The role of gender in OB/GYN: recruitment problems
European OB/GYN

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Introduction: The European meetings and exchange programmes for trainees in Obstetrics and Gynaecology have been held annually since 1992. During the exchange programme, trainees from all over Europe will visit training departments in obstetrics and gynaecology in the host country for a week. The exchange programmes allow us to experience different methods of training and practices of obstetrics and gynaecology, and usually give some lively input to the seminar on training matters that have traditionally been held on the last day of the exchange programme. The exchange also has a positive social impact on our specialty—friendships and professional bonds are made that can last a lifetime.

The success of the 15th European Meeting and Exchange Programme of Trainees in Obstetrics and Gynaecology was due to the hard work of two local trainees in obstetrics and gynaecology, Jordi Deu Martinez and Anabel Montero Armengol, in collaboration with the European Network of Trainees in Obstetrics and Gynaecology (ENTOG) and Professor Luis Cabero Roura. The seminar was well attended by both trainers and trainees, with more than 80 participants from over 20 countries, also welcoming colleagues from countries previously absent from our European fora e.g. Turkey, Iceland, Romania and the Baltic States. We were particularly pleased to see the increasingly active and assertive participation of trainees in the discussions at the meeting; this year, most of the presentations were done by trainees, and it was generally felt that the quality of presentations was excellent.

The role of gender in OB/GYN has been discussed informally in European fora for many years, mostly with a focus on the so-called problem of feminisation of the specialty. To our knowledge, there has not been a formal and structured discussion of the issue of gender since the ENTOG Seminar in Basel in 2000. We felt it was time to have a nuanced, balanced and evidence-based—i.e. one might say academic—approach to the issue of gender, and we very much succeeded with the Barcelona seminar.

With the introduction of an invited key note speaker we aimed to increase the impact of our seminar, and with the eminent lecture of Dr. Connie Wiskin we were introduced to the front line of contemporary studies in gender behaviour in medicine. We are very happy that Dr. Wiskin has accepted our invitation to summarize her lecture in a review paper in this issue of the ECOG.

From our discussions in Barcelona, it became clear that barriers and difficulties still exist for female colleagues to achieve specialization in OB/GYN and to obtain senior positions. Much still needs to be done to improve social conditions such as maternity leave, working hours and child care for professional mothers. It was also widely accepted that the contribution of both genders was necessary for the future of OB/GYN, and efforts should be made not to loose promising young male doctors to other specialities. As for recruitment in general, decreasing numbers of trainees enter the field of obstetrics and gynaecology for a variety of reasons. This has serious implications for the future health care delivery for women. It became clear that proactive measures have to be introduced to address the decline in applications.

INVITED KEYNOTE LECTURE

Does gender matter? - Whether communication behaviour is different between male and female doctors
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Introduction: This article consists of a brief reflection on some of the literature pertaining to gender and communication, followed by a synopsis of the keynote given in Barcelona on December 2, 2005. Given the general interest in gender awareness, the literature relating to gender and communication is modest, and the overall picture is somewhat scattered. Research is generally, but not exclusively, weighted to psychological issues, with few papers considering gender as a single or multiple variable in the communication skills assessment process. However, gender has been considered in relation to scoring bias, e.g. Dorsey and Collier’s 1995 study of blind test grading in relation to gender and race [1]. A popular view is that qualities associated with women or men make that group more likely to perform well when the task is culturally associated with that gender role. Evidence here might impact on communication performance, but findings are inconclusive, as references exist that confirm and deny difference. In 1999, Krupat et al. [2] established that female students were more patient-centred than doctor-centred (compared to their male colleagues). They also identified a link between these attitudes and future career aspirations. In the same year, a study in the Netherlands [3] found that ‘In contrast to previous studies, gender was not related to patient-centredness.’ A fashionable area for gender research relates to subject specialties. In 2000 McDonough et al. found that female students had a similar or
lower likelihood of pass/fail than male students, outperformed their male peers in all subjects, and seemed more likely to achieve honours grades. The most significant differences were in paediatrics (p < 0.01), psychiatry (p < 0.01), and obstetrics/gynaecology (p = 0.01).

Again, evidence for gender performance in particular specialties is not consistent. A study by Kruger [5], focusing on the performance of women in obstetrics and gynaecology, produced different results. No significant difference was found between male and female populations, although women did score higher.

The emphasis in the literature on relating gender to subjects traditionally associated with women, as opposed to in general, or in relation to exclusively ‘male’ problems is interesting. To examine this, a British [6] study considered clinicians’ and medical students’ views on management of HRT, obstetric practice and contraceptive counselling. The authors concluded that there were more similarities than differences in the decision-making process.

There is potential to relate gender to outcomes. The above are Western examples, but elsewhere, the relevance of gender consideration has also been recognized [7]. Although academic success appears to favour women, McDonough et al. [4] concluded that high female performance ratings were not reflected at registrar and consultant levels.

A further finding concerns patient perceptions of doctor gender. In one GP study [8], 86% respondents (n = 130) expressed ‘...no concern’ about gender, and these results are reflected in secondary care [9].

