Using Gender Differences and Patient Satisfaction As Predictors To Patient Attitudes

By

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Abstract

One hundred-fifty-seven subjects participated in a study using three dimensions of patient satisfaction scores (Competence, Respect, Access) to determine their attitude classification: Favorable, Unfavorable, Neutral, Apathetic, or Undifferentiated (Ambivalent). Analyses were conducted to determine the effects of gender on satisfaction and attitudes. In general, while men and women were equally satisfied with their physicians' communication, women found issues associated with physician-patient communication to be more important than did men. Controlling for physician gender, we found that males were less satisfied with their female physicians on the Respect factor than the overall mean for that factor. In terms of attitudes, we found that women were more likely to be favorable, unfavorable, or neutral (characterized by high importance scores) while men tended to fall into the apathetic or undifferentiated categories (characterized by low importance scores). Further, women were most likely to rate elements of the physician-patient interaction as substantially more consequential than men. The implications and future directions of this research are discussed.

<u>Note</u>: Authors listed alphabetically as equal contributors to this research article.

Introduction

Patients have role expectations for how physicians should or should not behave based on the value orientation a patient has regarding the social situation (Ben-Sira, 1976). These expectations shape the interaction in the medical episode and reinforce patterns of behavior that shape future interactions. Patient expectations, according to Ben-Sira, are a function of expectations with regard to our Western notion of medical ethics and medical competence.

Our attitudes, according to Ajzen (1988) have cognitive, affective, and behavioral components, and are formed from our experience through the socialization process. They shape our expectations for how we believe people should behave in their social roles. Attitudes toward the patient-physician relationship are the result of the reinforcement of those role expectations. That reinforcement is more likely to take place through what Ben-Sira refers to as the Mode (affective behaviors) dimension of physician-patient interaction rather that the Content (medical information) dimension. These affective behaviors seem to be more reinforcing, for the patient, in shaping perceptions of the relationship.

This study investigates factors that contribute to the role perceptions and expectations in the physician-patient relationship. Specifically, we are interested in patient attitudes that are formed regarding three physician-patient interaction factors: perceived competence, perceived access or availability, and perceived respect from the physician. Fundamentally, we are concerned with the role that gender plays in attitude formation in the physician-patient relationship.

Research of the physician-patient relationship from an expectancy theoretic approach has been useful in predicting differences based upon social role

constraints. For example, there is some evidence that older patients have different expectations of their relationship with physicians than younger patients and are more reluctant to challenge the physician's authority (Beisecker, 1988). Patients socialized in more traditional cultures may also have a perception that the locus of authority in the relationship rests with the physician. The same may be true for female patients. Bush (1985) suggests that gender may be a factor in how medical information provided to the patient is recalled. Burgoon, Birk, and Hall (1991) suggest that female physician communication is perceived differently by patients than male communication and those perceptions are a function of sex-typed role expectations. Arntson (1985) likewise argues that patient reports of satisfaction are a function of how well the physician met socialized role expectations and is critical of the use of the patient satisfaction construct for that reason.

These differences in expectations can influence patient perceptions of the appropriateness of physician communicative behaviors and patient affective responses to those behaviors (O'Hair, Allman & Moore, 1996; Moore, 1997). Certainly, the impact of socialized role expectations should be considered when examining the physician-patient relationship. These broader relational contexts allow us to look at communication and outcome variables in a useful interactional framework.

Patient Attitudes

Physicians adjust, modify, and communicate more effectively when they assess a patient's attitudes and personality in order to achieve that synchronicity. Geist and Hardesty (1990) argue that physicians rely heavily on patient attitudes to determine the communicative strategy that they will employ.

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Understanding the concept of attitude is essential to understanding effective physician-patient communication. However, assessing patient attitudes is not easily accomplished.

