

Dominance and gender in the physician-patient interaction

Keywords

Dominance

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Abstract

The goal of this review is to show that physician-patient interactions differ in the degree of dominance asymmetry between the physician and the patient, that physician's dominance behavior is related to negative patient outcomes, and that physician gender affects how physician dominance is perceived by patients. The article provides (1) an overview of existing findings on dominance in the physician-patient interaction, (2) a summary of gender differences in dominance with an emphasis on the physician-patient interaction, and (3) an explanation on why it might be more important for women doctors than for men doctors to adhere to a non-dominant interaction style. © 2004 WPMH GmbH. Published by Elsevier Ireland Ltd.

The physician-patient interaction is inherently hierarchic in many different ways. First, the physician generally has more medical knowledge or expertise than the patient. The help-seeking position per se is one of low power, characterized by a lack of resources (e.g. information, physical integrity) and often accompanied by anxiety and uncertainty about prognosis and treatment and by discomfort or pain. Also in terms of social standing, most physician-patient interactions are encounters among unequals: The physician usually has higher socioeconomic status than the patient. Moreover, a physician can behave more or less dominantly during the medical visit and therefore either enhance or attenuate existing dominance differences between him/her and the patient. The present article focuses on the latter, the dominance asymmetry in the physician-patient interaction as it occurs during the medical visit through physician behavior.

To clarify the terms, dominance is understood as having or striving for control or influence over another or as having privileged access to restricted resources. This broad definition encompasses status and power. Hierarchy is defined as dominance differences among people.

Dominance in the physician-patient interaction

Although the topic of dominance in the physician-patient interaction has been addressed in a theoretical way by many researchers [1-4], not much empirical evidence has been gathered to date. Roter and Hall [3] introduced a model of the physician-patient relationship based on high or low physician and patient power. They call a physician-patient relationship *paternalistic* if the physician's power is high and the patient's power is low. The physician sets the goals of the visit and the agenda, makes all the decisions and has more control over the interaction than the patient. Patient's values and preferences for treatment are not explored and the physician's role is the one of a guardian. This is the traditional form of the doctor-patient relationship, based on a biomedical understanding of medicine and health care. However, not all physician-patient relationships are characterized by such a pronounced power asymmetry in favor of the physician. The reverse of this relationship is the *consumerist* relationship in which the patient has high power and the physician has low power. In this relationship, the patient sets the goals and the agenda and is viewed as a

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consumer buying a service or expertise from the physician. The physician is merely a basis of information and the patient makes all the decisions.

If patient and physician are in a relationship of equal power, they can have a *default* relationship or a *mutual* relationship. In the default relationship, both patient and physician have low power and are therefore relatively uninvolved. None of them wants to take over responsibility. The goals and agenda, patient values, and physician's role all remain unclear. In the mutual relationship, both patient and physician have high power and are involved in diagnosis and treatment. It is a collaborative relationship in which goals and agendas are negotiated, the patient's values are jointly examined, and the physician's role is the one of an advisor. This is the prototypical relationship advocated by the biopsychosocial medical model [5]. Under a biopsychosocial perspective, the patient is seen as the expert when it comes to experience with the disease and is therefore treated as a partner in the medical encounter (e.g. shared decision making). Moreover, the patients' emotions are explored by the physician and the physician expresses support and empathy. A physician interaction style that is characterized by partnership and emotionality is commonly called "patient-centered". In the same vein, *sharing* and *caring*, have been suggested as two aspects of patient-centredness [6]. Sharing refers to how much power and control and how much information should be shared between physician and patient and is similar to the idea of partnership. Caring refers to how much caring about emotions and good interpersonal relations is important in the medical encounter and refers to the aforementioned dimension of emotionality. From these considerations it becomes clear that physician dominance (as the opposite of partnership or sharing) is a rather negative behavior that should be avoided. Indeed, there is ample empirical evidence bolstering such a negative relation between physician dominance and patient outcome. Patients who perceived their doctors as dominant were less satisfied with the physician's communication [7]. Down the same alley, there was a negative relation between perceived physician dominance (rated by independent observers) and patient satisfaction [8]. The more patients perceived that their physi-

cians shared information with them (the opposite of dominance) the more satisfied they were with the visit [9]. When dominance difference between the physician and the patient was measured objectively as the ratio of physician to patient talk, the same result emerged: a higher ratio of physician to patient talk was negatively related to patient satisfaction [10]. And, primary care physicians who were never sued by patients were found to adopt a less dominant interaction style than physicians who were sued [11]. In sum, there is strong evidence that patients are less satisfied if the physician adopts a dominant interaction style. It has to be noted that most studies have assessed patient satisfaction as the patient outcome variable. Although patient satisfaction is important and has been shown to be related to adherence and positive health outcomes [12,13], more research is needed to show direct effects of physician dominance on patient outcomes other than satisfaction (e.g. adherence, health status).

