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**QUALITY OF CARE FROM A GENDER PERSPECTIVE:  
AN UPDATE ON PAHO'S EFFORTS IN THIS AREA**

This document presents the advances made by the Program on Women, Health, and Development towards promoting gender equity in health care delivery. The first two sections provide the justification for exploring the ways in which gender-based factors might influence the quality of health care and a summary of the research on this issue. The third section delineates the research currently under way in two countries of the Region to develop and test a methodology to evaluate gender equity within the socioemotional dimension of quality of health care service delivery. Two health conditions have been selected as the focus of this research: diabetes and adolescent pregnancy. The selection of diabetes permits an analysis of the similarities and the differences in the treatment of men and women for the same condition, whereas adolescent pregnancy has been selected because of the priority Member States have assigned to this social and health concern. The annex provides an example of the application of the methodology to a specific case and exemplifies the inherent complexities in providing quality of care that takes into account gender dimensions.

The Subcommittee is asked to review the document and provide comments on its applicability in different settings in countries of the Region.

## CONTENTS

	<i>Page</i>
1. Justification . . . . .	3
1.1 Institutional Considerations . . . . .	3
1.2. Conceptual Considerations . . . . .	3
2. Research on Gender Equity in Health Services . . . . .	5
2.1 Review of the Literature . . . . .	5
2.2 Challenges of an Equity Focus . . . . .	7
3. Summary of the Research Proposal . . . . .	8
3.1 Unit of Analysis . . . . .	9
3.2 Design and Methods . . . . .	10
3.2.1 Key Health Care Problems . . . . .	11
3.2.2 Evaluation . . . . .	12
Bibliography . . . . .	14
Annex	

## 1. Justification

### 1.1 *Institutional Considerations*

The overarching principle orienting this project on gender and quality of care is the concept of equity. The interest of the Pan American Health Organization (PAHO) in equity in health services was emphasized in a recent document that set forth priorities and strategies for health sector reform in the Region of the Americas:<sup>1</sup> *A basic requirement for achieving equity is that health services be adapted to the specific needs and problems of the various groups* (PAHO/ECLAC, 1994). As such, the research-based action in this area is part of a larger process within PAHO of promoting a critical revision of the way in which health care is imparted in services, through a variety of quality assessment techniques. Various instruments developed by PAHO have been used in Latin America and the Caribbean, including the "hospital accreditation" process (Paganini, 1993; Novaes and Paganini, 1994), "conditions of efficiency" (Suarez Ojeda, 1987), "lost opportunities" (Suarez Ojeda, 1993), and "quality assessment in reproductive health" (Mora et al., 1994).

Within the Women, Health, and Development Program, the background to the present initiative was a document presented by the Secretariat to the Special Subcommittee on Women, Health, and Development in April 1993, which proposed the development of a *model to evaluate health services in order to determine the critical areas of disadvantage within the system and identify the factors to be addressed*. The proposal, called *Female Friendly Health Services*, resulted in a recommendation by the Subcommittee to support the proposal, in which *the need to reconsider the health care model from the gender perspective in order to make it fairer and more effective* was cited.

### 1.2 *Conceptual Considerations*

The justification for exploring the ways in which gender-based factors influence the quality of health care stems from a central premise: gender, as one of the basic organizing principles of society, influences all facets of social interaction and creates, in

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<sup>1</sup> Inequity in health, as defined by Whitehead, are those differences which, in addition to being unjust, are unnecessary and avoidable (1990:3). Wyszewianski and Donabedian, in describing inequity in the distribution of quality of health care, have focused their definition on *the degree of match between services needed and services received by population subgroups*. They further suggest that this implies *a concern with those differences in treatment which, because they exhibit a systematic pattern, are evidence of discrimination* (1981:32).

many situations, a power imbalance between men and women.<sup>2</sup> This imbalance is manifested in the different value attributed to reproductive and productive roles,<sup>3</sup> and in men's and women's different access to and control over resources, in the home in particular and in society in general.

From the point of view of health services, few would dispute the notion that clinical decision-making is influenced not only by scientific knowledge, but also by a complex web of social factors. The latter include, for example, culturally-specific experiences of class, education, race, age, and income, as well as gender. As defined by Ashmore and Del Boca, the resulting presence of stereotyping may or may not be a problem, but in some cases it can impede an appropriate response to specific groups (1979).<sup>4</sup> If, for instance, women's work in the reproductive sphere is viewed as "natural," and therefore unalterable, the associated risks to women's health may be overlooked by providers in the formulation of a diagnosis and in treatment and counseling. Not only may damaging social situations be ignored, but they may be exacerbated by reinforcing roles.