Researchers (c.f. Ajzen, 1988; Triandis, 1971) frequently define attitudes as having cognitive, affective, and behavioral components. The essence of our attitudes is derived from a variety of influential social and psychological sources and leads us to think, feel, and act. Attitudes are emotionally charged ideas which predispose "a class of actions to a particular class of social situations" (Triandis, 1971, p. 2). Negative and positive attitudes toward people, objects, or ideas influence our behaviors (Fishbein & Ajzen, 1975) and our predisposition toward innovation and change (Rogers, 1983). In addition, when attitudes are combined with reinforced expectations, associated behavioral changes are likely (Triandis, 1971).

Satisfaction also appears to be key in conceptualizing attitudes. Hylton and Lashbrook (1972) provide a useful attitude model for operationalizing and classifying attitudes. Specifically, they argue for four distinct types of classifications: favorable, unfavorable, neutral, and apathetic. Conlee and Aleman (1989), employing Hylton and Lashbrook's classification scheme, use satisfaction question items to construct an instrument identifying attitude classifications. Their investigations indicate an attitude may be favorable or positive toward change, unfavorable or negative toward change, neutral - neither positively nor negatively predisposed toward change, or apathetic - those individuals who are neither positively nor negatively predisposed toward change. It is important to note that neutrals are generally characterized as open to change, and responded positively to change

efforts. Neutrals' greatest need is to receive more information regarding change, whereas apathetics indicate a lack of interest or enthusiasm for the issue of change.

Patient Satisfaction

Often, patient attitudes toward health care have been conceptualized using a patient satisfaction construct which is typically viewed as an affective orientation toward physicians, nurses, hospitals, and the health care industry in general. It has become an important criterion variable in health communication research. Patient satisfaction has been linked to compliance with treatment advice (Burgoon, et al., 1987), recovery (Bass et al., 1986), and factors such as satisfaction with the hospital (Ben-Sira, 1983), with nurses (Morse & Piland, 1981), with medical interview (Stiles, Putnam, Wolf, & James, 1979; and Smith, Polis, & Hadac, 1981), patient referrals (Kasteler, Kane, Olson, & Thetford, 1976), and malpractice suits (Adamson, Tschann, Gullion, & Oppenberg, 1989).

Patient satisfaction has variously been defined as the confidence the patient has with his/her physician's interpersonal skills and conduct (Wriglesworth & Williams, 1975), or as a belief that one is informed truthfully by the physician (Korsch, Gozzi & Francis, 1968). Burgoon et al. (1987) make a distinction between cognitive satisfaction, "believing that one is well-informed by the physician about the illness, prescribed medications, and prognosis...," affective satisfaction," trusting the physician, feeling the physician is concerned, feeling accepted and liked, and feeling free to self-disclose," and behavioral satisfaction, i.e. the "rushed," or "incomplete" examination.

This study is concerned with the patient-physician relationship because of the potential link that the interaction in that relationship has to patient recovery. Bass et al. (1986) argue that psycho-social (affective behaviors) factors are the most important predictors of early symptom resolution. They also found effective reciprocal communication (understanding) to be an important predictor of recovery. Achieving understanding through communication requires significant skills or competencies on the part of participants. These competencies, when practiced by the physician and perceived by the patient, may lead to greater compliance on the part of patients and ultimately influence recovery. Most pertinent to this study was the application by Buller and Buller (1987) and Burgoon, Birk, and Hall (1991) to study satisfaction of communication between a physician and a patient. This study uses the operationalization of patient satisfaction as conceptualized by Conlee, Vagim, and Amabisca (1993) which is sensitive to the multi-dimensionality of the patient satisfaction construct. Specifically, patient satisfaction is defined as having three principle factors: Competence, Accessibility, and Respect. Competence is conceptualized as the confidence a patient has in the medical competence of the physician. Accessibility is conceptualized as the perceived availability of the physician. Respect is defined as the patient's perception of positive regard provided by the care giver.

Gender Differences

Gender research in physician-patient relationships is abundant. Patient preference of physician gender has been investigated and found to be a function of gender homophily, the nature of illness or clinical complaint or the degree of intimacy of the medical

situation (e.g. gynecological or male genital/rectal examination or psychologically intimate problems) (Heaton, & Marquez, 1990).

