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Marianne Upmark, Karin Borg and Kristina Alexanderson

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ORIGINAL ARTICLE

Gender differences in experiencing negative encounters with healthcare: A study of long-term sickness absentees

MARIANNE UPMARK[1,2], KARIN BORG[3] & KRISTINA ALEXANDERSON[1]

[1]*Section of Personal Injury Prevention, Department of Clinical Neuroscience, Karolinska Institutet, Stockholm,* [2]*Department of Public Health Sciences, Karolinska Institutet, Stockholm, and* [3]*Division of Social Medicine and Public Health, Department of Health and Society, Faculty of Health Sciences, Linköping, Sweden*

Abstract
Aim: In most countries there are gender differences in sickness absence and in absentees' return to work (RTW). According to different theories sick-listed persons' experiences of encounters with healthcare professionals can influence self-esteem and RTW. The aim was to analyse gender differences in sickness absentees' experiences of negative encounters with healthcare professionals. *Methods*: A questionnaire, comprising numerous questions on experiences of positive and negative encounters with professionals, was constructed and sent to 10,100 individuals who had been on sick leave for the last 6–8 months. The response rate was 58% (n=5,802). *Results*: Almost one-third (32%) of the female respondents and one-quarter of the male (24%), respectively, had experienced negative encounters. The most common of such experiences among both women and men were: that they were treated with indifference, with disrespect, that the professional did not take his/her time, did not listen, did not believe in, or doubted complaints. In regression analyses the women had higher significant crude odds ratios, ranging from 1.29 to 1.71, for agreeing to the separate statements on negative encounters. When adjusting for age, ethnicity, and level of education the gender differences were still significant for 14 of the 23 the statements. *Conclusion*: Women's high rate of sickness absence is considered a problem in most countries. The subjective experiences of women are an important factor to consider in efforts aiming at reducing the sick-leave rates. One important endeavour among professionals in healthcare could be to shift the focus towards a more empowering professional role.

Key Words: *Gender, negative encounter, sickness absence, sick leave*

Background

In most countries there are gender differences in sickness absence and in absentees' return to work (RTW). According to different theories sick-listed persons' experiences of encounters with healthcare professionals can influence self-esteem and RTW [1].

Medical encounters unfold according to a complex interplay of style, perception, and adaptation in an interpersonal context reflecting the interactant's goal, skills, perceptions, and emotions as well as the constraints and opportunities created by the actions of their partners. Gender differences may in these encounters come from several sources including differences in men's and women's communicative styles and may occur within a number of contexts [2]. These encounters are influenced by values and power relations, as well as by the cultural context in general. Thus, gender, as an accomplishment rather than an individual difference and as one important aspect of the division of power in a society, could be expected to affect these encounters [3]. In the patient–physician relationship patients are generally considered to have less status and power (power imbalance) than medical professionals.

Gender differences in communication in general and in clinical encounters specifically have been reviewed by Elderkin-Thompson & Waitzkin [4]. Physicians tend to give female patients more time,

Correspondence: Marianne Upmark, Personal Injury Prevention, Department of Clinical Neuroscience, Karolinska Institutet, 171 77 Stockholm, Sweden. Tel: +46 8 524 832 00. Fax: +46 8 524 832 05. E-mail: marianne.upmark@sll.se

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more explanations, and more responses to questions at the level of speech of the patients. On the other hand, physicians seem to be more likely to reject medical explanations from female patients [5], and female patients were spoken to in a less interested fashion than male patients by physicians of both sexes [6]. More women than men reported that they felt that physicians talked down to them (25% vs. 12%) and told them their problems were only in their heads (17% vs. 7%) [7].

An optimal encounter in clinical medicine rests on an interpretive meeting between the patient and the professional [8]. Today, many medical consultations include handling aspects of sickness certification, a task many physicians experience as problematic [9,10]. Thus, such consultations may cause quandaries that could be expected to complicate encounters. From the perspective of long-term sickness absentees these encounters could be expected to be of extreme importance, for instance economically, as they need a certificate for sickness benefits. However, the specific perspective of the sickness absentees – in contrast to all patients – has seldom been highlighted, with a few exceptions [11–14].