As mentioned, specific references to communication and gender are infrequent. Examining Birmingham’s work (as reported later), Colliver et al. [10] looked at the interaction of SP and student gender on SP ratings of communication and interpersonal skills. The focus on gender and assessment of qualifying doctors is relatively rare. More frequently, citations refer to gender differences in the postgraduate context [11], often in the form of patient satisfaction surveys [12–14].

Survey results tend to focus on differences rather than similarities in communication. Communication is often used as an umbrella for many criteria. Roter et al. [14], for example, included length of visit devoting of more communication to agreements, disagreements and laughter alongside ‘facilitative communication (i.e. making sure they were understood and providing direction and orientation)’. In this study, significant differences were identified. Male obstetricians devoted more time to visits and to clarification, but patients were more satisfied with the lady physician’s’ role. Roter also collaborated on similar work in the primary care setting [14].

A question to consider is whether these results indicate that women are ‘better’ at certain skills. Hopkins Tanne states that ‘Women doctors are better communicators’ [16], but concedes that ‘Patients in some studies were all women.’

The question of style may be also be asked in terms of language choices. Progress has been made in this area by John Skelton et al. [17, 18], which differs from work from work in the previous decade [19] and challenges a number of assumptions. This work from Birmingham is elaborated on later in this presentation.

It is easy to succumb to stereotyping, especially given claims of gender differences in face-to-face communication [20]. The existence of difference is supported by a small number of review papers [21, 22], notwithstanding that few studies analyse similarity. Understanding of the relationship between gender and communication skills performance remains limited. In particular, meaningful research in the assessment context is scant. A study from Birmingham hoping to address this deficit will be discussed later [23].

**Context:** The importance of clinician gender is of enduring interest in medical education, potentially informing teaching initiatives, career pathways and specialty recruitment strategies. The historical male domination of medicine is well known, but female role models often predate our expectations. Some 2,322 years B.C., for example, Pereshet was documented as being not only a physician, but ‘The lady overseer of the lady physicians’ [24].

However, never has female representation in medical training been so prolific as at present. Birmingham’s current annual intake of 450 medical undergraduates is 62% female, a trend increasingly reflected in the UK generally, and elsewhere.

Of the many questions asked about gender, some of the most interesting are those less frequently addressed at academic level. Examples are why are we interested in doctor gender in the first place, and in the broader scheme of things, whether it actually matters?

Obstetrics and Gynaecology is of course an obvious example of one specialty in which intimacy might reasonably result in gender preference, but clinical examination aside, it is plausible that many key professional qualities are generic. The current trend towards patient-centred or holistic practice suggests that (in the UK at least) the preferred doctor style is one that is inclusive and empathic, where expertise is communicated in an articulate and meaningful way that is simultaneously accessible and acceptable to the individual patient.

That being the case, say, it is arguable that as long as the clinician meets the preferred requirements, then his/her gender is not necessarily relevant.

However, this premise rests on the existence of interactional similarities, whereas the majority of interest lies more typically in the identification and exploration of differences.

There is a great deal of reporting on differences, both actual and perceived, between men and women, especially regarding career experiences [25–27]. We are also exposed socially to a range of assumptions, typically involving subjects such as division of labour and reproductive roles. Although much of the latter is light-hearted, gender stereotyping is an influential phenomenon and as such will be expanded upon later.

The moot point for this introduction is the emphasis given to difference, which may be displaced. There is (unsurprisingly) less null reporting in medical literature, that it so say more studies report findings of difference than no difference. This in itself is an interesting finding. Does it confirm that gender difference indeed outweighs gender similarity? Or is it simply a reflection of which contemporary subjects are deemed interesting (and by association, publishable)?

Interest in gender difference, or similarity, has extended into many aspects of medical life. This paper focuses on one aspect—the way that doctors consult. It considers the impact of stereotyping, the existence of difference in male and female speech patterns, how male and female doctors communicate with patients and whether factors other than gender are equally powerful variables. The material presented represents research undertaken by the author and by colleagues from the Interactive Skills Unit, Birmingham Medical School, UK. The team is multidisciplinary, so the ideas presented represent a range of interests and specialties.

**Stereotyping:** Social stereotyping doubtless influences perceptions of men and women in and outside of the medical arena. By basic definition, a stereotype is “A preconceived and oversimplified idea of the characteristics which typify a person or thing [28].” It is worth noting that “preconceived” and “oversimplified” are not synonymous with “fictitious” or “incorrect”. Indeed, most stereotypes originate in trends based on knowledge or reported evidence. It is true for example that more women than men take career breaks to have a family.

Reasonable presumption relating to gender is not prejudice. Prejudice occurs when trends are applied to a group in its entirety, without consideration or acceptance of individual variance. The degree of assumption inherent in any given statement is conveyed by the choice of words used. As examples “can be”, “tend to be” and “are” convey different meanings. Using the example already suggested, there is a difference in intent between suggesting that women “can” or even “tend to” leave work to have children, and that they “are” going to leave work to have children. In short, prejudice occurs when open-mindedness to individual variance from what is considered ‘the norm’ and respect for a person’s attributes and beliefs are not adhered to.