Selection of medical specialization has also been examined. According to Kutner and Brogan (1990) in a ten year study, women were no more likely to choose ob-gyn as a specialty than were men. Martin, Arnold, and Parker (1988) did find differences in male versus female physician career paths. Women chose primary care fields and entered fewer lucrative specialties like surgery. Women are also more likely to be self-employed and are generally paid less than male physicians.

Differences in male and female physicians' interaction have included that female physicians spent more time talking to patients, providing more positive talk, more question asking and providing more information (Roter, Lipkin, & Korsgaard, 1991); that male physician attitudes toward their patients tended to be more traditional while female physician attitudes tend to be more egalitarian (Kutner & Brogan, 1990).

Weisman and Teitelbaum (1985) argue that the impact of gender is a function of several interacting "mechanisms," specifically: (1) gender differences between physicians, particularly those having to do with attitudes regarding their roles and toward their patients; (2) differences in patient expectations in different or same sex dyads; and (3) status similarity between physician and patient. In addition, the manner in which physicians are professionally socialized may be a fourth important mechanism and may account for differences between expected and observed behaviors. The research on difference between genders warrants further investigation into the nature of attitudes toward physicians. The current study is an indirect investigation of these mechanisms

by measuring gender's relationship to patient satisfaction and attitudes.

Socialized gender-roles are molded to conform with societal norms beginning in early childhood and continuing throughout one's lifetime. Role identification is based on modeling behavior of the child for the parent, teacher, peers, etc. While acknowledging the importance of prior socialization, researchers argue that medical school socialization may change the impact of prior socialization for many female physicians (Leserman, 1981; West, 1993). Martin et al. (1988) make the argument that a dynamic exists between prior and continuing socialization: "In some instances new experiences may supplant or moderate the influence of earlier experiences; in others prior experience may integrate the impact of new experiences (p. 333). For males, professional socialization continues to reinforce their traditional roles, while for women, their traditional roles may be challenged. The role of professional socialization cannot be ignored with regard to professional behavior of physicians.

Medical socialization for male physicians tends to be a continued emphasis of their traditional male roles. However, for a women, medical schools force her to frame her role identity in a whole new way. Martin et al. (1988) assert that, as a consequence of female physicians' dual socialization, some of their professional behaviors are similar to their male colleagues while others are different.

Research Questions

This study is a preliminary investigation of attitudes and satisfaction patients have toward their physicians. This is one step in a larger body of research designed to describe the complexities of the physician-patient relationship.

By describing (and defining) the composition of the population, we can target our resources to bring about change in the most efficient manner. Factors such as gender, attitudes, and satisfaction are hypothesized to be salient in describing and defining sub-groups amenable to change. As such, the following two research questions are proposed:

RQ_1: *What is the patient satisfaction (compliance, respect, and access) toward a physician by patient gender and physician gender?*

RQ_2: *What are the patient attitudes (favorable, unfavorable, neutral, or apathetic) toward a physician by patient gender and physician gender?*

METHOD

Participants

One hundred-fifty-seven adult participants were contacted by students to complete a pencil and paper survey instrument.

Instrument

Participants were asked to complete a three page questionnaire including demographic information on themselves, demographic information on their physician, information on communication satisfaction, and attitude information. Patient satisfaction was measured using the 14-item Conlee, Vagim, and Amabisca (1993) Patient Satisfaction with Physician Care (PSPC) instrument with a previously established record of reliability (r=.80 - .93). See Appendix A for a copy of the survey questions. This instrument measures three dimensions of patient satisfaction: Competence, Respect, and Access.

Subjects were also asked to responded to a second set of Likert-type responses to quantify attitudes in

terms of the perceived importance of the PSPC items. Four attitude classifications (Favorable, Unfavorable, Neutral, Apathetic) were calculated using Hylton and Lashbrook's (1972) model of attitude formation. This model utilizes various combinations of patient satisfaction and importance scores to construct each classification. Classifications are defined and calculated in the following manner: Favorable - a combination of high satisfaction and high importance; unfavorable - a combination of low satisfaction, and high importance; neutral – a combination of medium satisfaction and high importance; apathetic – a combination of medium satisfaction and low importance.