Because it is the responsibility of health services to try and reduce the impact of factors that interfere with the satisfaction of different population subgroups' health needs, we believe that the issue of gender equity is pertinent to quality assessment research and management. The challenge, in this regard, is to determine whether gender-related factors adversely affect the quality of care and, if so, the manner and extent of their influence.

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<sup>2</sup> "Gender" considers the relational characteristics that define male and female being and behavior within specific social contexts, as well as the web of cultural symbols, normative concepts, institutional patterns, and internalized self-image that intertwine to delimit masculine and feminine spheres and articulate them within a power structure. Gender roles and relations are historically and culturally determined. "Sex" refers only to the biological aspects of what is male and female. Thus, gender may be utilized as a social category that interconnects with other categories of social analysis such as ethnicity, stages in the life cycle, and social class, while sex is an attribute, which in research, for example, constitutes a variable.

<sup>3</sup> Reproductive roles include the biological reproduction of the species and all the activities necessary to guarantee the survival and well-being of the individuals that comprise the household, whereas productive roles include the production of goods and services remunerated in cash or kind.

<sup>4</sup> Ashmore and Del Boca define sex stereotypes as *the structured set of beliefs about the personal attributes of women and men* (1979:222).

## 2. Research on Gender Equity in Health Services<sup>5</sup>

### 2.1 *Review of the Literature*

There is a paucity of large-scale research initiatives on gender equity as a quality of care issue even in the developed countries. One explanation may be that there has been a gap between the priorities of quality assessment research, which until recently emphasized technical competence and productivity, and the priorities of feminist research in health care, which has focused principally on women's reproductive health, an area in which the comparative focus of equity is more difficult to apply.<sup>6, 7</sup>

An interesting attempt to raise the issue of equity in general as an integral component of quality of care was made by Wyszewianski and Donabedian, in an article in which they proposed a framework for considering all equity issues in quality (class, age, ethnicity, etc.), based on the categories of structure, process, and outcome (1981). As pointed out by the authors, equity has usually been considered an issue of access to services, or an issue of health outcomes, with very little research on what they call the *distribution of quality*, particularly in the process of providing health care itself.

López (1989), in an important review of research on what he terms *patient variable biases*, concentrates on just one aspect of the problem, i.e., the unjust distribution of equal types of care, and thereby implicitly excludes the problem of inappropriate norms for different population subgroups. Even in this restricted area, he concludes that there is insufficient data and encourages further research.

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<sup>5</sup> A more extensive review of the literature presented in this section is provided in an article in press in the *Health Care for Women International* journal by Patricia Pittman and Pamela Hartigan.

<sup>6</sup> Wyszewianski and Donabedian, for instance, write that . . . *equity implies a concern with relative rather than absolute levels of quality. . . Information on one particular population group, no matter how good or how poor the care for that group, is not sufficient to establish whether there is equity or inequity* (1981:32).

<sup>7</sup> There has been important work on quality of reproductive health care from a gender perspective in Latin America, although the focus has not been specifically on identifying inequity. Research led by nongovernmental groups in this field includes the work of Matamala, Berlagosky, Salazar, and Nuñez in Chile (1994), Londoño in Colombia (1995), Davies in Peru (1995), and Pizarro in Nicaragua (1995).

The clusters of studies reviewed that have touched specifically on gender inequity were carried out for the most part in industrialized countries. The studies cover such varied aspects of the problem as:

- (1) *Differences in providers' attitudes towards female and male patients*, as revealed in "hypothetical" situations constructed with analogous research methods, such as vignettes or questionnaires (Broverman, Broverman, Clarkson, Rosenkrantz, and Vogel, 1970; Wallston, Nowacki, and Poe, 1973; DeVellis and Wallston, 1983; Bernstein and Kane, 1981; McDonald and Bridge, 1991; McCranie et al., 1978; and Phillips and Gilroy, 1985).

It has been found that providers tend to attribute to women a series of characteristics that could be termed "stereotypes," including being overexcitable, submissive, and emotional. One study found that 25% of providers felt that women made excessive demands on their time, while another showed that nurses believed hospitalized men needed more attending to than hospitalized women. Two of the seven studies found no differences.

- (2) *Differences in clinical decision-making of providers in caring for female and male patients*, including the content and quantity of information exchanged, the actual diagnosis and treatment of specific conditions, and the rigor of follow-up. These studies are contextual and utilized either direct observation or clinical records to obtain data (Wallen, Waitzkin, and Stoeckle, 1979; Broom, 1991; Tobin et al., 1987; Kannel and Abbot, 1984; Dellborg and Swedberg, 1993; Clarke et al., 1994; Kjellstrand and Logan, 1987; Wells and Feinstein, 1988; Armitage, Schneiderman, and Bass, 1979; Greer et al., 1986; Verbrugge and Steiner, 1984; Cooperstock, 1976; and Burin, Wehkamp, and Velazquez, 1990).

