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Physician-patient interaction: A gynecology clinic in Turkey

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Abstract

Evidence for gender differences in physicians' communication with their patients comes primarily from Western countries. Little is known about whether these gender differences would also be observed in Turkey, where there are explicit rules about male-female conduct. The purpose of this study was to observe male and female gynecologists' communication with their patients in a gynecology clinic at a state hospital in Istanbul, Turkey. Four male and three female gynecologists were observed in their interaction with 70 patients over 10 days. The observations were conducted during both the history taking and the actual examination sessions by a woman researcher. The results reported in this paper are based on the extensive field notes taken during the observations. Important differences were revealed in interactions between male versus female gynecologists and their patients. Namely, interactions differed in terms of conversation initiation, communication style, use of technical and colloquial language, frequency of eye contact, patience, and provision of information. Communication characteristics specific to interactions between male gynecologists and their patients included a 'blaming the victim' approach, differential treatment of patients, and underestimation of patients' abilities. Environmental factors that affected physicians' interaction with their patients are reported in conjunction with physicians' use of these external factors to explain the problems they experienced in physician-patient interaction. The discussion focuses on alternative explanations for and future research implications of the observed differences between male and female gynecologists in this setting.

Keywords: physician-patient communication, gynecology clinic, Turkey

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A consultation between a health professional and a patient is a social encounter. As in every social encounter, the gender of the participants is one determining factor in this interaction. Gender differences in communication in non-clinical settings are well documented in both psychological and sociological literature (e.g. Coates, 1986; Kramarae, 1981). Likewise, studies in clinical settings have begun to document gender differences among physicians in specialist and primary care communication (Hall, Irish, Roter, Ehrlich, & Muller, 1994a).

Existing research on gender differences in physician-patient communication comes primarily from Western parts of the world. Research in this subject area has rarely been conducted in developing parts of the world where communication between men and women can be more challenging. Consequently, the research presented in this paper is an observational study conducted in a gynecology clinic at a teaching hospital in Istanbul, Turkey. The objective of this study was to describe and compare male and female gynecologists' communication with their patients. The larger context in which physician-patient interaction takes place was also observed in order to understand the nature of this interaction.

Increasing numbers of studies have shown that female and male physicians tend to differ in terms of certain characteristics in their communication with patients. For example, nationwide data from the National Ambulatory Survey in the United States, compiled from office-based visits, showed that female physicians spent more time with their patients than did male physicians (Cypres, 1980). Bensing, Van den Bruink-Muinen, and de Bakker (1993) found that not only did female physicians spend more time with their patients, but they also engaged in more counseling and listening and were less interventionist in their recommendations. The authors concluded that female physicians were more caring than curing, more passively guiding than actively intervening, and more open to the psychosocial context of the patient's health problems

than were male physicians. Bertakis and colleagues (Bertakis, Helms, Callahan, Azari, & Robbins, 1995) found that even when female and male physicians spent the same amount of time with their patients, they focused on different areas of the conversation. Female physicians spent a greater proportion of the visit on preventive services and in discussion of family information than their male colleagues, whereas male physicians devoted more of the visit to history taking.

Besides the time spent on specific issues, the communication style of female and male physicians may differ. For example, male and female physicians were found to differ in how they convey instructions to patients. In one study, male physicians were more likely to speak in an authoritarian manner, use explicit commands when giving instructions to the patients, and ask more direct questions, when compared to female physicians (West, 1993). In contrast, female physicians were more likely to give their instructions and directives as proposals, engaging the patient in a more balanced relationship and partnership building (asking for opinion, understanding, paraphrasing and interpreting), when compared to male physicians.

More generally, male physicians were more directive and informative than female physicians (Meeuwesen, Schaap, & Van der Staak, 1991), and also tended to interrupt their patients more frequently (West, 1998). Female physicians were more positive (Roter, Lipkin, & Korsgaard, 1991), more empathic (Wasserman, Inui, Barriatua, Carter, & Lippincott, 1984) and more focused on emotions (Mendez, Shymansky, & Wolrach, 1986) than male physicians. They also listened more actively to their patients by providing them with backchannel cues (Hall et al., 1994a). Studies of nonverbal communication support these differences. For example, Hall and colleagues (1994a) found that female physicians smiled and nodded more often and created a more responsive and positive atmosphere during patients' visit compared to male physicians.

