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Abstract: This study aimed to explore the communication in consultations between patients and healthcare staff from a gender perspective. We used 23 tape-recorded consultations between patients with Atrial Fibrillation and five nurses and five physicians at cardiac outpatient clinics at six different hospitals in southern Sweden during the autumn of 2009 to explore the verbal gendered constructions of patients. Through critical discourse analysis, we revealed that the male patients tended to describe their ailments with performance-oriented statements, whereas the female patients usually used emotional-oriented statements. The staff downplayed the male patients’ questions and statements, while they acknowledged concern toward the female patients. Both the patients and the staff made conclusions according to a mutual construction. Male patients were constructed as competent, and female patients as fragile through gender-stereotypical communication. Open-ended statements and questions enabled consultations to be less limited by gender stereotypes.
This study aimed to explore the communication in consultations between patients and health care staff from a gender perspective. We used 23 tape-recorded consultations between patients with Atrial Fibrillation and nurses and physicians at cardiac outpatient clinics at six different hospitals in southern Sweden during the autumn of 2009 and explored the verbal gendered constructions of patients through interactions between patients and caregivers in clinical settings. Through critical discourse analysis, we revealed that the male patients tended to describe their ailments with performance-oriented statements, whereas the female patients usually used emotional-oriented statements. The staff downplayed the male patients’ questions and statements, while they acknowledged concern toward the female patients. Both the patients and the staff made conclusions according to a mutual construction. Male patients were constructed as competent, and female patients as fragile through gender-stereotypical communication. Open-ended statements and questions enabled consultations to be less limited by gender stereotypes.

**KEYWORDS** communication, consultations, critical discourse analysis, gender equity

**RUNNING HEAD:** Gendered communicative construction in consultations
INTRODUCTION

A successful clinical practice depends on effective communication between health care staff and patients, which facilitates accurate diagnostics, treatment and quality of care (Wynia and Osborn 2010). Previous research has described communication as one of the most significant aspects of clinical care, because it affects the patients’ overall experience of care, but also as the most problematic, because ineffective communication can result in clinical and social disadvantages (Szczepura et al. 2005; Ackerson and Viswanath 2009; Berry 2006). Tools such as standardized communication (Enlow et al. 2010; Haig, Sutton, and Whittington 2006) and patient-centered care (The National Board of Health and Welfare 2006, 2009) have been advocated to improve communication, quality of care, and to increase efficiency and decrease mistakes and errors.

However, communication may also (re)produce gender differences. Many people tend to stereotype others (von Hippel et al. 2011), as well as themselves (Ridgeway and Correll 2004). Previous research has shown that men and women are being ascribed different ways to communicate (Andersson et al. 2008; Salander and Hamberg 2005), demonstrate different attitudes toward treatments (Ziefe and Schaar 2011) and use different ways to perceive information (Dearborn et al. 2006). Such assumptions, mediated through communication, may well result in gender bias and unequal care (Risberg, Johansson, and Hamberg 2009; Hamberg 2008; Hamberg, Risberg, and Johansson 2004; Thornton et al. 2011; Arber et al. 2006).

Decreasing gender bias

Assuming and emphasizing differences between the sexes is a frequent phenomenon within health care. It can be partly explained by past gender bias, which was caused by a lack of attention to biological differences which, in turn, led to improper care for women (Phillips 2005; Verdonk et al. 2009). In an attempt to take into account biological and social differences, “gender
sensitive health care” emerged (Celik et al. 2010; Briones-Vozmediano, Vives-Cases, and Peiró-Pérez 2012), in which health professionals use their competence in perceiving existing gender differences and incorporate these into their treatment of patients. However, if health professionals use biological differences to explain social differences, they may ascribe patients stereotypical characteristics (Agerström, Carlsson, and Rooth 2007; Foss and Sundby 2003), which may influence how they treat patients in terms of speech, acts, gestures, facial and tone of voice (Westerståhl and Björkelund 2003). This, in turn, may result in self-fulfilling prophecies in which women and men, patients as well as staff, end up behaving according to expected stereotypes (Rosenthal and Jacobson 2003; Ahl 2007).