Two of the studies in this area suggested that women receive less information and of a lower quality than men. In diagnosis and access to treatment, significant differences have been identified in the case of heart disease, lung cancer, and kidney transplants. While such differences may not automatically be attributed to gender bias, the American Medical Association's Council on Ethical and Judicial Affairs concluded that further research on the subject should be generated.

- (3) *Differences between male and female providers' attitudes and behavior toward patients* (Franks and Clancey, 1993; Levy, Dowling, Boulton, Monroe, and McQuade, 1992; Roter, Lipkin, and Korsgaard, 1991; Zambrana, Mogel, and Scrimshaw, 1987; Majeroni, Karuza, Wade, McCreadie, and Calkins, 1993; Self and Olivarez, 1993; West, 1993; Delgado, Lopez-Fernandez, and Dios Luna, 1993; and Lurie, Margolis, McGovern, Slater, and Van Horst, 1994).

Numerous studies in this area were launched in light of the growing number of female medical students around the world. Most of these studies demonstrated that women tend to be less authoritarian in their interpersonal skills than men and thus obtain better responses from patients in terms of compliance.

- (4) *Differences in the degree of appropriateness of norms and protocols for women and men*, given both biological and psychosocially constructed differences in health needs that may exist. This includes a critique of the resource allocation for research and the androcentric biases found in much of the biomedical research, as well a considerable body of research on mental health care protocols (LaRosa and Pinn, 1993; Stacey and Oleson, 1993; Clancey and Massion, 1992; Carmen et al., 1981; Dennerstein, 1993; Jarvis, 1992; Wallen, 1992; and Lennane and Lennane, 1973).

This fourth area is vast and continues to grow. While an equity focus is more complex when considering different needs, protocols, and standards for men and women, it is also undoubtedly the most important of the four areas reviewed because of the ramifications in relation to lost opportunities to promote women's health.

## 2.2 *Challenges of an Equity Focus*

The first two areas reviewed are what Lopez has termed "patient variable studies," i.e., sex of provider or patient is employed as a variable, in order to reveal possible discrimination. The third area explores the impact of the differences in male and female providers' interactions with patients and is similar in that the main independent variable is sex.

This last group of studies, however, focuses on differences in the degree of satisfaction of needs, presenting the issue of whether norms and protocols are more appropriate for men than for women. While an equity focus is more complex, involving two (instead of just one) levels of research, it is also undoubtedly the most important of the four areas reviewed in terms of potential impact in the quality of care. An equity focus centers on the danger of utilizing norms that, because they are the product of research processes that have often ignored women, may actually be inappropriate for women. If norms are inappropriate and equity is only measured as a "patient variable" in quantifiable terms, similarities in care that appear to demonstrate the lack of a problem could actually reveal the existence of an inequity problem.

One of the most difficult issues to be faced in attempting to operationalize a gender equity focus in the area of quality of care research concerns the choice of standards against which quality is to be measured. Who defines the standards of quality?

As Donabedian has pointed out, quality is a relative concept that is perceived differently by different groups (administrators, patients, providers, etc.).

It would seem that the incorporation of previously neglected problems, such as gender equity, into quality research and management not only demands critical thinking about what is being measured and why, but also requires the incorporation of new interest groups, such as women users, into the evaluation process itself.

Wyszewianski and Donabedian, referring to equity studies in general, have made the same point in regard to the definition of standards:

. . . there is some evidence that traditional measures of quality of care, and particularly process measures based on criteria lists, useful though they are in many respects, may not be sensitive enough to detect the kinds of inequities that are of interest here. . . . We can easily conceive of results that show no inequities when they in fact exist but were not detected because the evaluation criteria did not include the explicit consideration of the special clinical and other needs engendered by age, income, education . . . [or, in this case, gender] (1981:49).

One of their recommendations for researchers of inequity is not to focus exclusively on technical competence but also to emphasize the dimension of interpersonal relations, where issues of bias in norms may be less of an obstacle.

Important work has been done in this sense in the area of women's reproductive and sexual health. The quality evaluation model introduced by Judith Bruce (1990) of the Population Council, for instance, emphasizes elements that are generally perceived to be more important to patients than to providers, such as *information exchange* and *choice* in the determination of contraception methods. Further progress clearly needs to be made in other areas of health care.

