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CLINICAL CASE
Gender Stereotypes in Pain Diagnosis
Commentary by Andreea L. Seritan, MD, and Scott M. Fishman, MD

Mrs. Robertson was seeing her primary care physician of many years, Dr. Samuels, for back pain.

Mrs. Robertson had always led a busy life and was constantly on the go. She worked full-time as a financial analyst and was active in the Parent Teacher Association at her children's school; her husband was a regional sales manager for a large company.

During her previous visits, Mrs. Robertson described herself as "pretty healthy." Her family history included a father and cousin with high cholesterol and an aunt with arthritis of the hands. She had no hospitalizations other than for childbirth, and her only surgery was for a cesarean section at the birth of her second child.

Mrs. Robertson had seen Dr. Samuels earlier in the month because she had lower back pain that had started after she awkwardly bent down to lift a box. Though Dr. Samuels believed the back pain would resolve on its own, he ordered imaging and lab tests for evaluation at his patient's insistent request.

Mrs. Robertson returned to Dr. Samuels' office to find out the results. At this visit, Dr. Samuels started with his usual greetings and learned that Mrs. Robertson's back pain was unchanged. She indicated that she was eager to hear her test results, which, he revealed, were negative.

"This is great news, as the tests do not show an underlying disease or injury causing your back pain," Dr. Samuels said in an encouraging tone.

Mrs. Robertson sighed with relief. She replied, "That *is* good news. I was worried I might need surgery or something. But I'm still having this back pain and it's really affecting my life. What should I do now? I think I might need something stronger than ibuprofen for the pain."

Dr. Samuels considered Mrs. Robertson's comment for a moment. In his clinical judgment, based on the diagnostic test results and the nature of his patient's injury, Dr. Samuels decided to follow a conservative course for a while longer. Thus he responded, "I believe that continuing to take over-the-counter pain medications and doing the stretching exercises we talked about during your last visit is still the right

treatment plan. I understand that the pain is frustrating, but I think we need to give it more time before taking more aggressive action."

Mrs. Robertson immediately protested, "When my husband Larry strained his back, you gave him Vicodin for the pain, and all of his images and tests were negative."

Dr. Samuels paused in reflection. What Mrs. Robertson said was true; even with negative imaging results, he had prescribed opioid pain medications for her husband's back injury. Dr. Samuels found that his male patients were less likely to exaggerate pain. He also had the experience—and research statistics—that demonstrated that men tended to see the doctor only when absolutely necessary. Was he biased because Mrs. Robertson was a woman? Was it fair and within the standards of medical practice to treat these two people with the same symptoms differently?

Commentary

Sex and gender, age, ethnicity, cultural background, and personal history are some of the variables that can impact communication between a physician and a patient. For the purposes of this article, and in keeping with much of the recent literature, I use gender to refer to a social or cultural category and sex to refer to a biological classification. The patient-physician encounter, with its goal of restoring or maintaining health and well-being, can be a microcosm of the patient's interpersonal relationships. Personality traits, preferences, and values come into play on both sides of the dialogue, and, as much as health professionals take comfort in believing we are fully objective, we are all affected by our own biases or assumptions. It is how we manage these influences that determines how they affect the care we provide.

Appreciating and factoring in our own normal human responses in patient care is a key to avoiding misjudgments, mistakes, and injury to our patients and ourselves. This becomes even more important as escalating economic pressures reduce the amount of time we have to spend with our patients. It is understandable that patients report feeling rushed, not listened to, and misunderstood. If a patient is anxious, she might not be able to communicate her needs and concerns effectively and may be too easily dismissed because the physician does not have the time or economic motivation to explore her complaint in greater depth.

Such was the case with Mrs. Robertson, whose physician appeared to treat her back pain reflexively, with weaker, rather than stronger, analgesics. The exact factors influencing Dr. Samuels' decision are not clear and may have been guided by a complex interplay of biases and reactions. But in light of the stated disparity in care between the (apparently) similar symptoms of Mrs. Robertson and her husband, gender bias seems, at least in part, likely. As alluded to in the case, women are generally recognized as having higher utilization rates of medical care services [1]. In our scenario, we see that Mrs. Robertson is clearly familiar with Dr. Samuels and their greetings quickly progressed to a brief discussion of the unchanged pain, relief at the negative imaging findings, and a hasty recommendation of over-the-counter

analgesics, despite Mrs. Robertson's disclosing that her pain was impairing her function.