Satisfaction scores were divided in three parts. The first third indicated low satisfaction, the second medium, and the third high. Importance scores were divided using a median split with the first half indicating low importance and the second indicating high. Thus, the three factor satisfaction scale (Competence, Accessibility, and Respect) was analyzed based on the four attitude classifications (Favorable, Unfavorable, Neutral, and Apathetic).

Results and Discussion

Reliability

The Cronbach Alpha coefficients were consistent with past research. The reliability for the overall Patient Satisfaction instrument was .87 and for overall Importance .83. Reliabilities for the satisfaction were acceptable. See Table 1 for a summary of reliability scores for each dimension.

Patient Satisfaction and Gender

One-way analyses of variance were conducted to see if there were any significant differences between

male and female patient satisfaction scores and importance scores for overall satisfaction as well as satisfaction and importance scores for the three factors, competence, respect, and access. There was no significant difference in patient satisfaction scores by gender ($F = .74$, $p > .05$, $n = 144$). However, there was a significant difference in Importance scores by gender. Importance scores for female patients were higher ($M=63.17$) than those for males ($M=60.34$; $F = 7.09$, $p < .01$, $n = 142$, see Table 2). This would indicate that even though men and women experience communication with their physicians as similar, women perceive patient-physician issues identified in this study as more important than do men.

There were also no differences in patient satisfaction scores within each of the three dimensions of patient satisfaction: Competence, Respect, Access. But again, women felt those issues were more important than men. The means for all three factors were significantly different and higher for women than men (see Table 2). While none of these differences were large, the fact that they were consistent across the board is consistent, given what we know about gender issues in the physician-patient relationship. It is quite possible that females place more importance on the quality of the physician-patient interaction. For example we know that while males' communication tends to be activity centered, females tend to focus on relationship issues (Coates, 1986; Harriman, 1985), and that women tend to self-disclose more in conversation leading to greater trust in relationships (Mark & Alper, 1985). Although one could argue that the importance of physician-patient relationships transcends gender, this study seems to indicate that women view the interaction as having substantial elements of consequence. They desire

quality of interaction more highly than men. We were also interested in determining how male and female patients perceived their male and female physicians. We performed two-way analyses of variance to investigate differences in means for satisfaction and importance scores by patient gender and physician gender. We found no differences in overall patient satisfactions scores by physician gender. However, on overall Importance scores we found a significant difference for gender of patient ($F = 6.57$, $p < .01$, $n = 139$), but no difference for physician gender and no interaction effects. We did find differences in perceptions of the Competence factor by physician gender. While there was no main effect, there was a significant two-way interaction of patient gender and physician gender ($F = 8.82$, $p < .01$) explaining 10 % of the variance. The greatest difference in means was male patients for female physicians ($M = 13.00$ compared to an overall mean of 20.51). There were no two-way interaction effects in importance of competence scores.

Analysis revealed a two-way interaction effect ($F = 5.37$, $p < .05$) on the respect factor of patient satisfaction. Again, means for male patients' perceptions of their female physician were lower in respect (12.00) than the overall mean (16.76) (although there were no two-way interaction effects for the importance of respect scores). This may have consequences given the dynamic nature of health delivery. The health care industry is changing rapidly, and the number of female physicians is increasing. Given the trend to restricting patient choice of a physician, it is important to note the variance in male/female perceptions of their physicians by gender. It appears that gender perpetuated stereotypes are resilient in the physician-patient interaction (Burgoon et al., 1991). This

finding is also consistent with past research on male attitudes toward women's power and competence. Many researchers argue that gender differences in communication behaviors is due to perceptions that women are less powerful than men in our society (Mulac, Wiemann, Widenmann, & Gibson, 1988) and are perceived as less competent (Wheeless & Berryman-Fink, 1985).