Social and communicative construction of gender

To consider gender as a social construct implies that preconceived and unconscious assumptions about gender influence a person’s perception and responses to men or women. A social constructionist framework (Berger and Luckmann 1966; Burr 2003) sees human identity and social positions as socially and linguistically constructed, and the “core of human” cannot be reduced to an individual’s alignment with one or even several social positions (de los Reyes, Molina, and Mulinari 2006). This implies that gendered characterizations contribute to construct a patient’s identity through communication in consultation settings. It is therefore important to acquire further knowledge on the expression of verbally communicated gendered stereotypes and unconscious assumptions in a clinical setting to complement current research, and to increase quality and equality of care. Previous research has primarily focused on the role of the caregiver in health communication, but the patient also contributes to the caregiver’s construction of the patient. Consequently, the purpose of the study was to explore whether, and in such cases how, patients were reciprocally verbally constructed as male and female patients in communication with health
care staff in consultation settings. Specifically, by evaluating the patient’s role in gendered communication, the study contributes to existing research on the topic of gendered communication in the clinical setting.

METHOD

Design, setting and selection criteria

We used a qualitative research design to evaluate tape-recorded consultations between patients with Atrial Fibrillation (AF) and nurses and physicians at cardiac outpatient clinics in Sweden during June to December, 2009. AF is an irregular and rapid heart rhythm caused by abnormal electrical impulses in the heart. Approximately 85% of patients who suffer from AF are older than 65 years. Symptoms include heart palpitations, lack of energy, dizziness, chest discomfort and shortness of breath. Usual treatments are Warfarin/anticoagulants and cardio version in persistent cases (Kotowycz et al. 2011). Previous studies on heart diseases have shown that assumptions that male and female patients can be diagnosed and treated similarly – often based on research on men – has had negative consequences for women (Low, Thurston, and Matthews 2010). Regarding AF, research has demonstrated more severe clinical effects for women, including a higher mortality rate, bleeding complications (Michelena et al. 2010), risk of stroke (Sullivan et al. 2012; Michelena et al. 2010), recurrences and higher heart rates (Volgman et al. 2009) and depression-like conditions (Ong et al. 2006). Consequently, attention has increased for biological sex differences and thus might be reason to suspect gender differences in communication regarding AF on the part of physicians and nurses.

The present analysis used data from another study which aimed at highlighting variations in topics discussed in consultations (Siouta, Broström, and Hedberg 2012), and sample variation was therefore given priority in selection of the study sample. Siouta, Broström and Hedberg purposely
and strategically selected (Hedberg, Johanson, and Cederborg 2008) seven hospitals in southern Sweden that had established nurse-based outpatient clinics for patients with AF and based selection of these hospitals on the clinics’ location, size, and the number of AF patients that they treated. One hospital declined to participate due to a lack of time. The head of the department at each of the remaining six hospitals selected physicians and nurses so as to achieve diversity in sex, age and clinical experience in cardiology. They selected five physicians and five nurses in total. The consulting nurses selected patients to provide a diverse sample in terms of sex, age, type of AF, time since diagnosis, type of planned visit, treatment regimen, and their ability to communicate in Swedish.

Participants and procedure

We asked the selected five nurses and five physicians to participate. They received written information about the study, and all agreed to participate and provided written consent. Each nurse and physician performed one to four consultations. In all, the number of recorded consultations was 11 with nurses and 12 with physicians. The consulting nurses and physicians asked twenty-three of their patients (13 women and 10 men) to take part in the study. After the patients agreed to participate by phone, they received an information letter about the study. When the patients arrived at the clinic, the nurses/physicians introduced them to the fourth author, who obtained written consent to tape the consultation. None of the patients declined. Three accompanying spouses attended their partners’ consultations. The mean age among the female patients was 70.1 years, and 69.9 years among the male patients. The age of all patients exceeded 60 years. Two non-native Swedes participated but did not differ from the Swedes in their verbal interactions with their care providers. The duration of the consultations ranged from 20 to 90 minutes. Twenty of the consultations included a physical examination. The transcriptions of the consultations generated
250 pages of text. The first author translated the citations from Swedish to English, and a native English speaker and professional translator then checked the accuracy of the translations.

Analysis

Because we wanted to include the role of the patient in the communicative construction, we separated the patient and the staff in our analyses. We, therefore, used the three discourse dimensions of Fairclough (2001) as pragmatic, analytical tools for categorizing identified communicative patterns in the empirical data and subsequently for analyzing them.

The first dimension, ‘discourse as text’, looked at how the text represented and thereby produced social identities and social relations. The second dimension, ‘discourse practice’, attended to the conditions for production (or consumption) of text. The third dimension was the ‘socio-cultural practice’. According to Fairclough, this dimension is to see the implications of discourse in a social and cultural context and results from the former two.