### 3. Summary of the Research Proposal

In May 1995 a research and training proposal was formulated, the research component of which received approval in early 1996 from the Spanish Agency for International Cooperation (AECI) and the International Development Research Center of Canada (IDRC).<sup>8</sup>

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<sup>8</sup> Once the research is completed, a stage is programmed to design a guide to assist in training the care providers. The guide will be prepared on the basis of the research conclusions and will make use of the research materials produced. Consideration will also be given to a similar exercise of the Gender Working Group of the Special Program for Research and Training in



The purpose of the research is to develop and test a methodology to evaluate gender equity in the socioemotional dimension of the quality of medical care.

### 3.1 *Unit of Analysis*

In conceptual terms, equity will be understood as the differences in the degree of satisfaction of the felt needs of men and women in relation to the medical care they receive. In these patterns of needs, emphasis will be placed on the differences that emerge on the basis of the gender conditions of each one.

The research will be limited to the socioemotional dimension of quality of care because differences are more likely to be found in this area, and this is the dimension of care that has priority for patients.<sup>9</sup> The socioemotional dimension, as the flip side of the technical dimension, was described by Wyszewianski and Donabedian (1981) in a review of the literature on the evaluation of the quality of medical care as being "of approximately equal importance (as the technical aspects) in evaluating care."<sup>10</sup>

Two countries have been selected for the study, Argentina and Peru. These countries contrast markedly in socioeconomic levels and health systems. However, in view of the substantial heterogeneity that characterizes the Americas, the conclusions of the study are not intended for application in the rest of the Region. Rather, the intention is to offer a methodology that can be adapted and applied in other parts of the Region in order to evaluate and improve this dimension of the quality of medical care.

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Tropical Diseases of WHO. The Group supported the preparation, based on participatory workshops, of a methodology to raise gender-issue awareness among health workers and also promoted the formulation of local strategies to improve the quality of care for women. This methodology has been successfully tested in five African countries. HDW has translated and adapted the manual for Latin America and hopes to be able to run a pilot experience in Argentina in March 1996.

<sup>9</sup> The term *socioemotional domain*, used by Roter and Hall (1989) in their work on physician-patient communications, refers to the same elements generally attributed to the interpersonal relationship. For research purposes, use of the term will be extended to information exchange and participation in decision-making.

<sup>10</sup> Wyszewianski and Donabedian use the following definition of *technical performance*: "The application of medical knowledge and technology in a manner that maximizes its benefits and minimize its risks, taking account of the preferences of each patient." However, they define the management of the *interpersonal relationship* with "the client" as "the milieu, manner, and behavior of the provider in delivering care to and communicating with the patient" (1981:34).

This research will sample selected urban populations living in extreme poverty that receive care at public health facilities. The selection of this group is based on priorities. Although problems in the socioemotional domain exist in private and public health services, there is no doubt that the problem is more acute in the most needy sectors.

This study will address the health care for two conditions: diabetes and adolescent pregnancies. The first condition, a chronic disease, was selected for several reasons. In most of the countries of the Region, programs to improve the quality of care are generally targeted at the area of maternal and child health, which generates less knowledge on care for chronic diseases. The epidemiological profile in Argentina shows that the burden of chronic disease is increasing, heightening the need for promoting improvements in the prevention and treatment of these diseases. As mentioned above, the socioemotional domain during hypertension and diabetes consultations is critical, since without patient satisfaction and the corresponding continuity of care, these diseases are almost impossible to control. Persons with these diseases seek attention at times of crisis, thereby generating far higher costs from, for example, days of work missed, drug purchases, and hospitalizations.

The second condition of the study, adolescent pregnancy, was chosen because of its epidemiological priority in the Region. Some authors have called it "the gateway to the cycle of poverty." In the population of metropolitan Buenos Aires, for example, it accounts for approximately 30% percent of all pregnancies. In addition, in terms of the costs of morbidity, mortality, and care, a direct relationship is recognized between the young age of the mother, low birth weight, and neonatal mortality in children. As for the socioemotional domain during medical visits, it would be particularly interesting to explore the views of young fathers, since most of the projects for pregnant adolescents deal exclusively with women.

These two conditions selected for study will provide a contrast, allowing for a first approximation of the relative utility of a gender equity approach toward care for chronic diseases and reproductive health. The selection of these two markedly different age groups will also provide elements of analysis because the research process will reveal similarities and differences in the problems related to the quality of care that are identified by the subjects under study.

### **3.2 *Design and Methods***

The research process will consist of two stages. The first will explore what male and female patients and physicians have to say about key problems in health care delivery. On the basis of the conclusions from the first stage, the evaluation instruments will be formulated in the second stage; they will then be applied and their results analyzed.