Svensson et al. [1] discussed the importance of interaction with professionals who have some power over a patient's future, such as the professionals you meet when sickness absent, in relation to RTW. The interaction may evoke social emotions such as pride or shame, which could be expected to result in empowerment or disempowerment, respectively, which in turn, hypothetically, could be related to RTW. From a feminist frame of reference Werner & Malterud [15] explored efforts made by female patients to be believed, understood, and taken seriously when consulting physicians. They emphasize the relationship between dignity and shame, power and disempowerment for female patients with medically unexplained disorders.

In a review [16] of studies on patient satisfaction it was pointed out that the instruments used for data collection often are biased toward issues that concern health professionals rather than patients and that researchers should pay greater attention to expressions of *dissatisfaction* than to refine instruments which repeatedly show high levels of satisfaction.

Possible gender differences in experiences of negative encounters among sickness absentees are of special interest because of women's higher sick leave and slower RTW rate [17,18] and because a number of women ''doctor-shop'', indicating dissatisfaction with encounters within healthcare [19–21].

Aim

The aim was to analyse gender differences in sickness absentees' experiences of negative encounters with healthcare professionals.

Material and methods

A cross-sectional population-based questionnaire survey was conducted.

Study population

The study population comprised a random sample of 10,042 individuals from the 22,158 persons in Sweden who, on 31 January 2003, were aged 20–64 years, had an ongoing sick-leave spell for 6–8 months, and had not been granted part-time disability pension. The sample was drawn from the register of all people on sick leave kept by the National Social Insurance Board. Of these, before sending out the questionnaire, Statistics Sweden excluded 58 persons due to death or emigration.

Questionnaire and respondents

A comprehensive questionnaire regarding perceptions of contacts with professionals was constructed, based on findings from qualitative [11,13,22] and quantitative studies [12,14], clinical experiences, theoretical considerations [1], and small pilot studies. The questionnaire comprised questions in terms of statements regarding experiences of positive and negative encounters with healthcare and social insurance professionals, the emotions such contacts evoked, and whether positive and negative contacts might promote or hinder RTW. A few questions on demographics were also included (e.g. level of education). Data on gender, age, and ethnicity were obtained from the National Social Insurance Board (Table I). The questionnaire took approximately one hour to complete. It was administrated by Statistics Sweden in April 2004. A reminder was sent to non-responders after one week and again after another 10 days.

Data on 5,802 respondents (58%) were available for the analyses. In general, the response rate was higher among females ($p<0.001$), native Swedes ($p<0.001$), and individuals aged 50–64 compared with younger people ($p<0.001$) (see Table I).

In the present study answers to the questions on negative encounters with healthcare were analysed. Respondents were first asked whether they had experienced such encounters in connection with their sickness absence. Individuals with negative

Table I. Demographic factors regarding study population and respondents.

	Study population *n* (%)	Respondents *n* (%)
All	10,042	5,802
Sex		
Women	6,031 (60)	3,698 (64)
Men	4,011 (40)	2,104 (36)
Age		
20–29	882 (9)	460 (8)
30–39	2,307 (23)	1,177 (20)
40–49	2,605 (26)	1,424 (25)
50–59	2,901 (29)	1,825 (31)
60–64	1,347 (13)	916 (16)
Ethnicity		
Swedish	8,439 (84)	4,997 (86)
Non-Swedish	1,603 (16)	805 (14)

experiences were requested to rate 23 statements on negative encounters (listed in Table III), by choosing one of four alternatives: ''agree completely'', ''agree to a large extent'', ''agree to a limited extent'', or ''do not agree''. The 110 individuals who had not answered either the first question or any of the statements were excluded.

Statistical analyses

Separate mean values, stratified on gender, for the answers to each statement were calculated. Logistic regression analyses were carried out to identify possible associations between gender and experiences of different aspects of negative encounters. For each statement the answers were dichotomized into ''agree'' (answer ''agree completely'', ''agree to a large extent'', or ''agree to a limited extent'') and ''do not agree''. The odds ratio (OR) for agreeing among women was related to the corresponding odds ratio among men. Persons who in the first question claimed no negative encounters were, for each statement, included as disagreeing. In a second step multiple logistic regression analyses were used to adjust for possible association with age, ethnicity, and level of education. Analyses were performed where age was regarded as continuous; ethnicity was divided into four categories – born in: Sweden (1), other Nordic (2), Asian, African or South American (3), and other countries (4), i.e. people born in other European countries and people born in North America. Level of education was divided into those with only compulsory school, those with education from high school, and those who had attended university.