Patient Attitudes and Gender

Patient satisfaction and importance scores were combined to identify four discrete attitude categories: favorable, unfavorable, neutral, and apathetic. Overall, 25.9 % of the subjects were favorable, 12.9% were unfavorable, 18.5 % were neutral, 18.5 were apathetic, and 24.2 % were "other." Other is an undifferentiated category of individuals who rate an item low on satisfaction that they also report is unimportant to them. Theoretically, if you are highly dissatisfied with a phenomenon, then you must care about it. This undifferentiated category may reflect a certain ambivalence in attitudes toward physician-patient issues on the part of patients and may in fact reflect the need to consider adding it as a fifth category to the current attitude classification typology.

Most interesting is the fact that a higher percentage of females fall into the Favorable, Unfavorable, and Neutral categories while more men fall into the Apathetic and Ambivalent categories. That is consistent with the finding that women view the patient satisfaction with physician care factors as more important.

Underlying much of the physician-patient research is the notion that the relationship and its functional outcomes is a result of the interactional dynamics of the medical episode. According to Ben-Sira (1976), one way to understand the physician-patient

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relationship is from a functional approach, which would account for role expectations based on "internalization of norms" and the "value orientations characterizing the social situation (p. 3)" and a social exchange theoretic approach, which would account for previous interactions experienced by the pair. He goes on to explain that, as patients, we expect physicians to behave in certain ways constrained by medical ethics and standards of medical competence. Thus, the perception of and outcome of the patient-physician relationship is the result of the reinforcement of those role expectations. That reinforcement is more likely to take place as a result of affective rather than cognitive communication behavior.

One aspect of the interactional relationship that Ben-Sira and others don't discuss is the role expectations physicians have for patients based on an additional set of norms, values, and previous encounters. Although this study does not deal with physicians' perceptions or affective responses to patients, they are certainly important variables to the overall model and should be considered. Future studies comparing patients' and physicians' expectations for the interaction in the relationship might be very revealing. Nevertheless, the importance of directing the primary focus to patients' perceptions of physician behaviors has been well documented (c.f. Street & Wiemann, 1988, who report that physicians' perceptions of their own communication behavior to be unrelated to patients' satisfaction with medical care received).

<u>Conclusion</u>

In recent years the relationship between a physician and a patient has been exposed to a changing climate of health care delivery systems. The

traditional face-to-face relationship with the physician continues to change. Future research may wish to continue to study which segments of the population are most amenable to change in the currently volatile environment.

The results of this study suggest that gender may be an important issue with regard to patient attitudes toward the physician-patient interaction. For example, women, in general, viewed elements of the interaction as more important than male patients. Their attitudes, as a result, reflect that bias. That is, they fell into the attitude categories characterized by high scores on the importance scale (Favorable, Unfavorable, and Neutral) while men tended to fall into those low importance categories (Apathetic and Undifferentiated).

This study was a preliminary investigation of patient attitudes and satisfaction. It utilized the four-dimension Hylton and Lashbrook (1972) classification scheme. Our analysis and coding of Hylton and Lashbrook's original definitions resulted in an additional patient category, Undifferentiated (Ambivalent). Future research may wish to revise the Hylton and Lashbrook's coding scheme to incorporate all possible patients. In addition, other demographic categories such as ethnicity, age, patient type, etc. should also be investigated.

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References

Adamson, T. E., Tschann, J. M., Gullion, D. S., & Oppenberg, A. A. (1989). Physician communication skills and malpractice claims: A complex relationship. *The Western Journal of Medicine*, March, 356-360.

Arntson, P. (1985). Future research in health communication. *Journal of Applied Communication Research, 13*, 118-130.

Azjen, I. (1988). *Attitudes, personality, and behavior*. Chicago: Dorsey Press.

Bass, M. J., Buck, C., Turner, L., Dickie, G., Pratt, G., & Robinson, H. C. (1986). The physician's actions and the outcome of illness in family practice. The Journal of Family Practice, 23, 43-47.

