last 12 Months	
	(1)	(2)	(3)	(4)
All Physicians	34.0%	16.8%	2.3%	68
Under age 40	8.2%	1.8%	1.2%	10
Age 40-54	28.7%	11.6%	2.6%	50
Age 55 and over	49.2%	28.0%	2.6%	109
Men	39.4%	20.4%	2.5%	82
Women	22.8%	9.7%	2.1%	41
Observations	3211	3145	3147	3145

Source: Author's tabulation of data from the AMA's 2016 Benchmark Survey.

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Looking into the differences of physician gender in medical practice

The feminisation of the medical profession is a relatively new phenomenon that has grown dramatically over the past two decades worldwide. Indeed, there is an increasing percentage of women in medical professions and its strong impact on medical knowledge and clinical practice is an issue for ongoing debate[1]. Over the past century, women have progressed from being practically excluded from medical schools to forming the majority of new graduates in medicine, a trend referred to as the "feminisation of medicine"[2]. Women currently constitute more than 50% of the medical workforce gravitating towards general or primary care fields, and the number of women enrolled in specialist training programmes has risen considerably. As in much of the Western world, over the past two decades, the majority of medicine graduates have been women. The specialties that have been most widely feminized worldwide are primary care in family medicine, obstetrics and gynaecology, paediatrics and psychiatry. Surgical specialties (i.e. general and digestive surgery), the prerogative of men in years gone by, have been "colonised" by female doctors. This change must be analysed with special attention, focusing on the differences between female and male doctors. A complex social system underlies the working lives of male and female doctors differently, with female doctors being torn between behaving according to the stereotypically 'feminine' traits of being a woman and the 'masculine' stereotype of being a doctor. Potential differences in practice patterns between male and female physicians may have important clinical implications for patient outcomes because male and female physicians practice medical care differently. Despite the substantial increase in the proportion of women practicing medicine today, cultural conventions and gender-related customs in medicine continue to exist and may influence the working practice of male and female doctor. Academic literature documents gender differences in the medical profession. Gender is a peculiar characteristic that is able to influence professional style. Male and female physicians have been shown to have different practice styles, with regard to medical communication, technical skill sets and patient-centred approaches[3]. Sex and gender represent factors that modify the way doctors and patients communicate, with differences in the duration of consultations and the style and content of communication[4-6].

Unlike male consultants, who often adopt direct, abrupt and didactic communication styles, female consultants are more understanding of problems with nursing staff, more affable with patients and less inclined to immediately redirect patients' conversation back to their line of medical enquiry. Female consultants display varying levels of dominance in different contexts, for example, they appear assertive and formal with medical colleagues but often more friendly, approachable and personal with patients and nurses. Women tend to use more affective communication during consultations, with greater displays of nurturing, empathy and sympathy through their verbal and body language. The working style of female consultants, including relatively lower dominance and a more holistic approach, may contribute to reduced overall activity if they struggle to gain support from colleagues or if consultations overrun. Gender differences are particularly apparent when discussing upsetting news with patients. In routine conversation, differences in the interpersonal style of women compared with that of men are well documented. Male consultants, although clearly sympathetic, tend to focus on biomedical information. Female consultants convey greater warmth through their voice and body language and use physical contact more frequently. Some male consultants mention discomfort when discussing personal issues with patients, and also a concern that this can lead to excessive patient conversation, referred as "opening the floodgates". Female consultants routinely ask patients if they have any questions at the end of consultations, but this occurs less often with men. This opportunity is often taken by patients to open social conversations, raise medical concerns that are outside the consultant's specialty or to discuss psychological aspects of their condition. Women disclose more information about themselves in conversation, they have a warmer and more engaged style of nonverbal communication, and they encourage and facilitate others to talk to them more freely and in a more intimate way. Women are also more accurate in judging others' feelings expressed through nonverbal cues and in judging others' personality traits. Female doctors engage in a range of communication styles that may be associated with longer consultation times (medical appointments with female physicians are, on average, two minutes longer than those of male physicians), including a more 'partnership-building' approach which encompasses behaviour such as encouragement, reassurance, lowered dominance, positive talk, active partnership behaviour,

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THE PATIENT-PHYSICIAN RELATIONSHIP

Physician Gender Effects in Medical Communication

A Meta-analytic Review

Debra L. Roter, DrPH
Judith A. Hall, PhD
Yutaka Aoki, MS, MHS, ME

Context Physician gender has been viewed as a possible source of variation in the interpersonal aspects of medical practice, with speculation that female physicians facilitate more open and equal exchange and a different therapeutic milieu from that of male physicians. However, studies in this area are generally based on small samples, with conflicting results.