Not all studies that examined communication of male and female physicians in medical settings found significant differences between these two groups. For example Sleath, Chewning,

Svarstad and Roter (2000) recently looked at whether certain physician characteristics influence patient expression of complaints and adherence problems with continued medication regimens. They found that physician gender was not one of the significant predictors of patients' expression of complaints and adherence problems.

However, findings described above are derived from studies conducted in general practice. There are very few studies of physician gender differences during a gynecology consultation in primary care (e.g., van Elderen, Maes, Rouneau, & Seegers, 1998) or in a gynecology setting (e.g., van Dulmen & Bensing, 2000). These studies yielded some differences in how male and female gynecologists communicate with their patients. For example, it was found that in encounters which include a gynecological examination, patients perceive female physicians as more attentive and informative (van Elderen, et al., 1998) and believe that female physicians take more time (Kerssens, Bensing, & Andela, 1997). When compared to male gynecologists, female gynecologists performed longer physical examinations, expressed their agreement with the patient more often, and asked fewer medical questions (Van Dulmen, 1999; Van Dulmen & Bensing, 2000).

The present study aims to contribute to what little we know about physician communication in a gynecology setting, and to expand on this by studying physician communication in a gynecology clinic at a teaching hospital in Istanbul, Turkey. In the absence of previous research in this setting, we decided to conduct an observational study to provide a detailed description of the nature and possible determinants of physicians' communication styles.

Since the gynecology setting brings issues related to women's sexuality into the fore and puts women into interaction with unknown male or female physicians, it is important to understand the larger cultural context in which women's status and sexuality is experienced and perceived. Turkey is a country in which differences between men and women and among

different socio-economic segments are experienced with considerable salience in everyday life. The prevalent gender segregation results in restriction of women's access to public spheres by way of social norms. Talk about women's sexuality has been considered 'shameful' in the Turkish society (Arat, 2000). Women's bodies and sexuality are kept under control not only in the familial sphere, but also by the Turkish state discourse (Sirman, 1989).

The Turkish family has patrilineal and patrilocal characteristics that emphasize the importance of male members in the family. Men tend to create their own male networks in the public sphere from which women are usually excluded. Particularly in rural parts of Turkey, women tend to interact with other women; they interact with men only when the male is a son, husband, or father. Women's purity is highly valued in Turkish society, so premarital virginity is a high priority. In order to protect the family honor, female members of the family are often 'kept under control' by the males. In conservative cases, these control mechanisms prevent women from engaging in public activities, such as going to a movie theatre, talking with other men or having a paid job other than the family business (Sev'er & Yurdakul, 2001).

Because gender roles and female sexuality are subject to explicit social control in Turkey, the interaction between women and especially male, but also female, physicians, represents an interesting case. The interaction in this setting focuses on a sensitive topic and the examination procedure is intrusive. As most patients feel uncomfortable and embarrassed during a gynecologic examination (Salter, 1985; Wijma & Areskog-Wijma, 1987), how the physician communicates with the patient and handles the examination is expected to be more problematic than in other less intimate clinical settings.

Method

Setting/Participants

The observations were made in a gynecology clinic at a teaching hospital in Turkey. The hospital is located in one of the central areas of Istanbul and can be reached easily using public transportation. The gynecology clinic is one of many other specialty clinics located in the hospital. The clinic consists of a waiting room and an examination area. In the absence of concrete walls, physicians could communicate with each other while seeing patients in different compartments. This setting also allowed the researcher to observe the interaction among doctors in addition to the interaction of physician-patient pairs.

The gynecologists who were observed were residents in their training, including a chief resident. The length of their experience as residents ranged from 1 to 4 years. Each day, physicians in the clinic examined on average 70 patients.

Patients came early in the morning to get their numbers and waited in the waiting room outside the examination area to be called in by the nurse. Some patients were self-referrals, while others were referred to this clinic by other health institutions¹. Not all of patients were residents of the city of Istanbul. Some of them came from other cities, even from the eastern regions of the country. Most of the patients were traditionally dressed and seemed to belong to the low to middle socioeconomic class. Some were illiterate and could not understand Turkish if they spoke another local language. Some patients came with their husbands, although most of them came either with a female family member or a female friend. Neither male nor female companions were allowed into the examination room unless the patient was under the age of 18.

