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# Women and Health Care: Exploring the Communication Dynamic Between Women and Their Doctors

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Women and Health Care:  
Exploring the Communication Dynamic Between Women and Their Doctors  
Mairin McCurdy  
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### **Abstract**

This is a qualitative study examining the effects of the communication between patient and doctor on the self-concept of female patients. The researchers will use a combination of the Health Belief Model, which studies the individual constructs and beliefs that one feels and how this affects decisions made about health, and the Spiral of Silence, which explores how minority groups stay silent for fear of retaliation. Through the scope of these theories, the researcher will attempt to understand how insufficient communication on the part of the doctor, both in situations of diagnoses and in general practice, impacts how the female patient perceives herself and her own well-being.

**Keywords:** Doctor-Patient Communication, Health Belief Model, Spiral of Silence, Gender, Self-Concept, Well-Being

### **Introduction**

While the issue of health care is a topic currently popular in American culture, many do not recognize that the lack of communication between female patients and their doctors has negatively impacted women's self-concept. Several researchers agree that women, as a whole, have been suffering under current standards of health care (Muturi & An, 2010; Schneider & Tucker, 1992). Many women feel ostracized by their doctors, whether it is because they do not have an adequate level of literacy about their specific health needs (Schmidt, Kowalski, Pfaff, Wesselmann, Wirtz & Ernstmann, 2015), a cultural stigma surrounding a specific issue (Muturi & An, 2010; Chien-fei & Lu, 2013), or because they are being mistreated by their doctor, most of whom are male (Sobnosky, 2013).

There is a significant lack of research surrounding the diagnosis process for women – specifically women who believe they might have a disease or disorder that affects women at higher percentages than men (Sobnosky, 2013). This seems to be because there is a lack of information about these types of diseases in general, and our society is just beginning to openly address these diagnoses that have had a negative stigma placed around them. While the physical health of these patients is highly important, this phenomenon is also taking a toll on the mental health of these same women; negatively impacting their self-concepts (Schneider & Tucker, 1992). And it does not stop there. Studies show that when a woman goes to her health care provider for a simple check-up, without the worry of a disease, they still tend to be treated with less respect than their male counterparts (Chien-fei & Lu, 2013).

The purpose of this study is to understand how women could possibly be impacted by having a more inclusive voice while communicating with their doctors. Very few studies in the health communication field have been centered around the self-concept and well-being of the

female patient alone. For this reason, as a researcher, I felt it essential to study the perspectives of women who have been left out of these studies to date; how they communicate with doctors, how they cope with ineffective communication, and how this affects their ideas of themselves and their health care decisions.

## **Literature Review**

### **Historical Background**

The history of women's health care in the United States is a somewhat sordid tale. Most women's health issues, no matter what symptoms were presented, were treated as mental illnesses. As mental illness carries a highly negative stigma, even to this day, the woman suffering was often sent away to "recuperate" as far away from her normal life as possible (Johnson, Bottorff, Browne, Grewal, Hilton & Clark, 2004). One of the most famous cases of this being that of Nellie Bly, the reporter who admitted herself to a women's mental institution in the late nineteenth century in New York and exposed the horrible abuse that women there were being subjected to – some of them for as simple of a reason as they did not speak English (Chokshi, 2017).

While these atrocities do not occur on the same scale any more, it is still commonplace to see women's opinions about their own bodies being brushed aside in favor of whatever a doctor believes to be true. While this approach can work well in many situations, there are an equal number of women who have gone undiagnosed and untreated because their health care provider did not believe or consider what they were saying (Lee, Ozanne & Hill, 1999; Schneider, Tucker, 1992). Being ignored about your own health then leads to these female patients having negative feelings about themselves and their own bodies, creating a negative self-concept (Carpenter, 2010). It is the intent of the researcher to study what went wrong in the communication between

female patients and their doctors in these situations, and how these women's perceptions of themselves are being affected.