Objective To systematically review and quantify the effect of physician gender on communication during medical visits.

Data Sources Online database searches of English-language abstracts for the years 1967 to 2001 (MEDLINE, AIDSLINE, PsycINFO, and Bioethics); a hand search was conducted of reprint files and the reference sections of review articles and other publications.

Study Selection Studies using a communication data source, such as audiotape, videotape, or direct observation, and large national or regional studies in which physician report was used to establish length of visit, were identified through bibliographic and computerized searches. Twenty-three observational studies and 3 large physician-report studies reported in 29 publications met inclusion criteria and were rated.

Data Extraction The Cohen *d* was computed based on 2 reviewers' (J.A.H. and Y.A.) independent extraction of quantitative information from the publications. Study heterogeneity was tested using Q statistics and pooled effect sizes were computed using the appropriate effects model. The characteristics of the study populations were also extracted.

Data Synthesis Female physicians engage in significantly more active partnership behaviors, positive talk, psychosocial counseling, psychosocial question asking, and emotionally focused talk. There were no gender differences evident in the amount, quality, or manner of biomedical information giving or social conversation. Medical visits with female physicians are, on average, 2 minutes (10%) longer than those with male physicians. Obstetrics and gynecology may present a different pattern than that of primary care, with male physicians demonstrating higher levels of emotionally focused talk than their female colleagues.

Conclusions Female primary care physicians engage in more communication that can be considered patient centered and have longer visits than their male colleagues. Limited studies exist outside of primary care, and gender-related practice patterns in some subspecialties may differ from those evident in primary care.

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STUDIES HAVE LINKED PHYSICIANS' communication skills to a variety of positive outcomes, including patient and physician satisfaction, higher levels of adherence to therapeutic recommendations, improved physiological indicators of disease control, and enhanced physical and mental health status.[1-3] Within this context, gender has stimulated a good deal of interest as a possible source of variation in the interpersonal aspects of medical practice, with speculation that female physicians facilitate more open and equal exchange and a different therapeutic milieu from that of male physicians.[4-7]

Outside of the medical context, differences in the interpersonal style of women compared with men are well documented.[8-11] Women disclose more information about themselves in conversation,[10] they have a warmer and more engaged style of nonverbal communication,[8] and they encouraged facilitate others to talk to them more freely and in a warmer and more intimate way.[9] There is also evidence that women take greater pains to downplay their own status in an attempt to equalize status with a partner, in contrast with men's ten-

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SAGE

Effect of physicians' gender on communication and consultation length: a systematic review and meta-analysis

Laura Jefferson[1], Karen Bloor[2], Yvonne Birks[3], Catherine Hewitt[3] and Martin Bland[4]

Abstract

Objective: Physician gender may be a source of differences in communication between physicians and their patients, which may in turn contribute to patient satisfaction and other outcomes. Our aim was to review systematically research on gender differences in the length, style and content of communication with patients.

Methods: Seven electronic databases were searched from inception to September 2010 with no language restrictions (included MEDLINE; PsychINFO; EMBASE; CINAHL; Health Management Information Consortium; Web of Science; and ASSIA). 'Grey' literature was also searched. Data extraction and quality assessment was carried out in accordance with Cochrane Collaboration guidelines by at least two reviewers. The review uses mainly narrative synthesis due to the heterogeneous nature of the studies, with only data on consultation length being pooled in a random effects generic inverse variance meta-analysis.

Results: Searches yielded 6412 articles, of which 33 studies fulfilled the inclusion criteria. Studies were heterogenous and of mixed quality. Conflicting results are reported for many communication variables. There is some evidence that female physicians adopt a more partnership building style and spend on average 2.24 min longer with patients per consultation (95% CI 0.62–3.86) than their male colleagues.