Some patients were seen for the first time, whereas others came for a follow-up. In most cases though, the patient and physician met for the first time because the clinic was not a continuity clinic and residents worked at the clinic for a few months before moving to the next rotation. Patients were assigned to a physician who was available at the time, so they had no

control over whether they would be examined by a female or a male physician. The waiting time for patients ranged from 1 to 3 hours.

At the time of the study, only one nurse was present in the clinic and her main task was to call a new patient after a physician finished the examination of a previous one. Other tasks that the nurse performed included trying to keep patients outside of the examination area when they impatiently asked about their turn and telling women's companions that they were not allowed to go in with the patient. She also seemed to have some administrative duties.

Procedure

Permission was obtained from the Head of the Gynecology Clinic to carry out the observations both during the history taking and the actual examination on the condition that all the information to be collected would be treated anonymously. Four male and 3 female gynecologists were observed while interacting with 70 patients over 10 days. The number of interactions observed per physician ranged from 8 to 14. Thirty-nine patients were observed while interacting with a male gynecologist and 31 with a female gynecologist. The observations were made by a female researcher whose age was similar to that of the younger residents in the clinic. At the beginning of each observation, the physician introduced the female researcher to the patient and explained the reason for her presence. The patient was then asked if she would approve the researcher's presence throughout the examination. Only three patients expressed discomfort, so the researcher left the room. A verbal consent was preferred over a written one because of the low literacy level of most patients. The first 5 physician-patient dyad interactions were only observed without taking any field notes. After becoming familiarized with the setting, the researcher started taking extensive field notes of the entire interaction between the gynecologist and the patient, and the general characteristics of the setting.

Field Notes and Coding

Findings presented in this paper are based on the analyses of the field notes taken during observations by the first author. She openly recorded observations about what she saw, what she felt, how the research was evolving, what she understood and misunderstood and what she thought was important (Banister, Burman, Parker, Taylor, & Tindall, 1998). A divergent, rather than convergent, observational focus was intended (Shank, 2002). Thus, attention was paid not exclusively to the physician-patient interaction, but also to what was happening on the edges and the limits of the observational setting. Although the main research method was observation, field notes also included conversations between the researcher and the physicians. Sometimes, the physicians reflected on what they were doing or conveyed their own complaints to the researcher. These were also used in the analysis and were helpful in making sense of the setting.

The field notes were analyzed to generate an interpretive account that looks at how male and female gynecologists communicated with their patients, describes the conditions under which this communication took place, provides alternative explanations for the communication styles observed, and suggests directions for future research. Analysis was performed both during the period in which observations were conducted and after all the observations were finished. It involved identifying common or recurring styles of communication and the conditions under which conditions they appeared. The field notes were organized and categorized using the QSR-NUDIST (1995), a computer program that facilitates qualitative data analysis and allows researchers to explore data documents and record memos about them. Findings are presented under 6 communication categories that applied to both male and female gynecologists in different ways. Three additional categories were extracted from the field notes that seemed to be unique to male physicians' communication with their patients (see Table 1). The environmental factors that were observed to affect the physicians' communication with their patients are reported under a separate heading. Similarly, physicians' comments about their communication,

based on their conversations with the researcher, are presented separately. The observations reported in this paper are not solely concerned with how physicians communicated with their patients, but also with an interpretation of their communication. It may not be how they would describe themselves, but it is rather how the first author of this paper interpreted what she observed.

Researcher's Presence in the Setting

The researcher started her observations as a complete observer (Gold, 1958) who gradually turned into an observer-as-participant. This was an unintended switch in roles. After a short period of time, the characteristics of the setting imposed a certain role on the observer. In the absence of a nurse in the examination rooms, both the physicians and the patients started seeing the researcher as a person who could take over the role of a nurse. The patients seemed to get some comfort from the researcher's presence. An elderly patient told the researcher, "I was thinking that I would be seen by a male physician. I am so glad that you are here." The patients who were seen by a male gynecologist tended to develop more frequent eye contact with the researcher than with the physician. The physicians (especially male physicians) started asking the researcher for help in the form of getting the patients ready for the pelvic examination or reaching them out some devices during the physical examination.