In the text dimension, we examined how the text represented and thereby produced social identities and relations and identified two different discourses. We did this by searching for communicative patterns in the way in which patients talked about their ailments and thereby constructed themselves. The staff constituted the focus of the discourse practice dimension. We saw a consultation as a practice which caregivers produced and for which they have acquired the rules of production. We identified two prevalent, gendered discourses drawn upon by the staff by focusing on the types of questions they asked to the patients and their follow-up to these. In the social practice dimension, we identified two additional discourses. These discourses reflected statements that summarized the patient’s health status in the consultations. Finally, we considered variations and exceptions from the observed patterns.
We analysed the transcripts as follows: First, the first and fourth author closely read the transcripts and identified patterns of gendered communication using Fairclough’s framework as an interpretative frame. The first author systematized the observations and developed a coding scheme, based on variations of statements made by the staff and the patients, and coded the entire material accordingly. The second and third author used the coding scheme to analyze and code independently the same selected parts of the material to confirm the validity of the coding and the three discourse dimensions. Using three different colored pens, we classified, and counted statements belonging to each of these dimensions. This served to establish the frequency of each observed discourse dimension in the total material. We present our analysis of the content of each dimension below.

**Ethical considerations**

The Regional Ethics Committee in Linköping, Sweden granted ethical approval of the study protocol (Dnr. M8-09). The approved application considered issues such as research aim, potential practical applications, confidentiality for patients and staff, selection of participants, data collection, relations between researchers and staff/participants, analysis method, security and risks.

**RESULTS**

--- insert table 1 here ----

Patients’ Self-Construction

This discourse dimension represented the verbal communicative construction of the patients, from the patients’ perspectives. Thus, the patients’ own statements regarding their ailments formed the
basis for the analysis. We identified two discourses: the performing patient discourse and the emotional patient discourse (see 1a. and 1b. in table 1).

The Performing Patient Discourse

This discourse centered on practical topics and physical coping strategies. The patients that drew on this discourse used physiological statements to describe their experiences, for instance, what sort of limitations the ailment caused, but also what possibilities still existed. Below, a male patient, 76 years old, used elements of physical activities to describe his experiences:

I was out swimming, I had four meters left to the end and then I felt something in my body […] I got tired […] I have even been out playing golf, 18 holes and it was 10 kilometres approximately […] I have cycled […] Walked, I have been out almost every day.

Primarily, the male patients used a physical activity discourse when they described how the ailment influenced them as a means to filter their experiences. Moreover, they used it as coping tools with which they measured the consequences of the ailment. By noticing that the ailment had some effect, for instance on the ability to exercise, the ailment may have appeared less serious. The health status of the patients allowed them to carry out demanding activities, and even though some of the patients admitted that they had become tired, they revealed no indications that the ailment would prevent them from doing these activities in the future. In one consultation, the staff even warned a patient not to exercise too much. In summary, this discourse symbolized the communicative construction of the male patients as performance-oriented.

The Emotional Patient Discourse

In this discourse, the communication centered on the ailment from an emotional perspective. The patients that drew on this discourse talked about the emotional consequences of the ailment and mentioned feelings instead of physical abilities and practical implications. A female patient, 77 years old, used emotional explanations to describe her experience:
I didn’t dare to drive here today because I feel a little just unusual. I don’t feel so I’m not so safe.

Primarily, the female patients used this type of emotional discourse and while the male patients in the former discourse had an outward-looking perspective toward themselves and their ailment, the female patients in this discourse had more of an introspective perspective and talked about restrictions due to the AF. When the patients talked about the ailment and its symptoms, they primarily described how these made them think and feel. The patients’ worries, fears and anxiety maintained the communicative focus in these instances. This discourse thus symbolized the communicative construction of the female patients as emotional-oriented.

Discourse Practice – Staff’s Construction Of Patients

Building on the former dimension, this discourse represented the staff’s verbal communication in terms of addressing questions to the patients and the manner in which they related to their statements. We identified two discourses: The confirmation discourse and the assurance discourse (see 2a. and 2b. in table 1).

*The Confirmation Discourse*

The staff used this discourse primarily in consultations with the male patients when the communication consisted mainly of disarming and positive statements, instead of dramatizing statements about the patient’s health conditions. The staff sought to confirm the well-being of the patient. Below, a staff member used positive formulations in a fairly typical way:

> You have felt good now haven’t you? [...] And the heart beats well? It feels like you think so or?

Frequently, the staff used leading questions with positive connotations with the patients, which generated quite positive answers. In several consultations, the staff used previous observations that showed positive and stable health conditions as a starting point when discussing
the patient’s condition. Thus, the staff encouraged the patients to confirm their health status as fairly good or at least not so serious, given the current circumstances.