Conclusions: Greater patient engagement by female doctors may reflect a more patient-centred approach, but their longer consultation times will limit the number of consultations they can provide. This has implications for planning and managing services.

Keywords
meta-analysis, physician gender, physician-patient communication, systematic review

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LETTERS

BEING A GOOD DOCTOR

Good communication reduces risk of a complaint or claim

Pallavi Bradshaw *medicolegal lead, risk prevention*

Medical Protection Society, London SE1 9SG, UK

Chen is right to point out the importance of empathy in being a good doctor.[1] Empathy is fundamental to good communication. The Medical Protection Society's experiences consistently show that patient dissatisfaction with their doctor's way of communicating fuels most complaints. A 2017 YouGov survey we commissioned of more than 2000 British adults found that 82% would be unlikely to complain if their general practitioner communicated openly and with empathy; 76% would be unlikely to complain if their GP explained the reasons why they could not meet their expectations; and three of the top five reasons for having made a complaint about a GP related to poor communication and behaviour.[2]

Analysis of claims tends to focus on the precipitating clinical factors, such as a delay in diagnosis, incorrect surgical technique, or medication error. But other research indicates that the risk of complaint and litigation is related to predisposing factors such as communication skills, sensitivity to patient needs, and management of expectations.[3-7]

In modern medical practice, patients are seeking not only clinical capability but also communication competence. A patient will often use a doctor's bedside manner as a proxy for quality of care. Effective communication will build trust, increase patient satisfaction, and help ensure that patients receive the care that they want and need. Patients want to know that doctors care.[8]

Doctors are continuously perfecting their clinical expertise in their specialty, but perfecting their communication and empathy skills is essential to improving patient outcomes. With that in mind, many of our risk prevention programmes focus heavily on communication skills—covering interactions with both patients and colleagues.

For more information, please visit https://www.medicalprotection.org/uk/hub/workshops-masterclasses.

Competing interests: None declared.

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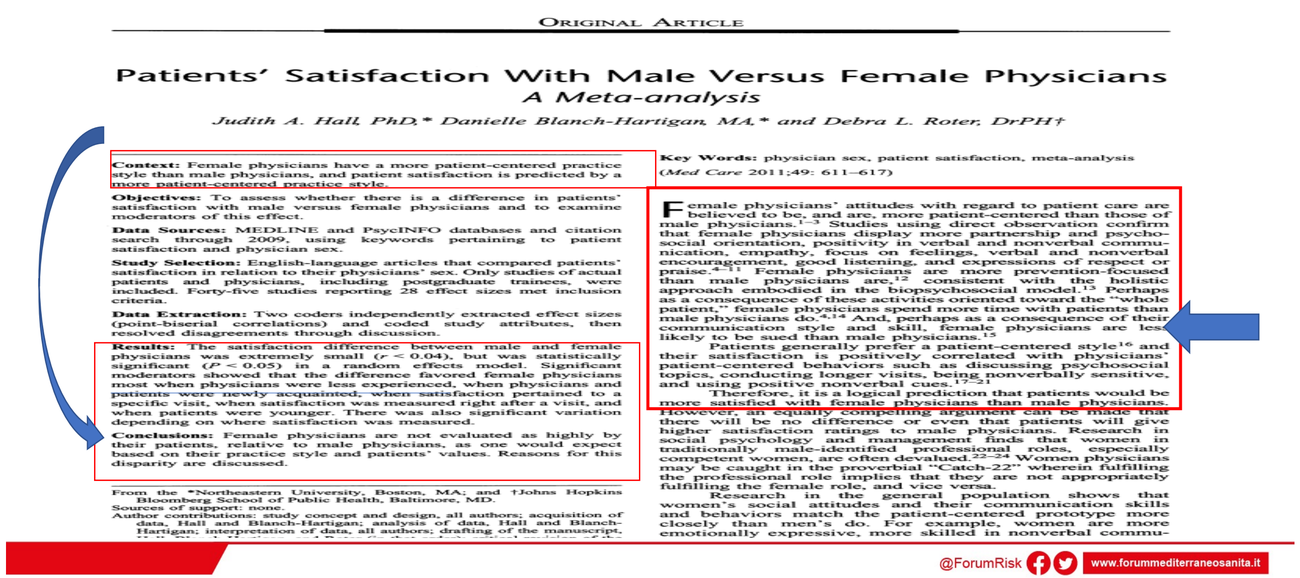

ORIGINAL ARTICLE

Patients' Satisfaction With Male Versus Female Physicians
A Meta-analysis

Judith A. Hall, PhD, Danielle Blanch-Hartigan, MA,* and Debra L. Roter, DrPH†*

Context: Female physicians have a more patient-centered practice style than male physicians, and patient satisfaction is predicted by a more patient-centered practice style.