### **Doctor-Patient Communication**

The intricacies of the relationships between doctor and patient are challenging to study, because a researcher cannot be present during an appointment to observe them. Therefore, we must rely on the opinions and reflections of female patients after the fact, which is what researchers in the field of health communication have done. Based on interviews and surveys, studies have proven that 40% of Americans have low levels of emotional well-being, and that the relationship with their doctor plays a noteworthy role in improving emotional health (Jiang, 2017). Most people report a positive relationship with their health care providers when said providers use a patient-centered model of communication (Jiang, 2017), which emphasizes the importance of listening to the patient without interruption, prompting open-ended questions, and attempting to understand the situation from the perspective of the patient (Hashim, 2017). However, these studies were done with both male and female patients. In fact, very few studies have been completed exclusively surrounding communication between female patients and their doctors; with the exceptions of pregnant women and women with breast and cervical cancers.

### **Effects of a Lack of Communication**

For the patients of doctors who do not practice a patient-centered approach, both emotional well-being and trust in their physician is much lower. Reports of doctors who do not answer questions satisfactorily, do not seem open minded towards the ideas of their patient, and do not seem to display a sufficient level of health literacy about a given subject are high (Tsimtsiou et al., 2012). The complex dynamics between female patients and health care professionals can begin to be understood through the lens of the Health Belief Model, while the

effects of this problem can be studied through the Spiral of Silence; both of which can aid in changing the current health care standards (Carpenter, 2010; Neuwirth & Frederick, 2004). The Health Belief Model posits that an individual will take a health-related action if that person believes that taking said action will help them avoid negative help, and if they deem that they can complete the action successfully (Carpenter, 2010). If the individual does not take the health action, the Health Belief Model studies four potential factors; perceived susceptibility, severity, benefits and barriers in an attempt to discover why that individual did not take action (Carpenter, 2010). The Spiral of Silence theory states that individuals have a fear of isolation, and a belief that if they state their opinion, there will be a consequence, possibly worse than isolation (Neuwirth & Frederick, 2004). Stress affects everyone differently, but in situations so potentially life-changing as getting a negative diagnosis, it tends to affect not only the mental health, but the physical health of the patient as well (Patel et al., 2013). In this study, the researcher will seek to isolate both the primary appraisal and the secondary appraisal from a pool of participants, hoping to determine how much stress they determine themselves to be under after an initial meeting with a doctor, and then, based on that level of stress, how their self-concept is impacted.

### **Physical and Mental Well-Being**

While not every female patients' self-concept is negatively impacted because their doctor refuses to believe medical symptoms, this is a large part of why women report feelings of dissatisfaction with their health care provider. In a viral video produced by BuzzFeed, with more than one million views, five women recount interactions they had when their doctors failed to prescribe treatment (Williams-Hauwanga, 2017). After just one viewing of this video, it is apparent that the way these women viewed themselves was altered by the disbelief of their doctors, someone they trusted. Unfortunately, because there is so little research focused

singularly on women in this situation, this video is some of the best information about the impact of doctor-patient communication on self-concept. Therefore, the researcher plans to study the following question:

RQ1: How can a more inclusive female voice in doctor-patient communication impact their self-concept?

## **Methodology**

### **Qualitative**

The researcher will conduct a qualitative study in hopes to provide data to be compared to a larger group. In contrast to a quantitative study, the personal experiences gathered from a focus group will deliver the researchers with much more in-depth data from a sample group which can then be used to represent women in America; making the data statistically representative (Hashim, 2017; Tsimtsiou, Benos, Garyfallos & Hatzichristou, 2012).

### **Method Selection – Focus Group**

This study will be centered around a focus group. Members of the group will be asked to attend a scheduled meeting time in which they will be asked to participate in a discussion, consisting of questions assessing their perception of and satisfaction with their doctors, as well as how interactions with said doctors affect the way they feel about themselves. Beforehand, all participants will be asked to complete a consent form and a demographic form. The focus group method will allow for a great number and diversity of participants, as well as more detailed and reflective information (Beach & Dozier, 2015).