Findings

I. Male and female gynecologists interaction with gynecology patients

a) *Starting the conversation.* Male gynecologists were more likely to start the conversation with straightforward questions that were directly related to patient's complaints. Questions such as 'Tell me what your problem is' or 'Why did you come to see me?' were typically used by the male gynecologists as a way of starting the history taking session. The female gynecologists were more likely to start the conversation with their patients by asking

questions about their daily or family issues (such as asking how old their children were) or about an issue that they would not know but these women were likely to know about (for example, a question related to local characteristics of the city that the woman came from). How physicians started the interaction seemed to have an effect on the remainder of the communication.

b) Style of communication. Throughout the interaction, the male physicians used a more distant and hierarchical way of communication that included imperatives, or questions that were not necessarily asked to raise answers. For example, after entering the examination room, most patients did not prepare themselves by undressing for the examination and just waited there for the doctor to come in. After the doctors entered the room and saw them still dressed waiting on the gynecology table, they tended to get upset and ask women whether they expected the doctor to examine them while they were dressed. One doctor said: “Why do you think I told you to go into this room? For you to sit there still dressed? If I wanted to talk to you, why would I send you here? Get undressed immediately and call me when you are ready”.

The female gynecologists’ interaction with their patients tended to be more egalitarian and contain empathy that was shown by a more frequent usage of statements that were in a proposal format and were more attentive and directive such as “Shall we have the examination now?” One female physician uttered the following statement when she saw a woman still dressed who was waiting for her still dressed in the examination room: “Oh, you need to get undressed from your waist below so that I can take a look to see if everything is okay with you.” Some female physicians also referred to the discomfort they had experienced when they had vaginal examinations themselves in the past, probably to remind the patients that they know what the patients are going through.

Use of technical vs colloquial language. Male physicians tended to use technical terms more frequently in describing the tests that patients needed to get, the diagnosis and the

treatment. In most cases, patients were asked to get some tests done before they revisited the doctor in the afternoon on the same day. An example of the instructions used by one of the male physicians regarding what the patient should do was, 'You now, go to the building of microbiology, give this smear sample, give some blood and then go to the ultrasound room and then come and see me in the afternoon'. Similarly, descriptions given by male physicians about the source of patient's physical problem were likely to contain many technical terms. In most cases, the patients did not ask the physicians what all these terms meant, so physicians were aware of what patients did and did not understand.

Unlike the male physicians, female gynecologists were more likely to give instructions and explain diagnoses and treatment non-technical language. When they used terms that were not understood by the patients, the patients were more likely to ask the physician what these terms meant.

Frequency of eye contact. During history taking, the physicians made notes of what the patient told them. They asked questions while they were writing their notes in a patient's file. As a consequence, eye contact was likely to be minimal regardless of the physician's gender. The female physicians tended to have more frequent eye contact with their patients, especially at the beginning of the interaction where they asked the patients non-medical questions. In the male physician-patient interaction, most of the eye contact tended to occur when patients failed to give an appropriate answer following a question asked by the physician. Thus, in the presence of a break in the conversation, the male doctors tended to have eye contact with the patient more.

Patience. The male physicians showed signs of impatience especially if the patient derailed the conversation or did not understand a question (the more frequent eye contact at times like this may have been a sign of impatience). Sometimes, patients started talking about their general complaints and easily derailed the conversation by referring to unrelated events or

problems. In other cases, patients did not understand the question, but nevertheless answered it by referring to something else. The male physicians seemed intolerant of such situations and tended to remind the patient of the question in an authoritative way such as “answer my question”.

In patients' interaction with female physicians, examples of not understanding a question, but answering it anyway, occurred less frequently, primarily because patients tended to ask the physician to repeat the question when they did not understand it. When the patient did not ask the physician to repeat the question, but nevertheless seemed to have not understood it, female gynecologists were more likely to repeat the question in another format. Derailing the conversation by switching to other topics also occurred less. This might be due to the fact that female physicians tended to give their patients an opportunity to talk about other issues.