The Assurance Discourse

The staff used this discourse primarily in consultations with female patients, and the communication consisted mainly of statements of a fairly dramatic and negative character. The staff would go to great lengths to rule out the existence of any health problems and used repeated questions to search for experienced troublesome symptoms. Below, a staff member used repeated questions in order to dismiss what the 70 year-old patient had earlier dismissed:

Staff:  […] So you don’t feel depressed or so?
Patient:  No no no.
Staff:  No, so you don’t feel like that?

In several consultations, the staff focused on the patient’s statements from earlier consultations, when patients described their health conditions as worse, rather than concentrating on the statements made in the current consultations, when patients described their health condition as improved. The staff would also often repeat the patient’s answer and ask a summarizing question to ensure that the answer given by the patient really corresponded with what they felt. Often the staff would also use repeated questions about potential symptoms, even though the patient initially indicated that they felt good. In summary, the staff encouraged the patients to affirm their health status as fairly bad, based on the current conditions.

Social Practice – Discursive Implications

The former two discourse dimensions together resulted in the third dimension, comprised society, culture and, therein, the local practice. It summarized the conclusions of the consultations. Here, we identified the carefree discourse and the concerned discourse (see 3a. and 3b. in table 1)

The Carefree Discourse
This discourse represented summaries regarding the male patients and it arose as a result of, in the 
performing patient discourse, patients talking about rather undramatic experiences and, in the 
confirmation discourse, it arose as staff sought to confirm the well-being of the patients. Below, a 
staff member and a 44 year-old patient discussed the health condition of the patient:

Patient: It’s almost like I forget that I have diabetes […] Even though I misbehave.

Staff: That’s not how it should be.

Patient: Well no I don’t do that. […] A little bit […] It’s not so strict.

Staff: […] You have to get it down also. […] It’s like you cannot be living as an 
ascetic because then you will be bedridden.

In some consultations, the patients initially described their health status with some concern, 
but the staff encouraged them to focus on what had improved. This tended to lead to the patients 
changing focus, and to replace concern with confidence in their descriptions of themselves. In 
summary, the patients and the staff exhibited no major concern about the status of the patients’ 
health. The discourse reflected assumptions about male patients with AF as a group not in need of 
further or/and specialized care.

The Concerned Discourse

This discourse represented summaries regarding the female patients, and it arose as a result of the 
emotional patient discourse; patients talked about their ailment with worries and emotional 
distress, and the assurance discourse, in which the staff sought to exclude the patients’ poor health 
from the conversation. Compared to the discourse available to the male patients, the statements 
here expressed a fairly dramatic content. This manifested itself, for instance, in the form of further 
referrals even though the patients’ fibrillation had not returned, and recommendations for 
moderation of physical activity and additional drugs. Below, a staff member and a 75 year-old 
patient took precaution even though the former estimated that the patient’s AF was under control:

Patient: Well it’s not so often, last time was yes 2008.
Staff: So it’s not even appearing every year? […] It was back in 2005 […] I’ll send a referral now enalapril it’s called […] We’ll ask the physician XXX to follow up.

Unlike the discourse available to male patients, this discourse expressed assumptions about female patients with AF as a group in need of further or/and specialized care.

Discursive Variations and Exceptions

Most consultations followed the patterns discussed above, but we found some exceptions. These exceptions opened up communication patterns that challenged the prevailing gender order as manifested in the three discourse dimensions. We found the most significant deviations in the social practice dimension, which contained statements that went counter to the predominant discourses, particularly regarding the male patients. Overall, the consultations with the male patients had more statements with positive references and disarming comments, but especially in two of the consultations, a remarkably high number of the statements had negative references and dramatic summarizing conclusions. The explanations for breaking the pattern of negative references and dramatic summarizing conclusions may have been many. For example, these two patients could have experienced themselves as being in a worse state of health than the other male patients, with the staff agreeing. However, we observed that the health care staff used open ended questions to a greater extent in these two consultations.

Below, a staff member attempted to elicit answers through comparatively neutral or open statements:

I want to know how you've felt since you were discharged? […] Better but not good? […] What is it that?