### **Variables**



The focus group will examine the relationship between the independent variable of communication between patients and their doctors, and the dependent variable of the resulting self-perception of patients. A focus group method of collecting data will allow for the researcher not only to observe individuals and their responses, but the interaction between participants as well, allowing for even more data to be collected. These variables will be operationalized through the Health Belief Model – specifically looking for individuals’ perceived susceptibility, severity, benefits and barriers about the communication between their doctor and themselves and how this influences their self-concept (Carpenter, 2010). Additionally, the Spiral of Silence theory will be used to study the impact of communication on self-concept, in terms of whether the communication made them feel as if they were safer staying silent (Neuwirth & Frederick, 2004; Carpenter, 2010).

### **Setting & Sample**

This study will take place on the campus of Western Washington University. Because the study relies on the disclosure of the participants, their comfort is important, so we will set them up in a smaller lecture room, with the chairs in a circle. The participants for this study will be a range of ages, ethnicities and socioeconomic statuses – we would like as much diversity of experience as possible; although they all will be residents of the greater Bellingham area. The population will include forty participants, with an age range from eighteen to seventy years. The researcher will ask questions to the group, and will attempt to foster an environment of discussion (Beach & Dozier, 2015). The participants will be broken into two groups of twenty over the course of two days, so that everyone has a chance to be heard.

## **Procedures**

### **Sampling Technique**

This study will use stratified sampling to regulate participants, because each participant has at least one thing in common – they are a female who goes to a doctor. To attract participants, the researcher will send a mass email to Western Washington University students, create a Facebook event, post flyers around town, as well as in some doctor's offices (with the permission of the doctor). All volunteers ages eighteen to seventy will be accepted, unless there are too many of one demographic or too many patients of a singular doctor (Hashim, 2017).

### **Method of Gathering**

To gather this data the researcher will require the participants to sign both consent and demographic forms, only after being informed by the researcher what the study will require of them. Furthermore, the study will necessitate the use of a room on Western Washington University's campus for two days, so the researcher must speak with facility management to sign up for a designated time. Additionally, there will be a short questionnaire for each participant to fill out, consisting of basic questions revolving around individuals' perception of and satisfaction with communication with their doctor, to help facilitate discussion (Beach & Dozier, 2015).

### **Validity and Reliability**

The qualitative method of a focus group has strengths and weaknesses as a methodology. It is useful for obtaining detailed, personal information from participants, as well as being able to observe how the group interacts with each other and how this impacts their answers. The researcher will acquire a broader range of answers than they might from a survey. However, the group setting may result in disagreements or tangents that become hard for the researcher to control, and it may be more difficult to recruit participants (Beach & Dozier, 2015).

The focus group method is high in internal validity, because the research findings will be an honest reflection of the reality that participants experience (Brink, 1993). External validity, however, might be more difficult to obtain, because the reflections of this specific group of women – all residents of Bellingham – may not represent the reality of all women across the country (Brink, 1993). Although, the use of the stratified sampling technique may help in collecting more diverse data, making it more generalizable (Beach & Dozier, 2015).

### **Ethics**

Participants of this study will be informed of the purpose of the research from the initiation of the process. This allows for the participants to reflect on their experiences before focus group sessions. They will be verbally informed at the commencement of the focus group, as well as being provided with a print out to refer to whenever needed. As well as obtaining consent from participants, the researcher will acquire approval from the Western Washington University human subjects board and will comply with any rules or regulations (Beach & Dozier, 2015).

The foremost ethical concern within this study is the boundary of doctor-patient confidentiality and the potential for career-harming information about doctors to be published. To combat this, the names of doctors and participants will be withheld in the release of the study. There will be no deception of participants, the researcher will be asking participants to reflect on their own self-concepts and believes that deception would be counterintuitive (Tang & Chen, 2013). The benefit of this study will be increased inclusion of female voices and perceptions in the medical community, especially in the fragile area of doctor-patient communication, with the long-term goal of improving self-concepts of female patients that have been harmed by doctors.