Information provision. The male gynecologists provided limited information on what they were doing during the examination, why the patient needed the tests, where they could get the tests and what the details of the diagnosis and the treatment were. In the absence of information, some patients, who did not know that an ultrasound or pap smear test was a common procedure, asked the doctor whether they had something serious. Such questions were not always answered satisfactorily. For example, one physician replied to such a question in the following way: “Don't you know that every woman has to get these tests every year?”

The female physicians tended to give the patients more feedback about the examination and provided more information about the diagnosis and treatment. There was much more information flow from woman physician to the patient and the other way around. The female physicians tended to tell their patients what they observed during the examination, and to explain why the patient needed to have some tests. Patients were also told how they should get prepared in the examination room. In the afternoon session, besides explaining the prescription and the

nature of the problem, female physicians also provided some general knowledge to their patients on issues such as hygiene and birth control. Patients who were examined by a female physician talked more and provided more information about their physical problem.

Despite the differences in communication observed between male and female gynecologists, there were also some within gender differences in communication, which seemed to relate to the length of the physician's experience in residence and to the physician's personality. The communication differences between male and female gynecologists were more noticeable when comparing a male gynecologist in later years of his residence and a female gynecologist in the earlier years of her residence. Thus, the differences in communication seemed to be more extreme with greater difference in experience. The smallest difference was observed between a male and female gynecologist in their later years of residence. Moreover, the between-gender differences were more likely to be observed when there was relatively less time pressure compared to when there was more time pressure and at the beginning of the day compared to towards the end of the day.

Individual differences in communication were another source of variation within each gender group. Some physicians had a more hierarchical way of communicating in general. Others tended to be more egalitarian and warm in their general communication style with the nurse, the researcher and other physicians. These styles were reflected in their interactions with patients.

II. Observations specific to male physicians' interaction with patients

Observations yielded some characteristics that seemed to be specific to male physician-patient interactions. The following observations were not noticed in the female physician-patient dyads.

'Blaming the victim' approach. There was a tendency for male physicians to see problems as the patient's fault. They tended to convey to the patients that they would not be sick if they had not done something "wrong". One male physician told his patient, "You don't look after yourself and then you end up being here." Another one said, "How come you don't know that you need a smear test every year. You go to the doctor only when you give birth".

Differential treatment of patients. Male physicians tended to treat women from different educational and socioeconomic backgrounds and different levels of religiosity in different ways. For example, after the history taking, patients were asked to go to the examination room and lie on the gynecology table. At this point, male gynecologists sometimes faced a problem that was never an issue when the physician was female, namely some women refused to be examined because the physician was male. These patients appeared to be more religious compared to other patients. The male physician's first reaction was to tell the women that he would not be able to provide the right treatment if he could not examine her. This was not always done in a convincing way. One physician said, "There is no reason for you to be here if you don't want to be examined. Why did you come at all? You are taking my time and other patients' time. Do you have the right to do this?" When they could not convince the patients after an initial attempt, they picked up a sheet and asked the patient to sign, accepting that she herself refused to be examined by the physician.

Some other women, on the other hand, who looked to be educated and seemed to come from a higher socioeconomic class, also showed reluctance to be examined by the male physician. The strategy used here by the male physicians was different. In such cases they made several attempts to persuade the woman to be examined by spending time to explain how they might be wrong in their diagnosis and treatment if they could only would listen to her complaints

and not examine her. In all these cases, physicians eventually succeeded in convincing the women to undergo an examination.

Underestimation of patient's abilities. Male physicians had a tendency to underestimate patient's knowledge and ability to understand. When the researcher asked male physicians why they did not provide more information about the required tests or the nature of a patient's illness, male physicians replied that it would be useless to do so because the patients would not understand anyway. The differential treatment of patients from different educational backgrounds that is explained in the category above may be related to male physicians' belief that more educated women have a greater capacity to understand what is told to them.

III. Environmental factors that affected physician-patient interaction

The following observations were related to the environmental characteristics of the setting and in the researchers' view seemed to influence the interaction between the gynecologists and their patients.

Time pressure. Because many patients came each day, physicians were pressured to spend only a limited time with each patient.