The general working hypotheses are that:

- There is miscommunication in the discourse concerning needs<sup>11</sup> between both the male patient and the health care provider and the female patient and the health care provider in relation to specific key problems;
- These miscommunications<sup>12</sup> are influenced by the social construct of gender relations.

### 3.2.1 *Key Health Care Problems*

*Estimated time: 10 months; March-December 1996*

Based on the literature review, a group of key problems in the socioemotional dimension of medical care will be defined. Examples of possible problems include: (1) compliance with medical recommendations; (2) patient satisfaction; and (3) information exchange. In relation to each key problem, the discourse of the following will be analyzed (1) male patients; (2) female patients, both in reference to their own care needs; and (3) physicians, in reference to the needs of both male and female patients.

On the basis of the structure of these three discourses, attempts will be made to identify the matches and mismatches. The areas in which mismatches are found will be considered to be key problems in health care delivery and will be used to formulate quality of care indicators for the evaluation in the second stage of the study.

The methodology in this first stage will be qualitative and will consist of three techniques: semistructured interviews, focus groups, and participatory observation. The participatory observation has been included in order to complement the interviews, since physician/patient dialogues occur during consultations. In fact, the investigator and physician also engage in dialogue between consultations that nurtures and complements what is expressed in interviews.

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<sup>11</sup> By *discourse* is meant a linguistic practice that expresses the universe of symbols or values of the speaker. Using an interpretive methodology, an attempt will be made to gain access to this universe.

<sup>12</sup> When the client's discourse diverges from the discourse of health providers, with different orders of values, there is a "mismatch" or miscommunication.

The interviews with patients will basically address the negative aspects of their experiences, whereas the focus groups will dwell on the positive aspects and a classification of care.

- (1) In-depth interviews with male and female patients in their homes, in which their negative experiences with health services will be investigated;
- (2) Separate men's and women's focus groups in which positive aspects of medical care<sup>13</sup> will be explored;
- (3) In-depth interviews with care providers, preferably outside working hours in order to explore their notions of their relationship with male and female patients, what they consider to be their unmet needs, and the factors that they identify as helping or hindering improvement in care;
- (4) Direct observation of physician-patient consultations in order to learn the general rules of the health care system and the most common type of interaction taking place during consultations.

### 3.2.2 Evaluation

*Estimated time: 11 months (February-December 1997)*

The second phase of the study will consist of the evaluation of the quality of medical care. The way in which the evaluation categories are defined will depend on the conclusions from the first stage. To the extent possible, only quantifiable indicators will be used (see Section 4 of the Annex for examples).

Two evaluation techniques will be used: direct observation, with a list of indicators; and semistructured interviews that will be conducted with the patients at the conclusion of their medical consultations. These techniques will be complementary; in some cases, the same indicators will be used for both. These two techniques have been selected because of the need to standardize the methodology so that it can be easily adapted and applied elsewhere in the future.

Second phase activities will include:

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<sup>13</sup> The focus group as planned would have two components: (a) the psychodrama technique, which respects the holistic perception of care, and (b) the technique of classifying the importance of the elements of care.

- (1) formulation of indicators for each proposed category;
- (2) design of the two evaluation instruments;
- (3) preliminary test of the instruments and corresponding refinements;
- (4) evaluation and analysis of results;
- (5) formulation of a methodology to be adapted in other places where interest may so warrant.

The members of the Subcommittee are requested to comment on the content of this document, the proposed methodology, and its applicability to specific conditions in their countries.

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## A FIRST APPROXIMATION: NORA'S STORY

In order to refine the proposed methodology, a first approximation to the unit of analysis was conducted in late 1995 in a municipal clinic located in an area of extreme poverty in metropolitan Buenos Aires.<sup>1</sup> Both semistructured interviews and participatory observation were employed.

The subjects interviewed included nine physicians and four patients (three women and one man). The interviews with the physicians were conducted on site during their breaks. During the working hours of the physicians interviewed, the type of care they provided for both emergency and regular outpatient needs was observed.

The interviews with the patients were conducted in their homes. The patients were identified through a community organization in a neighborhood close to the hospital under study. The selection criteria for the people interviewed were that (1) they suffer from hypertension or diabetes, and (2) they were being treated, or have been seen several times, for these conditions at the hospital under study.

Conclusions cannot be drawn on the basis of this small a sample of interviews and observations. However, one of the main themes that emerged from this field test will be described in order to provide an example of the study methodology used in the first stage, when attempts were made to identify matches and mismatches in the discourse of care providers and patients in reference to the key problem areas.