## **Implications & Conclusion**

### **Implications**

Women have long been a marginalized group when it comes to their health. Women need to be concerned about this for themselves, but everyone should be equally motivated to maintain the physical and mental well-being of the women in their lives. This study will help to give a voice to this community and aid in starting a larger conversation about the issue. The effects of this study could potentially be far-reaching, changing policies in doctors' offices and the curriculum in medical schools to be more patient-centered and inclusive of female patients' voices (Hashim, 2017). It also delves into an area that has been woefully neglected by the academic community for years, broadening our horizons of knowledge in the health communication field (Carpenter, 2010).

### **Conclusion**

It is time to pull back the curtain on women's health and study the doctor-patient communication barriers that tend to effect female patients more than men. It is vital that we value the personal understandings of women experiencing poor doctor-patient communication, and work towards completing effective research on how to include female voices in the process. This study explores existing theories and text by utilizing the Health Belief Model (Carpenter, 2010) and the Spiral of Silence Theory (Neuwirth & Frederick, 2004) to analyze the accounts of female participants. Furthermore, the researcher seeks to discover the relationship between inefficient communication from a doctor, the patients' perception of their health and the resulting self-concept of the patient. Female patients have historically had a much more complicated relationship with their doctors than men, and this study hopes to open the doors into a new era of research on the subject, centered around the personal experiences of women themselves.

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CONSENT FORM

**Purpose and Benefit:**

Researchers are interested in the link between communication between doctors and their female patients, and the resulting self-concept of said female patients. The purpose of this study is to allow us to better understand the role of communication between doctor and patient and its effects. The results of this study will enable the academic community, and communication scholars to better understand and adapt communication in the health communication field.

**I UNDERSTAND THAT:**

This experiment involves the submission of my personal health experiences to be viewed by others participating in the experiment, and that the level of self-disclosure and self-concept during discussion will be evaluated by both the researchers.

There is no anticipated harm or discomfort involved in this study, however if at any point I feel uncomfortable I may choose to withdrawal from the experiment and my demographic form and personal account will not be used for this study.

My participation in this experiment is voluntary; there will be no monetary compensation received my involvement in this study.

All information is confidential; my signed consent form will be kept in a locked cabinet, separate from the questionnaires and demographic forms, which will not have any identifying information on them.

My signature does not waive my legal rights for protection.

If you have any questions about your participation or your rights as a research participant, you can contact the WWU Human Protections Administrator (HPA), (360) 650-3220.If during or after participation in this study you suffer from any adverse effects as a result of participation, please notify the researcher directing the study or the WWU Human Protections Administrator.

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**I have read the above description and agree to participate in this study.**

\_\_\_\_\_  
Participant's signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Participant's name PRINTED

NOTE: Please sign both copies of the form and retain the copy marked "Participant."

PARTICIPANT DEMOGRAPHIC FORM

Sex:  Male  Female

Gender you identify with:  Male  Female  Other

Class you identify with:  Upper  Middle  Lower

Age: \_\_\_\_\_

Race: \_\_\_\_\_

How long you have been seeing your doctor: \_\_\_\_\_

### **Instrument Rationale**

For the purposes of this study, a short questionnaire will be utilized to give a loose structure to the focus group interviews, which will be largely discussion based. Five questions will be asked and participants will be required to answer on a scale from one, meaning strongly agree, to five, meaning strongly disagree. This instrument will not be relied on for a majority of the data, and therefore is valid as a starting point.

**Questionnaire**

1) I feel that my doctor is trustworthy.

1	2	3	4	5
Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree

2) I feel supported by my doctor.

1	2	3	4	5
Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree

3) I have little hesitation taking medical advice.

1	2	3	4	5
Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree

4) I feel that I have not been fully heard or understood by my doctor.

1	2	3	4	5
Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree

5) I feel bad about myself after leaving the doctor's office.

1	2	3	4	5
Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree