Disparities in care often are in the news. The lack of women in early cardiovascular disease research resulted in physicians failing to recognize how gender may influence the presentation of illness by a patient. Women are more likely to have completed advance directives, informing physicians of their wishes when faced with difficult health care choices, than men. And of course, there are studies showing women physicians are more likely to follow guidelines or provide better care. This last category results in much gnashing of teeth by male physicians and is often prominently displayed in the newsfeeds for the public and physicians.

A new study [2] in the Quarterly Journal of Medicine looks at how male and female physicians use the scarce resource of ICU beds. It has not featured prominently in the newsfeeds, perhaps because it runs counter to the narrative that women are better physicians. The retrospective study looked at 831 patients admitted to an intensive care unit (ICU) from the Emergency Department in an Israeli hospital over a two year period. The ICU in this hospital is a closed unit; only specific physicians can admit patients to the ward; unlike open units, a more frequent type found in the US, where any physician can admit a patient.
Patients, especially sick ones, have a range of severity. The researchers adjusted for a variety of factors including those they required mechanical ventilation or the institution of intravenous medications for life support, their initial heart rate, the rate of breathing, temperature, and their initial laboratory values. Despite adjustments, female patients were older, more anemic, less nourished and had a higher rate of dementia – dementia is often seen as a quality of life issue and a reason not to “squander” scarce resources. Male patients were often less stable in the emergency department requiring more mechanical ventilation and medication for life support.

Among the physicians, more women were trained in Emergency Medicine as compared to other specialties and were more recent graduates than men although neither was statistically significant. The only measure of care that differed was that male physicians saw more patients transported by EMS or directly placed in the area of the emergency department that receives the most direct attention.

- Women patients cared for by women physicians showed the lowliest likelihood of admission to ICU
- Male patients cared for by male physicians showed the highest probability of admission
- Male physicians with female patients and female physicians with male patients fell in between
- Fewer women were admitted overall, and fewer female physicians authorized ICU admission
- The interactions of gender had no impact on in-hospital mortality as well as 30, 180 and 365-day deaths.

Amongst physicians, we often speak of gates, who let anyone into the hospital or ICU, and walls, who let no one in. At least concerning patients of their gender, female physicians acted like walls.

The study has its flaws, single center, scarce resources, the decision to admit was made in consultation with the receiving physician in the ICU, and there was no one measure of severity that could be applied to all patients. All that the study demonstrated was that men and women judge patients differently. But that is no different than the other deeply flawed studies that made the evening news. Why was it not announced in anyone’s news feed? I would suggest that the reason was not the sudden realization that the study was flawed, but the fact that the findings did not fit the narrative that women physicians are better than men.

You can see the contortions that the researchers went to when they realized their findings in the discussion. They make a big point that women are more risk adverse and “prefer more conservative strategies with lower risk.” Women were more likely to perceive an unfavorable outcome and made a less risky choice. I would find that a reasonable generalization. But when faced with a sick patient, the less risky alternative is to place them in a higher level of care, in the ICU, not on the ward. If women were acting from a position of risk adversity, they would admit more patients to the unit, not less.

One last thought, and perhaps it reflects my age and fossilized views, but this line hit me as a bit odd, perhaps I should get used to hearing it. “In this study, we refer to the term “gender” as it is explained by a person’s self-representation as a man or a woman, which may impact the individual response to clinical scenarios, rather than pure biological differences.”
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[1] https://upload.wikimedia.org/wikipedia/commons/2/22/ICU_Diana_1.jpg