Despite the negative outcomes of a dominant physician interaction style, it has to be noted that there is not one-size-fits-all when it comes to patient preference for the distribution of power within the physician-patient interaction. For instance, people who are older, are less educated, or have more severe conditions prefer a more passive patient role, and therefore more dominance asymmetry [14,15].

Physicians' and patients' dominance behavior

But what exactly is physician dominance behavior? Certain aspects of the communication behavior of physicians are regarded as dominant or paternalistic: asking closed-ended questions, interrupting, making treatment decisions without involving the patient, scarce information sharing, or using medical jargon, to mention some of the most important ones [4].

It is important to note that the focus of the present article is on physician dominance and not on patient dominance. It goes without saying that patients also vary in the degree to which they show dominance behavior and patient dominance affects the medical visit. For instance, there is evidence that more domi-

nant patients receive more careful diagnostic testing [16]. Such findings are important in the realm of patient education and patient empowerment but are beyond the scope of the present article.

Gender and dominance

In interpersonal interactions, women are less competitive, behave less dominantly, emerge less often as leaders of groups, and are less motivated to lead than men are [17–20]. In a related vein, women have a preference for interpersonal interactions and relationships to be organized in a democratic way with flat hierarchies whereas men prefer inequality in dominance among group members [21,22]. It should be noted that women are not in general less prone to form hierarchies among themselves than men are; they however need more time to do so [23]. Once in a high dominance position, women and men do not differ in how well they perform their tasks: there is no difference in how effective a leader they are [24]. Nevertheless, there is a difference in leadership style. Women and men differ in the way they exert power. Women adopt a more democratic or participative leadership style while men show a rather autocratic or directive style [25]. Also, women use more indirect tactics to influence (e.g. give advice) than men [26]. In sum, women in high dominance positions show less dominance behavior than men in high dominance positions.

Dominance behavior in female and male physicians

Because being a physician means occupying a high dominance position we can ask whether the gender difference found for individuals in high dominance positions also applies to physicians. It could well be that the gender difference in dominance behavior disappears for physicians either through selection or the long years of medical training. The answer is that physicians show very much the same gender difference in dominance behavior as is evident in the general population. For instance, a meta-analysis showed that although there was no gender difference in the amount of information giving, female physicians showed

less dominance behavior than male physicians in that they included the patients in making decisions, accepted the patient's norms and values, and elicited the patient's rationale for the medical visit much more so than male physicians [27]. Such partnership building behavior is comparable to the democratic or participative behavior that characterizes women in leadership positions outside the medical field.

Gender roles and dominance

Men are more easily associated with dominance, leadership, and hierarchies than women and occupying a high dominance position is therefore more characteristic of the male than of the female gender role [28]. A woman occupying a high dominance position goes against the gender-stereotype. As long as she behaves in a gender-congruent way, no detrimental effects are to be expected. However, there are negative consequences if she behaves in a male-stereotypical way. For instance, women in leadership positions are evaluated particularly unfavorably if they adopt an autocratic and directive, thus gender-incongruent leadership style [29]. This finding bears an interesting parallel in the physician-patient literature. Female and male physicians who differed in the degree of communication dominance (non-aggressive, moderately aggressive, and aggressive) were presented to patients who indicated how satisfied they would have been with the communication style and how likely they would have adhered to the physician's instructions. Results showed that for male physicians, patient satisfaction and adherence were high regardless of whether the physician communicated aggressively or non-aggressively [30]. Conversely, for female physicians, patient satisfaction and adherence decreased with increased aggressiveness in the physician's communication style. In other words, female physicians produced negative patient outcomes if they behaved in a gender-incongruent way.

Patients' gender role expectations might be responsible for these results. Being a physician is associated with being male [31]. If the physician is a man, patients might be more satisfied and willing to adhere no matter how the

physician behaves only because their expectations have been met. If the physician is a woman, however, the patient's expectations are hurt. As a consequence, the patient's female gender role expectations might be activated and the patient is only satisfied and willing to adhere if the physician communicates in a (female) gender-congruent way. Although the empirical data support this conclusion, there is more research needed to directly address how gender role expectations of patients and physician behavior affect patient outcome.

Conclusions and implications for practice

Physicians should not forget that the relationship with their patients is characterized by a dominance asymmetry and that physician behavior can enhance or attenuate this asymmetry. There is a sound empirical basis for the claim that patients prefer a physician communication style that is non-dominant. Therefore, physicians who include their patients in decision making, elicit their patient's concerns,

expectations, norms, and values, ask for their patient's opinion, do not interrupt their patients, and treat their patient with respect will produce more positive outcomes in their patients (e.g. satisfaction, adherence). Whether the physician is a man or a woman also plays an important role when it comes to dominance behavior within the physician-patient relationship. Female physicians adopt a less dominant interaction style with their patients than male physicians do and for female physicians it seems to be especially important to behave in a gender-congruent way and not to express much dominance if they want satisfied patients. Male physicians seem to have more latitude in their behavior. Due to the limited empirical evidence available, the conclusion and derivation for the practice of this latter finding has to be drawn with caution.

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