A p-value of <0.05 was regarded as statistically significant and 95% confidence intervals (CI) were calculated. The chi-squared test was used to test for significant differences between proportions (e.g. gender).

Results

Almost one-third (32%) of the female respondents and one-quarter of the male (24%), respectively, agreed with one or more of the different statements on experiences of negative encounters. The great majority (91% among women and 87% among men) of the 1674 individuals who had had negative experiences also indicated experiences of positive encounters (Table II). Two-thirds of the respondents mentioned physicians as the profession in the encounter perceived as most negative (71% by women and 62% by men) followed by ''do not know the profession'' (12%) and nurse (8%). Younger persons (20–29 years) more often reported negative encounters than middle-aged (30–49) and older (50–64) as did persons with higher education (see Table II). A majority among both women and men with experience of negative encounters had agreed with 10–18 of the statements.

In general, there were great similarities in the response pattern between women and men: they had encountered the same dimensions of negative encounters often or vice versa (Table III). However, for a number of items women agreed more strongly than men (figures not reported) and more women had experienced different types of negative encounters; ORs ranged from 1.19 to 1.71, significant for all 19 out of 21 items. For nine of these the OR was 1.60 or above: ''Not believed what I have said'', ''Treated me with indifference'', ''Doubted my complaints'', ''Regarded me as stupid'', ''Been irritated/impatient'', ''Treated me with disrespect'', ''Not listened'', ''Interrupted me'', and ''Made unreasonable demands'' (see Table III).

When adjusting the ORs for age, ethnicity, and level of education significant gender differences were still found for 14 of the statements, indicating that there is a gender difference in perception of the encounter, regardless of the patients' age, ethnicity, or level of education (see Table III).

Discussion

Some 29% of the long-term sickness absentees had experienced negative encounters with healthcare professionals. There were no large differences in what type of encounters larger number of women and men had perceived often or less often; however, women more frequently reported experiences of

Table II. Demographic factors regarding respondents with experience of negative and positive encounters.

	A	B	C
	Total number of respondents	Respondents with experience of negative encounters *n* (% of A)	Respondents with experiences of negative and positive encounters *n* (% of B)
All	5,802	1,674	1,498
Sex			
Women	3,698	1,171 (32)	1,061 (91)
Men	2,104	503 (24)	437 (87)
Age			
20–29	460	233 (51)	192 (82)
30–49	2,601	948 (36)	858 (91)
50–64	2,741	493 (18)	448 (91)
Ethnicity			
Swedish	4,997	1,416 (28)	1,277 (90)
Other	805	258 (32)	221 (86)
Education			
Compulsory school	1,759	395 (22)	345 (87)
High school	2,423	783 (32)	689 (88)
University	1,564	485 (31)	455 (94)
Unknown	56	11 (20)	9 (82)

negative encounters, also when adjusting for age, ethnicity, and level of education. For those statements where no gender differences were found only very few had agreed.

Influence of gender on perceived encounter

Another study of sick-listed persons' contacts with health professionals has shown that women rated their contacts as more positive [12]. However, in the persent study the experiences of women to a greater extent than those of men reflected disrespectful behaviour of the health professional such as having been encountered with anger, distrust, doubt, blame, impatience, or been treated as stupid. One of many explanations could be women's higher utilization rate of healthcare thus increasing their chances of experiencing both negative and positive encounters.

Expectations are generally considered to be an important determinant of patient satisfaction [16] and presumably also of how encounters are perceived. Gendered attitudes in search for help, i.e. women's hope for help compared with a more demanding attitude of men [23], might affect how the encounter was perceived. Consequently, women could perceive the same encounter more positively than men since their expectations are lower.

Items directly reflecting a behaviour considered as nonchalant and disrespectful – ''Treated med with indifference'', ''Regarded me as stupid'', ''Was angry/unpleasant'', and ''Treated me with disrespect'' – were all more frequently reported by women. Moreover, almost one-fourth of the women (23%) perceived that they were regarded as stupid. To perceive that the encounter is characterized in a nonchalant and disrespectful way might not only induce shame but also be detrimental to rehabilitation efforts [22].