This left freedom for, and encouraged, the patient to choose his/her way to respond to a greater extent than in the other consultations.
DISCUSSION

This study aimed to explore whether, and in such cases how, patients were reciprocally verbally constructed as male and female AF patients, in communication with health care staff in consultation settings. Male patients described their health conditions mainly with physical explanations, while the female patients usually used emotional explanations. Health care staff responded to the male patients by using disarming statements, downplaying the symptoms, while the responses to the female patients expressed concern. Hence, the male patient’s health conditions were concluded as being rather good, whereas the female patient’s health conditions were concluded as being fairly bad. However, we also found exceptions and examples when these patterns were disrupted, which were made possible through the staffs’ use of open instead of leading statements and questions.

Communication as a Reproductive Action

The phenomenon of male and female patients being treated differently and ascribed diverse characteristics has been well-researched (Foss and Sundby 2003; Andersson et al. 2008; Salander and Hamberg 2005; Ziefe and Schaar 2011). The present study confirmed the presence of this differential treatment and highlighted the complexity of gendered patterns by focusing on the reciprocal aspects of clinical interactions and including the patient’s involvement.

In the text dimension, the female and male patients described their ailments in accordance with stereotyped expectations. In the discourse practice dimension, the staffs’ communicative response reinforced this and finally, in the social practice dimension, the different summary conclusions of the health status of female and male patients manifested it. This may have represented the Pygmalion effect (Rosenthal and Jacobson 2003) in that stereotypes were bearers of expectations that influenced the counterpart’s communication. Stereotypes such as female
patients as the most demanding patient group or older women as the most time-consuming group (Foss and Sundby 2003) may explain why, in the *discourse practice dimension*, female patients were asked repeated questions to identify problematic conditions and why, in the *social practice dimension*, summary conclusions were more dramatic.

However, the Pygmalion effect only influences one side of the equation – i.e. the expectations from those in positions of power (the health care staff). The consultations that were analyzed also showed signs that, irrespective of the staff’s statements and questions, patients tended to communicate in gender-stereotypical ways (reinforced, of course, by gender-stereotypical questions). The communicative construction was reciprocal in that patients met both the staff members’ and their own expectations and acted in accordance to these. Besides being potentially influenced by the concept of gender sensitive health care, this may also have reflected a basic assumption of male/female difference and separateness (Acker 1992). This dichotomy of male and female is deeply rooted and constitutes the ground from which we build “selves” (Eckert and McConnell-Ginet 2013). To go against the predominant discourse and to act as a “counter-stereotypical actor”, has been associated with blame (Phelan and Rudman 2010), while acting in accordance with stereotypes may avoid negative judgments from others (von Hippel et al. 2011). In the present study, this pattern seemed to include the male as well as the female patients. By merging the discourse dimensions, the understanding of the role of communication as a gender-stereotype mediating tool increases. When male patients communicated about their ailment from a performance perspective, this might signal a benign condition, in comparison to female patients when they communicated about fears and anxiety. Thus, any initial expectation might be enhanced and accordingly dominate the continuing consultation, which further influenced both the patients and the staff. Based on this sequence of events, the somewhat dire summary conclusions became logical and legitimizied by the coherence that existed between the patients and the staff.
Although the effects of AF tend to be worse for women (Michelena et al. 2010; Sullivan et al. 2012; Volgman et al. 2009; Ong et al. 2006), downplaying the symptoms or the health conditions for male patients may increase the risks for negligence and substandard care for these patients. Furthermore, overstating and, in some cases, almost forcing troublesome symptoms and effects onto female patients, may result in both unwarranted and inaccurate treatments, which may lead to necessary treatments being ignored (Michelena et al. 2010).

Communication as a Challenging Action

Discourses affect the construction of social reality, and social reality reinforces discourses in a reciprocal manner. However, change is possible; new ways of communication can challenge discourses. According to Berry (2006), health care staff tends to use leading questions to make consultations more efficient, but combining this strategy with the idea of patient-centred care (The National Board of Health and Welfare 2006, 2009) or patient-centred communication (Epstein et al. 2005), is not risk free. Patient-centeredness should ensure the respect of the individual patient’s perspective in consultation settings. Staff who avoid the use of leading questions and the imposition of their own perspectives during the consultation would more easily facilitate this. Aside from using leading questions, the staff’s questions differed between male and female patients. Proponents of gender-sensitive health care recommend this as a way for coming to terms with gender inequalities in health care (e.g., Celik et al. 2010). The assumption is that the sexes are indeed different; ailments manifest themselves differently and male and female patients communicate in dissimilar ways. Consequently, the treatments (both clinical and interpersonal) provided to these patients differ. In this respect, gender sensitive health care seems to be an established fact and even have a successor – oversensitive gender health care, which, to some extent, with the help of stereotyped assumptions and expectations together with leading statements
and questions, may bring forth differences between the sexes, irrespective of whether they are actual dissimilarities or not.