Objectives: To assess whether there is a difference in patients' satisfaction with male versus female physicians and to examine moderators of this effect.

Data Sources: MEDLINE and PsycINFO databases and citation search through 2009, using keywords pertaining to patient satisfaction and physician sex.

Study Selection: English-language articles that compared patients' satisfaction in relation to their physicians' sex. Only studies of actual patients and physicians, including postgraduate trainees, were included. Forty-five studies reporting 28 effect sizes met inclusion criteria.

Data Extraction: Two coders independently extracted effect sizes (point-biserial correlations) and coded study attributes, then resolved disagreements through discussion.

Results: The satisfaction difference between male and female physicians was extremely small ($r < 0.04$), but was statistically significant ($P < 0.05$) in a random effects model. Significant moderators showed that the difference favored female physicians most when physicians were less experienced, when physicians and patients were newly acquainted, when satisfaction pertained to a specific visit, when satisfaction was measured right after a visit, and when patients were younger. There was also significant variation depending on where satisfaction was measured.

Conclusions: Female physicians are not evaluated as highly by their patients, relative to male physicians, as one would expect based on their practice style and patients' values. Reasons for this disparity are discussed.

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Author contributions: study concept and design, all authors; acquisition of data, Hall and Blanch-Hartigan; analysis of data, Hall and Blanch-Hartigan; interpretation of data, all authors; drafting of the manuscript,

Key Words: physician sex, patient satisfaction, meta-analysis
(*Med Care* 2011;49: 611–617)

Female physicians' attitudes with regard to patient care are believed to be, and are, more patient-centered than those of male physicians.[1–3] Studies using direct observation confirm that female physicians display more partnership and psychosocial orientation, positivity in verbal and nonverbal communication, empathy, focus on feelings, verbal and nonverbal encouragement, good listening, and expressions of respect or praise.[4–11] Female physicians are more prevention-focused than male physicians are,[12] consistent with the holistic approach embodied in the biopsychosocial model.[13] Perhaps as a consequence of these activities oriented toward the "whole patient," female physicians spend more time with patients than male physicians do.[4,14] And, perhaps as a consequence of their communication style and skill, female physicians are less likely to be sued than male physicians.[15]

Patients generally prefer a patient-centered style[16] and their satisfaction is positively correlated with physicians' patient-centered behaviors such as discussing psychosocial topics, conducting longer visits, being nonverbally sensitive, and using positive nonverbal cues.[17–21]

Therefore, it is a logical prediction that patients would be more satisfied with female physicians than male physicians. However, an equally compelling argument can be made that there will be no difference or even that patients will give higher satisfaction ratings to male physicians. Research in social psychology and management finds that women in traditionally male-identified professional roles, especially competent women, are often devalued.[22–24] Women physicians may be caught in the proverbial "Catch-22" wherein fulfilling the professional role implies that they are not appropriately fulfilling the female role, and vice versa.

Research in the general population shows that women's social attitudes and their communication skills and behaviors match the patient-centered prototype more closely than men's do. For example, women are more emotionally expressive, more skilled in nonverbal commu-

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Randomized Controlled Trial > Health Commun. 2015;30(9):894-900.
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How patient-centered do female physicians need to be? Analogue patients' satisfaction with male and female physicians' identical behaviors

Judith A Hall [1], Debra L Roter, Danielle Blanch-Hartigan, Marianne Schmid Mast, Curtis A Pitegoff

