

Sex of Physician as a Determinant of Psychosocial Problem Recognition

Marjorie W. Bowman, MD and Stephen H. Gehlbach, MD
Hyattsville, Maryland, and Durham, North Carolina

With increasing scrutiny of the role of women in the medical profession, there has been speculation that women physicians provide more sensitivity and empathy to their patients. To compare the psychosocial awareness of female and male physicians, medical records were reviewed for 909 patient visits to six women and seven men who were first year family practice residents. Charts were audited for evidence of acknowledgement of 21 categories of psychosocial or sexual problems. Women physicians saw more patients than their male counterparts and had a higher percentage of visits from women patients (73 percent compared to 65 percent). Types of medical problems seen were similar for men and women physicians with 42 percent of patients noted to have at least one psychosocial or sexual problem. Recognition of problems did not differ significantly between men and women physicians. Women physicians found 44 percent of their female patients had at least one psychosocial problem compared to a 40 percent rate for men physicians seeing either male or female patients, but this small difference could have occurred by chance. When three family medicine faculty members were asked to rank the residents, their ratings were better predictors of psychosocial awareness than was the sex of the resident physician.

With increased consciousness of the role of women in society, discussion has focused on the contributions of women in the health professions. Women have long been characterized as more

humanistic and understanding.¹⁻³ As physicians, one might predict them to be more aware of the patients' psychological and social problems, and more open to discussion of other sensitive subjects such as sexual and marital difficulties.⁴ Women patients in particular might feel more at ease communicating with women physicians.

The authors wished to test this hypothesis by looking for differences between men and women family medicine residents in detecting and record-

From the Duke-Watts Family Medicine Program, Duke University School of Medicine, Durham, North Carolina. Requests for reprints should be addressed to Dr. Stephen H. Gehlbach, Duke-Watts Family Medicine Program, 407 Crutchfield Street, Durham, NC 27704.

ing patients' psychological, social, and sexual (PSS) problems.

Methods

Patient charts were reviewed for a seven-month period (September 1977 to March 1978) for all patients visits to 13 first year family medicine residents at the Duke-Watts Family Medicine Center in Durham, North Carolina. Six residents were women and seven, men. Residents saw patients one half-day each week throughout the study period. As part of the first month of their residency, all residents had participated in a course called Interpersonal Process Recall,⁵ designed to improve their interview techniques and affective awareness.

An audit form was developed based on the classification of the Diagnostic and Statistical Manual II.⁶ The audit included available demographic data (age, sex, race, marital status) and a checklist of 20 different categories of PSS problems plus a category concerning medical problems of the genitalia. The other medical problems for which the patient was seen were also noted.

The total progress note for each patient visit was reviewed by three non-physician auditors who had previous experience abstracting medical records and were unaware of the study's intent. Credit for recognition of a problem was given for any mention of the particular problem in the note.

To determine inter-rater reliability, every fourth patient encounter audited was given to a second rater for re-audit. The auditors were generally unaware of which encounters were re-audited. Inter-rater reliability was scored as complete agreement, general agreement (minor variations in interpretation), or major disagreement.

Seventy percent of visits audited twice were in complete agreement, 16 percent were in general agreement, and 14 percent showed major disagreement. Thus, 86 percent partially or completely agreed. There was little difference in the reliability between various pairings of the auditors.

Every fifth audit was re-audited independently by the two investigators. Eighty-nine percent of patient visits audited by the investigators and the

auditors were in general or complete agreement. This did not differ significantly by whether the investigators found PSS problems listed for the visit (88 percent), or found none (89 percent).

Data were analyzed using the Statistical Package for the Social Sciences. Statistical significance was tested using the t test for unpaired observations and the test for two independent proportions.

Results

Encounter Characteristics

A total of 909 patient visits, made by 652 patients, were reviewed. Males made 32 percent of the visits, females, 68 percent. Thirteen patient visits were not reviewed because charts could not be found or the appropriate progress note was lacking. Race, sex, age, and marital status of the patients studied were similar to the practice as a whole.

Women physicians saw more patients (an average of 58) during the seven-month study period than men physicians (an average of 43). Sixty-seven percent of visits were the patient's first encounter with the resident, 17 percent the second encounter, and 16 percent the third or more. Forty-one percent of the patients had other family members who were also seen at the family medicine center. On 49 percent of the visits, only one diagnosis was noted in the progress note, 31 percent had two problems noted, and 20 percent had more than two problems noted. The types of medical problems seen by the male and female physicians did not differ from each other or the practice as a whole.

Women physicians saw a higher proportion of female patients (73 percent) than their male counterparts (65 percent). This difference was statistically significant ($z=2.2$, $P<0.05$).