Beisecker, A. E. (1988). Aging and the desire for information and input in medical decisions: Patient consumerism in medical encounters. *The Gerontologist, 28*, 330-335.

Beisecker, A. E. (1990). Patient power in doctor-patient communication: What do we know? *Health Communication, 2*, 105-122.

Ben-Sira, Z., (1983). The structure of a hospital's image. *Medical Care, 21*, 943-954.

Ben-Sira, Z., (1976). The function of the professional's affective behavior in client satisfaction: A revised approach to social interaction theory. *Journal of Health and Social Behavior, 17*, 3-11.

Buller, M.K., & Buller, D.B. (1987). Physicians' communication style and patient satisfaction. *Journal of Health and Social Behavior, 28*, 375-388.

Burgoon, J. K., Pfau, M., Parrott, R., Birk, T., Coker, R. & Burgoon, M. (1987). Relational communication, satisfaction, compliance-gaining strategies, and compliance in communication between physicians and patients. *Communication Monographs, 54*, 307-324.

Burgoon, M., Birk, T. S., & Hall, F. R. (1991). Compliance and satisfaction with physician-patient communication. *Human Communication Research, 18*, 177-208.

Bush, D.F. (1985). Gender and nonverbal expressiveness in patient recall of health information. *Journal of Applied Communication Research, 13*, 103-117.

Coates, J. (1986). *Women, men and language*. New York: Longman.

Conlee, C. & Aleman, C. (1989). An evaluation of intervention strategies on worker satisfaction: A pre-test, post-test design. Paper presented to the Speech Communication Association Convention, San Antonio, Texas.

Conlee, C., Amabisca, W., & Vagim, N. N. (1995). Gender differences for patient satisfaction scores: The clash between medical socialization and patient expectations. Presented to the Speech Communication Association Convention, San Antonio.

WHITE LIBRARY ESU EMPORIA

Conlee, C., Vagim, N. & Amabisca, W. (1993). Measuring patient satisfaction with physician care II: A physician-patient interaction model. Presented to the Western States Communication Association Convention, Albuquerque, New Mexico.

Fishbein, M., & Ajzen, I. (1975). *Belief, attitude, intention, and behavior: An introduction to theory and research.* Reading, MA: Addison-Wesley.

Geist, P., & Hardesty, M. (1990). Reliable, silent, hysterical, or assured: Physicians assess patient cues in their medical decision making. *Health Communication, 2*, 69-90.

Harriman, A. (1985). *Women/men management.* New York: Praeger.

Heaton, C. J., & Marquez, J. T. (1990). Patient preferences for physician gender in the male genital/rectal exam. *Family Practice Research Journal, 10*, 105-115.

Hylton, C., & Lashbrook, W. B. (1972). Apathetic and neutral audiences: A computer simulation and validation. *Communication Monographs, 39*, 105-113.

Kasteler, J, Kane, R. L., Olson, D. M., & Thetford, C. (1976). Issues underlying prevalence of "Doctor Shopping" behavior. *Journal of Health and Social Behavior, 17*, 328-339.

Korsch, B. M., Gozzi, E. K., & Francis, V. (1968). Gaps in doctor-patient communication. *Pediatrics, 42*, 855-869.

Kutner, N. G., & Brogan, D. (1990). Gender roles, medical practice roles and ob-gyn career choice: A longitudinal study. *Women and Health, 16*, 99-117.

Leserman, J. (1981). *Men and women in medicine - how they change and how they compare.* New York: Praeger.

Mark, E. W., & Alper, T. G. (1985). Women, men and intimacy motivation. *Psychology of Women Quarterly, 9*, 81-88.

Martin, S. C., Arnold, R. M., & Parker, R. M. (1988). Gender and medical socialization. *Journal of health and Social Behavior, 29*, 333-343.

Moore, S. D. (1997). *The effect of health delivery systems on provider-patient communication.* Unpublished Dissertation. University of Oklahoma, Norman, Oklahoma.