The available background information on Mrs. Robertson suggests that she is neither capricious nor untrustworthy. She is a full-time working mother who is active in her community through the Parent Teacher Association at her children's school. There is no indication that she plans to "slow down." On the contrary, she is bothered by the impact her back pain is having on her life. She describes herself as "pretty healthy," and there is no evidence of multiple hospitalizations or repeat office visits with Dr. Samuels. The case tells us that Mr. Robertson is a regional sales manager, a job that may involve travel and may make him less available at home. If hers is a traditional family, where childcare falls mostly to the mother, Mrs. Robertson is probably under a fair amount of stress, despite appearing to manage the pressures of her complex "on the go" role.

As a result of Dr. Samuels' response, the patient may feel like her complaint is not heard or is minimized, and she might be inclined to be more proactive than she would otherwise, pushing for diagnostic studies or additional medications. Under these circumstances, a patient might amplify symptoms or demand more complex testing to justify concerns that are being ignored. This, in turn, might lead the clinician to assume that the patient is histrionic, perhaps suffering from emotional rather than physical symptoms, and ultimately that the patient's report of her symptoms is unreliable. Such traits are often mistakenly attributed to all females and are an important part of the gender bias that may have influenced this case.

Gender differences can have significant influence on patient presentations and physician response. While women tend to report greater amounts of pain than males, physicians are more likely to recognize severe pain in women than in men [2]. A recent general population study investigated the course of medically unexplained pain symptoms over a 12-year interval [3]. Women had twice the likelihood of having persistent pain symptoms as men. The only other significant predictor of medically unexplained pain symptoms was depression, which raised the likelihood of pain complaints threefold [3].

In the absence of adequate physical findings on repeated examinations, a competent physician will consider somatoform disorders as part of the differential diagnosis. Somatoform pain disorder—diagnosed as pain disorder in the *Diagnostic and Statistical Manual of Mental Disorders* [4]—has a lifetime prevalence of 12 percent and a 6-month prevalence of 5 percent in the general population and occurs twice as frequently in women as in men [5]. The key in diagnosing somatoform disorders is the absence of explanatory findings on physical examination or ancillary tests. When psychological factors are believed to have an important role in the onset, severity, exacerbation, or maintenance of pain, a diagnosis of pain disorder becomes more likely [4]. Taking sex into consideration, Mrs. Robertson has a greater chance of developing a somatoform disorder than her husband, although there is no indication

of recent negative events in her life. Onset of somatoform disorders is usually closely correlated with a severe stressor.

When a thorough medical workup has proven unremarkable and the presence of psychosocial stressors is thought to be a key to understanding unexplained physical symptoms, the physician should initiate open-ended conversation with the patient about any such possible events; he or she should not represcribe an over-the-counter analgesic and be done with it. The concern in our case is that Dr. Samuels, aware of these prevailing patterns, may not be giving Mrs. Robertson's pain experience the attention it deserves. Had he taken several additional minutes to listen, he might have been able to assess and address recent stressors in his patient's life.

Recognizing the differences between men and women in reports of pain and in psychiatric disorders can, in isolation, lead the otherwise genuinely concerned and well-intentioned clinician toward a gender bias and a self-serving position of relinquishing responsibility for diagnosing and treating symptoms effectively.

References

1. Bertakis KD, Azari R, Helms LJ, Callahan EJ, Robbins JA. Gender differences in the utilization of health care services. *J Fam Pract*. 2000;49(2):147-152.
2. Bertakis KD, Azari R, Callahan EJ. Patient pain in primary care: factors that influence physician diagnosis. *Ann Fam Med*. 2004;2(3):224-230.
3. Leiknes KA, Finset A, Moum T, Sandanger I. Course and predictors of medically unexplained pain symptoms in the general population. *J Psychosom Res*. 2007;62(2):119-128.
4. American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders.* 4th ed. Text Revision. Washington, DC: American Psychiatric Association; 2000:232-234.
5. Grabe HJ, Meyer C, Hapke U, et al. Somatoform pain disorder in the general population. *Psychother Psychosom*. 2003;72(2):88-94.

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