Recognition of Psychological, Social, and Sexual Problems

A total of 739 psychological, social, or sexual problems was found in the audit of 909 patient

Table 1. Numbers of Psychosocial or Sexual Problem Categories Recorded for 652 Patients in Rank Order

	Number	Percent
1. Neurosis, anxiety, hysterical, phobic neurosis, depression, hypochondriasis, fear, tension	123	18.9
2. Separation, divorce, marital problems, other family discord, wife/child abuse, recent or impending marriage, foster child, adoption, or other	70	10.7
3. Medical conditions of the genitalia including vaginitis, cervicitis, pelvic inflammatory disease, urethral discharge, venereal disease	55	8.4
4. Special symptoms including tics, psychomotor disturbances, disorders of sleep, enuresis, encopresis	48	7.4
5. Referral to psychiatrist, psychologist, social agency, public health nurse, or other	43	6.6
6. Psychophysiologic, psychosomatic, functional medical disorder	42	6.4
7. Work-related phenomena: mention of firing, new job, difficulties with employee or employer	33	5.1
8. Alcoholism, excessive drinking, drug dependence or addiction	30	4.6
9. Chronic disease in the family (excluding family medical history)	30	4.6
10. Transient situation disturbances, adjustment reactions	29	4.4
11. Social problems or poor social situations not included above	23	3.5
12. Recent death among family or close friends	19	2.9
13. Financial problems: inability to pay loans, office bills; non-support from separated partner; mortgage or loan foreclosure	19	2.9
14. Sexual difficulties including dyspareunia, frigidity, impotence, premature ejaculation, infertility, or sterility	13	2.0
15. Abortion	10	1.5
16. Personality disorders: paranoid, schizoid, obsessive-compulsive, hysterical, passive-aggressive, inadequate, sexual deviation	9	1.4
17. Psychosis, schizophrenia, manic-depressive, paranoia	9	1.4
18. Prison, arrest, or parole of patient, family member, or friend	5	0.7
19. Patient mentally retarded	5	0.8
20. Organic brain syndromes, senile dementia, dementia psychosis (secondary to medical factors)	5	0.8
21. Behavior disorders of childhood and adolescence	2	0.3

Table 2. Percentage of Patients with Identified Psycho-Social-Sexual Problems (PSS) for 13 Family Medicine Residents

Sex of Physician	Average Number of Patients	Percent of Male Patients with PSS Problems	Percent of Female Patients with PSS Problems	Percent of All Patients with PSS Problems
Female (n=6)	58 Range 40-94	40 Range 22-50	44 Range 34-57	43 Range 36-52
Male (n=7)	43 Range 37-50	40 Range 14-64	40 Range 23-52	40 Range 24-57
Mean	50	40	42	42

visits. Most frequently recorded were affective disorders like anxiety, depression, and neurosis, and marital problems including divorce (Table 1). Overall, PSS problems were noted for 42 percent of the 652 patients seen (Table 2). Recognition of problems was not associated with the patients' marital status, race, or having other family members enrolled in the practice. Among patients with PSS problems noted, male patients averaged 2.4 problems, females 2.3 problems.

Residents' notation of patients with PSS problems ranged from 24 to 57 percent of the patients seen; the mean was 40 percent for male residents and 43 percent for females. Women physicians noted PSS problems for 40 percent of their male and 44 percent of their female patients. Male physicians found problems for 40 percent of both men and women. The differences in these averages are not statistically significant by the test for two independent proportions, nor do they appear to be of practical importance. When physicians were ranked by the frequency with which they recorded PSS problems, there was no predominance by either sex. Three men and three women were above the median for the group ($P = .62$, median test).

Patients who were noted to have a PSS problem had a greater number of visits over the audit period, averaging 1.6 visits compared to the 1.2 visits for patients with no PSS problems identified. This differed slightly but not significantly by the sex of the physician. Though study patients made up to nine visits, the number of positive categories noted per patient visit was surprisingly constant. If more obvious physical or psychiatric conditions (ie, mental retardation, psychosis, organic brain syndrome, medical conditions of the genitalia, and abortion) were removed from scoring consideration, there was still no difference in recognition level between male and female physicians.

Faculty Assessment

The authors suspected that sensitivity to patients' problems was much more dependent on the individual personalities of residents than on physician sex. To test this, the authors asked three

faculty members who knew the residents personally and had precepted them but who had not generally observed direct interactions with patients to rank the resident group with respect to the ability to detect and record PSS problems. These faculty knew of the study but had no knowledge of the results.

The three independent ratings showed good concordance ($W=.61$, Kendall coefficient of concordance, $P<.05$). When the ratings were combined, the average faculty ranking correlated well with the rankings obtained from the audit ($r=.56$, $P<.05$, Spearman rank correlation).

Discussion

As the number of women physicians increases, there has been much speculation and some research into what special attributes women bring to medicine.^{1,4,7} Abramowitz⁴ found females to be more empathic before and after training. Singleton⁸ found no differences in the performance of male and female physicians on patient management problems. In development of a scale of empathy, Hogan⁹ found that women were slightly more empathic than men. Abramowitz¹⁰ noted "female therapists made more empathic remarks . . . men sought more clarification and confrontation."

If women have more empathy, women physicians should be more aware of the psychological, social, or sexual problems of their patients. In this chart analysis, women physicians did recognize PSS problems in a high percentage of their patients (42 percent). However, their male counterparts were equally sensitive (40 percent). All the residents did have a special four-week course in interviewing and affective sensitivity training at the beginning of their residency. Although one could speculate that this training obscured differences between men and women, it would then have to be inferred that men were more susceptible to the training. The only area in this study where the authors were able to detect any "sex bias" was that women physicians did see a higher percentage of female patients than their male colleagues, im-

plying some selection on the part of either the patients or the physicians.

In the final analysis, this study provides no convincing evidence that the sex of the physician is an important predictor of sensitivity in detecting psychological, social, or sexual problems. Variability among the residents in identifying problems was considerable, and competency in identifying and recording problems was better predicted by the faculty members who knew the residents personally than by the sex of the physician.

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