Directions by the chief resident. Time pressure was increased by occasional warnings from the chief resident who reminded other residents not to spend too much time with each patient. This warning seemed to be primarily directed to female gynecologists. The interaction style used by female gynecologists took longer than time spent by male gynecologists. The chief resident seemed to try to reduce this gap and speed up all residents by his warnings.

Absence of a nurse at the examination. The only nurse who was present in the clinic was responsible for calling the patients and attend to administrative duties. There was no nurse present to help the patients and physicians during the examination. Some of the problems that

emerged in the physician-patient interaction appeared to be due to the absence of assistance in each examination room.

IV. External attribution by physicians

During the observations, the physicians sometimes talked to the researcher about their problems and the causes of those problems. Physicians were aware of some of the problems experienced in physician-patient interaction. On some occasions, they referred to communication problems and attributed the causes of those problems to external factors such as lack of resources, their dissatisfaction with low salaries and high volume of patients, lack of attempt on the patient's part to understand the physicians' difficult situation and lack of collaboration. They were considering themselves to be doing the best they could under current difficult circumstances.

Discussion

Consistent with most of the previous studies in physician-patient interaction in Western countries, observations conducted at this gynecology clinic in Turkey showed considerable differences between female and male gynecologists' communication with their patients. Differences were found in how physicians started the conversation with the patient, the general style of communication, the use of technical language, the frequency of eye contact with the patient, the level of patience shown, and finally the amount of information flow from the physician to the patient. Male gynecologists were more likely to start history taking with straightforward questions related to patients' complaints, to show a hierarchical style of talking, to use more technical language, to have limited eye contact with patients, to show little patience and to provide them with limited feedback and information. Female gynecologists, on the other hand, were more likely to start history taking by referring to daily life issues, to show a more

egalitarian style of communication, to use colloquial language, to have more frequent eye contact with patients, to show more patience and to provide them with more feedback and information.

Some observations seemed to be specific to male gynecologists. They tended to use the 'blaming the victim' approach and to differentially treat patients from different educational and socioeconomic backgrounds and with different levels of religiosity. They also tended to underestimate patients' knowledge and ability to understand and used this as a reason for providing patients with limited feedback and information, but they nevertheless tended to use highly technical information. This controversy has been documented before in the literature originating in Western countries (see Taylor, 1995).

The communication differences between male and female physicians observed in this gynecology clinic can be explained by several factors. First, the smaller number of communication differences between male and female gynecologists with longer years of residency experience suggests that medical training obliterates the tendency of female gynecologists to be more egalitarian and empathetic. Van Dulmen and Bensing (2000) explained the fewer number of differences in the communication styles of male and female gynecologists in their study compared to the ones found in earlier primary care studies by referring to the long training in which female gynecologists gradually acquire a more masculine communication style. This finding is also in line with previous findings from other medical specialties (Lyon, 1997; Matilla-Lindy, Hemminki, Malin, Makkonen, Topo, Mäntyranta, & Kangas, 1997).

Communication differences may also be explained by the fact that only 3 female and 4 male gynecologists were observed in his study. Individual physician differences may be as important as differences related to gender. In fact, within-gender differences were observed with regard to physicians' general style of communication. Third, the presence of the researcher in the observed setting might have highlighted the gender stereotypic characteristics of physicians'

communication style. Since both physicians and patients knew that the goal of the researcher was to observe their interaction, they might have acted in a more self-conscious manner, although this would be true of both male and female physicians.

Fourth, the conditions in which the physicians had to work were also likely to have affected the way they interacted with their patients. Problems that were related to the immediate environment as well as to the general medical profession contributed to the problems in the clinic. In general, the high volume of patients seen by physicians, poor working conditions, absence of technical assistance, such as nurses, and low salaries lead to low job satisfaction among physicians. These difficulties in Turkey are likely to cause most of the physicians in the state hospitals to start working in their own private clinics or other private health institutions along with their work at the state hospital. Hence, residents are the physicians in training who are bound to work under poor conditions, as they are the ones who deal with most of the clinical workload. Under these circumstances, it is not difficult to imagine the negative impact of these problems on one's work and satisfaction. It is known that practitioners' own distress can affect their interaction with patients in a negative way. For example, their distress may be sometimes manifested in pessimism about their patients (e.g., Wills, 1978). Thus, work conditions may also have affected how physicians communicated with their patients.