''Not believed what I have said'' and ''Doubted my complaints'' were found to be two of the other most gender discriminating items. Klanghed et al. [13] found from focus-group interviewees that encounters with professionals were considered as positive when the interviewees were believed in and/or taken seriously. As a contrast, a number of studies have illustrated how women report that they experience that physicians distrust them – which seems to be related to disorders common among women usually described as illnesses with no clear-cut pathological findings [11,19,21,23]. In a study [11] on female patients' consultation experiences sick-listed women used different strategies to catch physicians' attention and to uphold self-respect, whereby physicians' attitudes, described as ignoring, disregarding, and rejecting, may be intensified by the patients' attempts to question and discuss assumptions. Åsbring & Närvinen, in a qualitative study [21] of female, mainly sick-listed patients diagnosed with chronic fatigue syndrome or fibromyalgia, found that the women's credibility was questioned

Table III. Number of women and men agreeing to statements on experiences of negative encounters among sickness absentees and odds ratios (OR) with 95% confidence intervals (CI) for women vs. men (n=5,692).

	Agreed (%)		Gender reference=men		Adjusted for age, ethnicity, and education	
Statement	women	men	OR	95% CI	OR	95% CI
Doubted my capacity to work	20	16	**1.33**	1.15–1.54	1.14	0.98–1.32
Questioned my desire/ motivation to work	23	17	**1.51**	1.32–1.74	**1.27**	1.10–1.47
Not believed what I have said	26	18	**1.64**	1.43–1.88	**1.38**	1.20–1.60
Treated me with indifference	28	19	**1.66**	1.45–1.89	**1.37**	1.19–1.57
Doubted my complaints	26	18	**1.63**	1.42–1.87	**1.37**	1.19–1.58
Regarded me as stupid	23	15	**1.68**	1.46–1.94	**1.39**	1.19–1.62
Rejected my suggestions and solutions	24	17	**1.57**	1.37–1.81	**1.30**	1.12–1.50
Was stressed/Not taken time for me	27	19	**1.53**	1.34–1.74	**1.27**	1.10–1.45
Was irritated/impatient	25	17	**1.58**	1.38–1.81	**1.31**	1.14–1.52
Was angry/unpleasant	22	15	**1.65**	1.43–1.91	**1.39**	1.19–1.61
Treated me with disrespect	26	18	**1.67**	1.45–1.91	**1.37**	1.18–1.58
Threatened me	5	4	1.19	0.91–1.55	1.01	0.77–1.33
Not listened	26	17	**1.71**	1.48–1.96	**1.41**	1.22–1.63
Harmed me physically	4	4	0.98	0.74–1.30	0.87	0.65–1.17
Was too impersonal	24	17	**1.55**	1.35–1.78	**1.28**	1.10–1.48
Not kept our agreements	14	11	**1.33**	1.13–1.57	1.10	0.92–1.31
Blamed me for my condition	15	10	**1.49**	1.26–1.76	1.22	1.02–1.46
Sexually inappropriate behaviour	2	2	0.71	0.60–1.42	0.79	0.51–1.23
Not explained things so that I could understand	13	11	**1.29**	1.09–1.54	1.12	0.94–1.34
Interrupted me	20	13	**1.67**	1.43–1.94	**1.40**	1.19–1.64
Made unreasonable demands	21	14	**1.65**	1.42–1.92	**1.39**	1.19–1.63
Not made enough demands	8	7	1.17	0.94–1.44	0.99	0.80–1.23
Not let me take responsibility for myself	16	12	**1.38**	1.17–1.61	1.16	0.99–1.37

Significant ORs in bold.

by the caregivers, particular by physicians, who seemed to regard them as malingerers.

''Not listened'' and ''Interrupted me'': More women than men confirmed that they had been interrupted. That gender is associated with pattern of interruptions with female patients being more interrupted (by both female and male physicians) is in line with a study of speaking and interruptions during primary care visits [24]. Interruptions could be interpreted as domination and control but also as physicians being more eager to receive additional information [25].

It is positive that only a small percentage had experienced inappropriate sexual encounters or being threatened or harmed physically. Nevertheless, 2–5% of the women and the men had had such experiences. Even regarding inappropriate sexual encounters, as many as 116 persons had experienced such encounters.