The following example is drawn from the interviews with the care providers and a female patient. This example takes up the key problem of patient compliance with medical recommendations. Compliance is considered to be an indicator of quality of care, and it has been included among what have been called "outcome indicators." Roter and Hall, for example, include it as an indicator for the quality of communication in consultation (1989).

In illustrating the methodological approach, our interest lies in (1) the structure of physician discourse on the issue of noncompliance with medical recommendations, and

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<sup>1</sup> The facility has seven beds, with an emergency care staff of three physicians, and two nurses, serving an average of 80 patients a day, as well as outpatient offices where approximately 100 patients a day are attended. The facility includes almost all medical specialties, except gynecology, pediatrics, and obstetrics, which are available in a maternal-child hospital next door. A complete laboratory and radiology service is shared with the maternal-child hospital.

(2) the structure of patient discourse on this issue. The analysis will in both cases be oriented by a gender perspective.

### 1. Physician Discourse

Patient failure to comply with medical recommendations generally seems to make physicians feel powerless and impatient. In all the interviews, the physicians identify it as a key problem of care and place responsibility for it squarely with the patient. The most frequently heard utterances were:

*They don't care about their health.*

*They only come here after it's too late.*

*I tell the family members (when they bring a patient suffering from a hypertensive crisis), "If you want to let her suffocate, don't bring her here." You'd like them to do something for themselves. It makes you want to throw up your hands.*

In response to a general question (not specifically concerning compliance) about differences in their relationship to female and male patients, most of the interviewed physicians indicated that none existed. However, when the issue of compliance among hypertensive and diabetic patients was brought up, the discourse changed. In that context, several of the physicians expressed the opinion that females are more difficult patients than males. To quote one of the female physicians, the reasoning is as follows:

*Despite the fact that women are more inclined than men to reveal data on their family life, women are bigger liars.*

The explanations offered by the physicians for possible determinants of this trait of female patients ran along two lines. The first response of one of the female physicians (without recognizing herself as a woman) was to laugh and say, "That's how it is. Women are like that." In this way the problem is seen as a fact of life and the telling of lies as part of the essence of being a woman.

The same female physician expanded on the explanation when asked to reflect further. She explained specifically in reference to diabetics that not only is a man more likely to say he cannot follow a diet, but, in many cases, he will come for the consultation accompanied by his wife, who will jump in to tell on her husband in front of the physician, saying that despite the fact that she prepares his food as the doctor has indicated, he still eats everything, keeps drinking, or continues to smoke. On the other hand, according to the doctor, a woman usually comes to the consultation alone.

The second line of reasoning was offered by another female physician who relates that:

*Women often say that they don't have any money, but that's not quite how it is. Many are well off.*

This physician then pointed to a lady reclining on a cot in the emergency room and said:

*Just look how fat she is! What do you expect (her blood pressure to be)?*

Thus, in explaining noncompliance and consequent lying by women, medical discourse identifies (1) the essence of being a woman, including the unilateral function of caring for her partner, and (2) doing what comes easiest.

In addition to these two elements, there is another one that seems to have been conceived by physicians as an immutable limitation of the medical care system and their professional responsibilities in a social environment of extreme poverty. A physician relates:

*We have many social problems that we miss, because we cannot change everything. We only take care of the medical aspect.*

## **2. Patient Discourse**

Chronic disease and the problem of complying with medical recommendations is entrenched in the complexity of everyday life; the female patient considers a multiplicity of constraints that prevent her from complying or telling the truth in a consultation. As will be seen in the following excerpts from this interview, gender constructs inevitably surface.

### **2.1 Nora's Case**

Nora is 42 years old and suffers from hypertension. The three times she has suffered hypertensive crises, she has been treated at the clinic under study. The mother of seven children, she discloses in the interview that she also has uterine cysts causing such inflammation that she appears to be seven months pregnant. As a related condition of her inflammation and multiple pregnancies, she also suffers from severe back pains.

The proposed unit of analysis was care for diabetes and hypertension, but Nora addresses the disease from her perspective. She points out:

*Everything is related. I cannot separate my hypertension from my gynecological problem because my gynecological problem has me very worried since I can't do anything about it, because I can't have the laser treatment now.*

## **2.2 A Mother Doesn't Get Sick**

Despite suffering from many health problems, Nora continues to see herself as the backbone of her household through a mirror that her family holds up to her, as appreciated in the following statement.