The proponents of gender-sensitive health care also stress the need for health care staff to be aware of the socio-political and cultural context within which they work. In our interpretation, this is a call for seeing gender as socially constructed and was the original intention with the invention of the term *gender* in place of *sex* (Ahl 2007). To consider and reflect upon gender as socially constructed, might facilitate the awareness necessary among clinicians to see in which ways stereotypes influence health care communication and reduce equality, which is a first step to change. A constructionist view on this matter entails understanding knowledge as a social process, as an adjustment to the socially shared representations of the world accepted as reality (Berger and Luckmann 1966; Burr 2003). This constructionist perspective employs a non-essentialist epistemology; it highlights the influence different social and cultural backgrounds, values and norms have on our thoughts, feelings and behaviour. This perspective allows for an understanding of people as coming into being through verbal interaction, rather than claiming an existence of this understanding prior to the interaction. The patient thus becomes a patient through the verbal interaction, during the consultation. This does not disqualify the fact that symptoms, at times, may vary between men and women when they are suffering from the same ailment; rather, it is an addition to this, a supplement that takes note of the intra-gender variation that is just as significant as the inter-gender variation.

**Practical Implications and Further Research**

A potential way forward to address this gendered communicative construction of patients might be to incorporate wider aspects of communication into the teaching of ‘standardized communication’ in the current training program for health care staff. Why not go further and advocate open
questions? As Epstein et al (2005), among others, suggest, this could bring clarity to what patient-centeredness entails. As this study suggests, open statements and questions help facilitate consultations that are less prone to be limited by gender stereotypes. Instead of starting from an individual staff member’s perception of the male or female patient, as proposed by the advocates of gender sensitive care (Celik et al. 2010; Briones-Vozmediano, Vives-Cases, and Peiró-Pérez 2012), patients ought to have the right to choose whether their gender or their ailment should be in focus. Health care staff, as well as patients, would benefit from an increased awareness and knowledge of gender. Creating conditions for clinical staff that allows more reflective approaches toward their own stereotyped expectations about men and women is therefore desirable.

The results of this study call for further research on the impact of gender in health care, for instance gendered communication in different subfields of health care and also whether gendered communication correlates with differences in the delivery of health care. Moreover, it is also important to clarify the ways in which health care communication is constructed/co-constructed in reference to other social positions, such as race/ethnicity, age, or class. We also invite more research on the patient’s contribution to this construction.

Methodological Considerations - Reflections and Limitations

This study explored the construction of male and female patients in consultations, attending especially to the role of the patient. Previous research into the differential treatment of men and women, which has often been to the female patient’s disadvantage, motivated this focus. We therefore chose a patient group with well-documented experiences of this phenomenon. The aim of the study and the corresponding theoretical framework led to a qualitative design and methodology. The study had limitations in terms of sample size, and the participants lived in a single country, were from a few select hospitals, had one particular diagnosis, and the
consultations varied in length, all of which limited the generalizability of the findings. Moreover, the strategic selection process posed risks of selection bias that decreased the representativeness of the sample, thus further limiting the generalizability (Winship and Mare 1992). The strategic selection was performed for another study, for which sample variation was desirable. The diversity that this entailed ensured a broad representation of participating nurses, physicians and patients in the present study. The conclusions presented in this study were primarily conceptual, and future empirical explorations in other contexts are therefore desirable. However, theoretical generalizations are possible through analytically derived results to one or several established theories.

By a careful coding procedure based on an established analytical framework, we enhanced the internal validity of the study. Our results, however, raised the question of whether AF patients differed from other patient groups. According to research on gender in health care, male patients generally receive better care, such as newer medicines (The National Board of Health and Welfare 2004), more thorough examinations, and more offers for testing (Hamberg 2008). Thus, better conditions for future care are possible for women. The findings here might have been a result of the attention heart disease has received in terms of differences in symptoms between women and men. This knowledge might have influenced the expectations of the staff, and thereby affected the interpersonal treatment in the form of addressing different leading questions to female and male patients.

CONCLUSIONS

We concluded that both patients and staff through their communications reproduced stereotyped gender expectations during consultations, thereby running the risk of contributing to differences and substandard care. We found that the use of open questions may help create a setting that is less
prone to be limited by gender stereotypes. We advocate training for health care staff which includes reflective study of the social construction of gender.

REFERENCES