Role of the professional: empowerment instead of belittlement

The encounters perceived by the sickness absentees give topical interest to the concept of empowerment, which could be seen as the opposite of oppression [26]. Malterud & Hollnagel [27] propose that a focus on women's self-assessed personal health resources can be a part of an empowering strategy. By recognizing the suffering of women with pain and their strengths the medical encounter can prevent further disempowerment [28].

Another way, proposed by Werner & Malterud [15], in which physicians can help patients transform

vulnerability into strength, instead of increasing a feeling of disempowerment, is by admitting the shortcomings of medical knowledge. Thereby the blame can be transformed to the medical discipline instead of the individual patient who presents symptoms or reveals behaviour that does not fit with biomedical expectations of what illness is and how it should be performed.

Asymmetry of the medical relationship

Overall, a larger percentage of the female absentees in our study expressed what can be interpreted as experiencing a subordinate position in the eyes of the professionals. Besides the interpersonal relation in the communication between the sick-listed and the professional their roles could be seen as interactional strategies that link social structure to social interaction, as proposed by Fisher & Groce [5]. Thus, the encounter between health professionals and sick-listed persons comprises a contextual power imbalance [29,30] shaped by the roles of health professionals and their place in the social structure, and laymen. The medical interview sustains both the institutional authority and status of physicians and the reality of genders. In encounters with sick-listed persons the gate-keeper role regarding sickness benefits could be expected to enhance the power imbalance still more.

When interpreting gender differences in encounters with healthcare professionals we are prone to agree with Hammarström & Ripper [31, p 289]: ''a power perspective in public health can bring a more comprehensive and subtle understanding of the multiple and contradictory elements of gender and other relations of power that impact on the health status of populations''.

Methodological considerations

Strengths of the study are that the sample is population based and large ($>10{,}000$ long-term sickness absentees). Previous studies are small and mainly qualitative [11–13]. The larger proportion of women in the study population is in line with the higher sick-leave rate of women [18]. The relatively low response rate (58%) is a limitation, however, comparable to other population-based questionnaire surveys to long-term sickness absentees [14,18]. Non-participation might have been due to severe diseases, psychosocial problems, or language difficulties; due to the inclusion criteria (long-term sickness absence) the rate of such persons was higher than in the general population [18]. We do not know in which direction potential selection biases caused by different experiences of healthcare might go. There are indications that the result is to some extent selective in so far as groups with lower response rates also reported more negative encounters, especially the immigrants. This implies that the findings of negative encounters might be underestimated.

As there were no open-ended questions we might have missed important aspects of encounters. However, the questions were based on previous interview studies with absentees and consequently were not biased towards issues that concern management and the health professionals [16].

At large it could be expected that the answers are reported less negatively than they would have been with the use of another method [32]. Because of this we included those ''agree to a limited extent'' with ''agree'' in the regression analyses.

Just as patient survey measures of satisfaction can be understood as measures of patient characteristics, physician characteristics, and relationship characteristics [33], measures of perceived negative encounters with health professionals among long-term sickness absentees might be interpreted in a similar way. To give a more comprehensive picture including the perceptions of both the sickness absentees and the health professionals it is necessary to use another design. Fossum & Arborelius have explored meetings between physicians and their patients by using video-taped consultations. The analyses of the comments made by the patients have been considered helpful in clarifying the difference between encounters experienced as satisfactory or unsatisfactory [34–36].

The gender differences in result can probably be generalized also to other long-term sickness absentees in Sweden, and possibly also in other Western countries. However, culturally defined structures of power reflected in relations between healthcare professionals and patients as well as between women and men could influence the results. Nevertheless, the subordination of women and the power imbalance between patient and physicians [30] are universal phenomena. The power imbalance may be strengthened when economic aspects are involved as in these encounters.

Conclusion

Many of the experiences of negative encounters with healthcare professionals, which could mirror disrespectful behaviour, were frequently reported by both women and men. There were no large gender differences in *type* of encounters; however, experiences of negative encounters among long-term

sickness absentees were more frequently reported by women. Since women's high sick-leave rates and low RTW rates in most countries are seen as problem their subjective experiences are an important factor to consider. One important effort among professionals in healthcare could be to shift focus towards a more empowering professional role, thereby reaching the optimal interpretive meeting [8] between the patient and the professional. To gain a more comprehensive picture of the gender differences in reports of negative encounters further studies are needed.

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