*If I get sick, I'll tell you, they think it is all in my head. Of course, it's inconvenient for them. As long as I'm well, they have clean clothes, a neat house. But the housework won't get done without me doing it.*

She relates that her husband never accompanies her to the doctor's. Elsewhere in the interview she recounts that when he had a "bad heart," she always went with him to the appointment. Her real reason, she confesses between chuckles, is to get the physician to pressure him to stop drinking.

## **2.3 The Children Come First**

One of the first problems that Nora mentions in her efforts to comply with the diet prescribed by the physician, is that, as a mother, it is impossible for her to set aside special food for herself.

*The first few days I'll stick to the diet, perhaps because my daughters, my sister, or my neighbors come bring me food. You just have to do it, so fine. But there comes a time when a little package of biscuits isn't enough. You can't be buying them all the time. If I cook without salt, they (the children) want to eat without salt. I boil a vegetable, they want boiled vegetable. . . .*

In addition, she places priority on the needs of her children over her own need to obtain medical care.

*The thing is that when the kids aren't in school, I can spend that money for the trip, but when the kids start school, I need that small change for them.*

## **2.4 Control of Resources and Activities**

Nora is only responsible in part for decisions on internal resource management in the family. Her husband works as a doorman in a downtown building. "A good job," she says, adding sarcastically, "Out of the 12 months of the year, he gets mugged

seven." Nora explains that on paydays her husband does not come home. He goes out to drink beer with friends, sometimes managing to spend his entire salary in a single night.

For years, Nora relates, she suffered the problem of sexual violence when he would come back drunk. She relates that she finally decided to sleep in her children's room.

*Since February, I've slept in a separate bed, and it's been a year since I had anything (money) for food. It's like you have to sell your body to your own husband just to . . . . You see? . . . Now his violence is not giving me money.*

In the same way that sexual control is tied to money, she relates that her husband also controls her activities using money as a reward or threat. She used to help out in the neighborhood children's soup kitchen.

*If I go run an errand for the kitchen, it's because I "have somebody else" and so forth. I gave up. I don't go out, but just the same he won't give me any money.*

Thus, Nora has pointed out three elements that influence her control over household resources: her husband spends money on alcohol, her husband deprives her of money because she will not acquiesce to his sexual demands, and her husband denies her money if she goes out to take part in neighborhood activities. This situation affects Nora's ability to pay for transportation, medicine, and special foods, all of which are necessary for compliance.

## 2.5 *The Consultation*

Nora's view of the consultation itself affords other elements of analysis. She relates that she knows she will not be able to comply with many of the recommendations the physicians give her, but she states:

*They don't give you a chance to say, "Doctor, this diet here, I won't be able to stay on it," because it's as if they placed themselves on such a higher level. . . . They give you the prescription and don't worry whether you can buy it.*

As for her inability to comply with a recommendation, Nora relates her emotions and strategies:

*And I think no one likes to be confronted or to go back to the same doctor without having been able to have a test. So we usually don't go back to the*



*same hospital, and we have clinical histories in all the hospitals, and we say, "Gee, I'm not going to go to this hospital any more because they want me to do this or that, and I can't do it." For instance, with the back doctor, have you got any idea how long it's been since I went to see the traumatologist? Because it is written down in my clinical history that I cannot sweep, that I cannot exert myself, that I can't get pregnant. . . . I didn't go back to that traumatologist because I had three more pregnancies.*

Asked what she believes would have happened had she told the traumatologist what had happened in her life, Nora reflects:

*I don't know if it's like this for everyone, but most of the women that I know go through the same thing. It's not because of religion or fear, but because we women sometimes won't ever say what really happens to us. I lied for many years about the whole sex thing with my husband. I'll tell you that when I spoke about it to my daughters, I could speak out. But for that to happen, I had to wait until my daughters were grown up. Today I feel like I can tell it to you, but a year ago I wouldn't have told you even if I'd been drinking. Because one lives a bad life.*

### 3. Miscommunications

It is clear from the structure of Nora's discourse how noncompliance is related to her economic circumstances, and how these in turn are permanently and in many ways affected by her gender situation. That she has no one to care for her, gives priority to the children, and lacks control over resources are all part of her gender construct. These factors, obviously, do not prevent her husband from complying with medical recommendations. In any case, there will be other factors, perhaps also related to his gender situation, that will affect his compliance.

The miscommunications in the physician discourse are rooted in the concept of the health/disease process. Nora is aware of the interrelationship of her many health problems when she considers the possibilities of recovery, although staying on a diet in order to reduce her blood pressure is apparently a lesser concern. On the other hand, the physician who sees her when she suffers a hypertensive crisis focuses his response exclusively on controlling that disease.