Morse, B. W., & Piland, R. N. (1981). An assessment of communication competencies needed by intermediate-level health care providers: A study of nurse-patient, nurse-doctor, nurse-nurse communication relationships. *Applied Communication Research, 9*, 30-41.

Mulac, A., Wiemann, J. M., Widenmann, S. J., & Gibson, T. W. (1988). Male/female language differences and effect in same-sex and mixed-sexed dyads: The gender-linked language effect. *Communication Monographs, 55*, 315-335.

O'Hair, H. D., Allman, J., & Moore, S. D. (1996). A cognitive-affective model of relational expectations

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in the provider-patient context. *Journal of Health Psychology, 1*, 307-322.

Rogers, E. M. (1983). *Diffusion of innovations*. New York: The Free Press.

Roter, D., Lipkin, M., Jr., & Korsgaard, A. (1991). Sex differences in patients' and physicians' communication during primary care medical visits. *Medical Care, 29*, 1083-1093.

Smith, C.K., Polis, E., & Hadac, R.R. (1981). Characteristics of the initial medical interview associated with patient satisfaction and understanding. *The Journal of Family Practice, 12*, 283-288.

Street, R.L., & Wiemann, J.M. (1987). Patient satisfaction with physicians' interpersonal involvement, expressiveness, and dominance. *Communication Yearbook*, Beverly Hills: Sage.

Stiles, W.B., Putnam, S.M., Wolf, M.H., & James, S.A. (1979). Interaction exchange structure and patient satisfaction with medical interviews. *Medical Care, 17*, 667-679.

Triandis, H. C. (1971). *Attitude and attitude change*. New York: John Wiley and Sons.

Weisman, C. S., & Teitelbaum, M. A. (1985). Physician gender in the physician-patient relationship: Recent evidence and relevant questions. *Social Science and Medicine, 20,* 1119- 1127.

Wheeless, V. E., & Berryman-Fink, C. (1984). Perceptions of women managers and their communicator competencies.

West, C. (1993). Reconceptualizing gender in physician-patient relationships. *Social Science and Medicine, 36*, 57-66.

Wriglesworth, J.M. & Williams, J.T. (1975). The construction of an objective test to measure patient satisfaction. *International Journal of Nursing Studies, 12*, 123-141.

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Table 1

Reliability Coefficients for PSPC

Instrument	Alpha	Prob.
Patient Satisfaction	.86	.000
Competence	.86	.000
Respect	.65	.004
Access	.76	.000
Importance	.83	.000
Competence	.72	.000
Respect	.55	.001
Access	.77	.001

Table 2

Differences in Means for Importance Scores by Gender

Variable	n	Mean	sd	F	sign.
Overall Importance	142	61.99	6.4	7.09	.009
Males	59	60.34	7.3		
Females	83	63.17	5.4		
Importance of Competence	150	22.89	2.5	6.00	.015
Males	61	22.30	3.1		
Females	89	23.29	1.9		
Importance of Respect	152	17.89	2.1	9.61	.002
Males	65	17.29	2.4		
Females	87	18.34	1.8		
Importance of Access	152	21.09	3.5	3.88	.051
Males	65	20.48	3.6		
Females	87	21.55	3.1		

Appendix A
Instrument

Note: Each item used two five-point likert scales, one for agreement, the other for importance.

1. My physician makes me feel everything be all right (gives me hope).
2. My physician does not talk down to me.
3. My physician is not constantly interrupted with telephone calls when conferring with me.
4. My physician pays attention to my symptoms and takes me seriously when I say something is wrong.
5. My physician is the best in the field.
6. I feel my physician is very knowledgeable.
7. I have a lot of confidence in my physician's medical capability.
8. My physician treats me as a whole person, not just the particular "part" that is ailing.
9. My physician returns calls in a timely manner.
10. My physician is usually available (easily accessible).
11. My physician keeps flexible hours, not just nine to five.
12. My physician is usually available if needed on week-ends.
13. My physician understands my need for a second opinion and is not insulted when I want one.
14. My physician speaks in laymen terms that I understand.