Fifth, the way patients interacted with the gynecologist might also influence the physician's communication in turn. With a female physician, patients were more likely to ask questions, give feedback, and disclose about their physical problems. With this input, female physicians might have had the opportunity to learn more about patients' information and communication needs.

In previous literature, it has been shown that when women encounter physicians who interrupt and intimidate them, they may become passive and submissive and thus less likely to

ask or talk (Chrisler, 2001). In this study, we cannot be sure why patients differed in how they interacted with male versus female physicians. These differences might be due to the physicians' communication style, but also to the general reluctance of women to interact with a man outside the family. Given the nature of communication between men and women in Turkish society, one might expect less disclosure by women patients to a male physician, particularly on taboo topics such as gynecology. Similarly, male gynecologists might also feel reluctant to interact with their female patients in a non-hierarchical and unreserved way. A more egalitarian and informative communication might not have matched patients' expectations of a male gynecologist.

Regardless of the explanation, the goal of a clinical examination, which is to arrive at an accurate diagnosis and optimal treatment regime, is more likely to be realized in a female gynecologist-patient dyad because of the greater amount of information conveyed by the patient. Such heightened disclosure in female-female pairs fits with previous findings in the literature (e.g. Dindia & Allen, 1992; Weisman & Teitelbaum, 1985). As Miles suggested (1991), especially for women of different religious, ethnic and socioeconomic background, the option to have a woman physician examine them can be vital.

The last explanation we propose for the observed differences in female and male physicians' communication with patients is the discrepancy between physicians' and most patients' socio-economic background. Physicians had very different social and educational backgrounds from those of their patients who came either from socially and economically deprived areas of Istanbul or were referred from other cities in the middle or eastern part of the country where the medical assistance was insufficient. In some cases, the patients could speak very little Turkish, which made the conversation almost impossible. These socioeconomic, cultural and ethnic differences seemed to play a more influential role in the interactions of male physicians with their patients compared to the interactions of female physicians with their

patients. The same gender differences might not have been observed if the majority of the patients were middle-class and educated. Male gynecologists may be less skilled in dealing with differences between their own socio-cultural background and that of their patients, perhaps because the gender difference creates such a profound effect in Turkish society. The important question here is whether medical education simply reinforces the gaps or can help to minimize them through training in empathy and communication skills.

Limitations of the study and future suggestions

Observations were made by a single researcher, which did not allow for reliability checking. However to enhance objectivity systematic field notes were taken during the observations. However, having another researcher observe the situation might challenge some of the results presented in this paper. It is acknowledged that observations made by the researcher might have been influenced by her interpretive framework. However, the primary goal of this study was not to generalize the findings, but to gain an in-depth understanding of the setting and generate hypotheses for future research.

One should also remember that the findings presented in this paper do not apply to all male and female gynecologists. These findings, obtained from observing 4 male and 3 female gynecologists, highlight the importance of certain communication features practiced in a clinical setting. The second important point is that the observations were conducted over a period of 10 days and do not preclude potential changes that might be observed in a longitudinal study. The communication differences might diminish over time or become exacerbated under certain circumstances. Longitudinal studies would be able to capture these issues.

Further research should go beyond merely observing the interactions between physicians and patients. This study attempted to establish the general patterns experienced in physician-patient interaction in a gynecology setting within the context of a teaching hospital in Turkey.

We hope that findings reported here will give directions for future qualitative and quantitative studies in developing parts of the world that will systematically examine the experiences of female patients with male versus female gynecologists, and how different kinds of communication affect patient communication, satisfaction and behavior. Challenges faced by male gynecologists dealing with female patients are higher and may require physician education interventions.

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Footnote

* Correspondence concerning this article should be addresses to the first author.

¹ The Turkish State medically insures its citizens who work legally, and the dependents of the insured person can also benefit from this social health system. In Turkey, private health insurance is also available for people who can afford it. Women who go to a gynecology clinic at a teaching hospital in Turkey are likely to be patients who are insured by the state and of a low to middle social class.

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