The miscommunication is even greater if the care providers' view of the "sick patient" is compared with the way that Nora sees herself, in which she is meeting the demand of her family to be their "mother" and source of support. But the role of mother who sustains others is seen by her family, and therefore by Nora herself, as incompatible

with the role of "patient." Her husband treats her as if she were crazy if she plays the role of a patient and seeks attention.

Nora knows that this situation is unfair. She clearly states that she can only keep her diet when her sister or neighbors spend the first few days with her. But her life is full of conflicts. In light of Nora's situation, the medical discourse fails to acknowledge the contradiction between the role prescribed to her—of the patient who tries to recover under doctor's supervision—and her traditional gender role—the mother who responds to the needs of her children and husband.

Along the same line, it is important for Nora to be "cared for" by others since she can only keep the diet when her sister or neighbors help her the first few days.

Another gap in the physician's discourse emerges with regard to "the social cases" outside their sphere of influence. By contrast, Nora sees the physicians as a higher level of authority than her husband, one to which she can appeal and speak out about his drinking.

Putting the children first definitely limits Nora's prospects for compliance. However, in this case the issue does not arise in the physician discourse, although it could be construed that there is strong reinforcement, starting with the pediatric service, for her role as the one who sacrifices herself in order to rear her children.

On the issue of access to resources, the medical discourse reflects the suspicion (probably tied to the idea of women lying) that the patient is making up an excuse to hide her irresponsibility when she attributes her inability to comply to a lack of money. On the other hand, Nora's discourse reveals the mechanisms of the gender system that subordinates her to her husband, who uses money to exercise power over her.

Finally, about the consultation situation, Nora identifies the unilateral style of doctor-patient communication, in which the physician gives orders, as a barrier to her giving advance warning that she cannot comply with the recommendations.

Finding herself in a situation in which she has failed to comply, Nora perceives two options: (1) not to return to the physician or (2) to lie.

The circle of misunderstandings is completed when this attitude on the part of a patient such as Nora is understood by the physicians as being "typically" feminine, or as evidence that she does not care about her own health.

#### 4. Conclusions

Using the key problem of compliance, several examples of miscommunication in the discourses of a patient with hypertension and a group of internists have been identified. The influence of gender relations on these breakdowns in communication was also clearly seen.

The case presented here is only an example of the proposed methodology. There remains the work of incorporating (1) an analysis of the male patient discourse, and (2) the data gleaned in the participatory observation of the consultations. Using this case, one can further explore the articulation between this first qualitative stage and the second stage in which instruments will be formulated to evaluate the quality of care.

In proceeding to the second stage of research, the key problem of compliance becomes an analytical category of evaluation. The specific examples of miscommunication will guide the definition of the indicators for this category. This case is concerned with the quality of care indicators developed for women. They will also be developed for men.

On the basis of this example, three types of indicators<sup>2</sup> can be envisioned.

(1) The situation when giving recommendations. For example:

- The number of women that receive explanations of the reason for recommendations (medication, analysis, diet, exercise, etc.)

Total women covered in the sample

Number of women asked (a) if they will be able to comply with recommendations or (b) what factors would impede compliance.

Total women covered in the sample

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<sup>2</sup> The observation guide will include definitions and examples for each indicator that are as specific as possible so that the indicators that require observer interpretation—such as the aforementioned "sarcasm" or "indifference"—have minimum subjective content. Nevertheless, as indicated in the summary of "design and methods," these same indicators will be measured from two different angles: observation and the consumer survey. Thus, if the values assigned to an indicator coincide with both instruments, its validity will increase.

- (2) The situation of reproach, either for not complying or lying, expressed in different ways. For example:
- Number of women confronted over noncompliance.  
Total women covered in the sample
  - Number of women subjected to sarcasm in relation to noncompliance.  
Total women covered in the sample
  - Number of women treated with indifference in relation to noncompliance  
Total women covered in the sample
- (3) The situation of seeking solutions: Is there discussion of possible obstacles to compliance and problem-solving strategies, which in the case of women, would include:
- Number of women invited to talk about their situation regarding access and control of money in their households  
Total women covered in the sample
  - Number of women invited to talk about their situation of being the last one to eat  
Total women covered in the sample
  - Number of women invited to talk about the situation concerning possible sources of family or local support for complying with recommendations  
Total women covered in the sample

These examples of possible indicators were formulated and would be subsequently interpreted within the framework of gender analysis.

It is important to point out that the basic criteria in formulating indicators will be to select those elements, emerging from the breakdowns in discourse, that offer possible improvements in the quality of care. In other words, the final goal that will guide the research at all times will be to reduce the communications gap between patients and health care providers and, in general, to better meet the shared and specific needs of men and women in the population under study.