Affiliations + expand

PMID: 25175277 DOI: 10.1080/10410236.2014.900892

Abstract

Previous research suggests that female physicians may not receive appropriate credit in patients' eyes for their patient-centered skills compared to their male counterparts. An experiment was conducted to determine whether a performance of higher (versus lower) verbal patient-centeredness would result in a greater difference in analogue patient satisfaction for male than female physicians. Two male and two female actors portrayed physicians speaking to a patient using high or low patient-centered scripts while not varying their nonverbal cues. One hundred ninety-two students served as analogue patients by assuming the patient role while watching one of the videos and rating their satisfaction and other evaluative responses to the physician. Greater verbal patient-centeredness had a stronger positive effect on satisfaction and evaluations for male than for female physicians. This pattern is consistent with the hypothesis that the different associations between patient-centeredness and patients' satisfaction for male versus female physicians occur because of the overlap between stereotypical female behavior and behaviors that comprise patient-centered medical care. If this is the case, high verbal patient-centered behavior by female physicians is not recognized as a marker of clinical competence, as it is for male physicians, but is rather seen as expected female behavior.

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Physician Gender, Patient Risk, and Web-Based Reviews: Longitudinal Study of the Relationship Between Physicians' Gender and Their Web-Based Reviews

Monitoring Editor: Amaryllis Mavragani

Reviewed by Bibiana Metelmann, Rebecca Krukowski, Deborah Verran, and Maryam Salimi

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1.4. Physicians' gender

An aspect that influences adherence to a physician's recommendation is the patient's trust in the physician.[40] The gender of the physician could affect this trust. It has been shown that female physicians were less trusted in training than their male counterparts.[41] In addition, female physicians were given worse evaluations by patients than male physicians.[42]

Fassiotto and colleagues showed in their study that female physicians also received significantly worse ratings by other physicians in specialist training than their male colleagues. This was especially the case if the female physicians being evaluated worked in typically male-dominated disciplines,[43] including orthopedics and trauma surgery. These findings are relevant for the present study since these very disciplines would be involved in the ACL reconstruction surgery.

Research findings are largely unclear, however, regarding the question of how a physician's gender influences patients' decisions. It is an empirically open question as to what extent a physician's gender has an impact in the context of SDM, especially in a preference-sensitive situation. The present study seeks to answer this question. Based on the considerations, we stated the following hypotheses regarding the impact of a physician's gender on participants' treatment preferences, attitude towards the treatments, and perception of professional competence.

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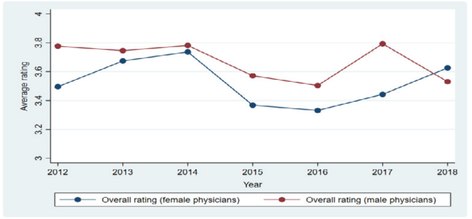
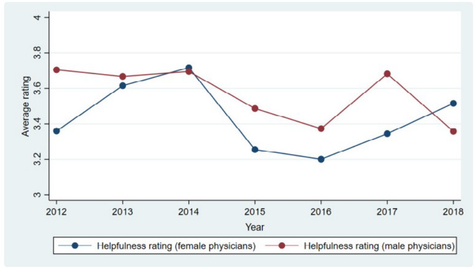
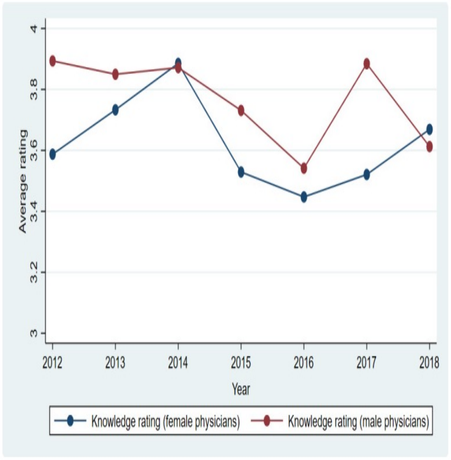


Comparison of average overall ratings for female and male physicians across years.



Comparison of average helpfulness ratings for female and male physicians across years.



Comparison of average knowledge ratings for female and male physicians across years.

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- Mancata comunicazione alla SIAE dei dati di identificazione dei supporti non soggetti al contrassegno o falsa dichiarazione (art. 171-septies legge n.633/1941)
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Torna all'inizio