Not Too Old, Not Too Young: Older Women's Perceptions of Physicians*

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RÉSUMÉ

Les femmes plus âgées interagissent avec les médecins plus souvent que les hommes âgés et les personnes plus jeunes; pourtant, la connaissance et la compréhension de leurs expériences avec les médecins sont limitées. Le but de cette étude était d'étudier les perceptions des femmes âgées de leurs interactions avec les médecins et d'identifier ce que les femmes veulent de leurs médecins. Les entrevues en profondeur avec 30 femmes âgées montrent que la majorité veulent être impliquée activement dans leurs propres soins de santé. Dans la relation patient-médecin, les femmes donnent généralement la priorité aux qualités personnelles de médecins et leur comportement à l'égard du patient. Pour de nombreuses femmes, l'âge et le sexe du médecin ont aussi leur importance.

ABSTRACT

Older women interact with physicians more frequently than older men and younger persons, yet knowledge and understanding of their experiences with physicians is limited. The purpose of this study was to investigate older women's perceptions of their interactions with physicians and to identify what older women want from physicians. Findings from in-depth interviews with 30 older women reveal the majority want to be actively involved in their own health care. In the patient–physician relationship, the women typically give priority to physicians' personal attributes and behavior towards the patient. For many of the women, the age and gender of the physician also matter.

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Keywords: aging, older women, physicians, patient-physician relationship, health care, symbolic interaction

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Older women interact with physicians more frequently than older men and younger persons, yet studies investigating their experiences with physicians are sparse (Tannenbaum & Mayo, 2003). The older-patient–physician relationship has, however, long been a topic of research interest (Adelman, Greene, & Charon, 1991). Research indicates, among other things, that older patients may experience ageism (Meisner, 2012). For example, physicians may be condescending, and symptoms of disease may be attributed to normal aging (Greene & Adelman, 2003). Physicians may spend less time with older patients (Radecki, Kane, Soloman, Mendenhall, & Beck, 1988), discount their medical problems (Black, 2000), and provide them with fewer proven medical therapies, or different treatment options (Maly, Leake, & Stillman, 2004), than are provided to younger patients (Cherubini, Corsonello, & Lattanzio, 2012). Physicians, furthermore, are less likely to recognize and treat depression in older adults (Burroughs et al., 2006; Koenig, 2007). Evidence suggests that older patients are less likely to prefer an egalitarian patient–physician relationship and shared decision-making style than younger patients (Adams, Price, Tucker, Nguyen, & Wilson, 2012). Older patients tend to be more passive

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than younger patients (Beisecker, 1996), are less likely to ask doctors questions (Weitzman & Weitzman, 2003), and are not as inclined to challenge physician authority (Bastiaens, Van Royen, Pavlic, Raposo, & Baker, 2007).

Women are more likely to seek medical attention than men (Armstrong, 2006), more critical of physicians, and more likely to express dissatisfaction with their care (Todd, 1989). Theorizing and research concerning women and health care highlight stereotyping, sexism, and gender bias. Male physicians can be condescending and paternalistic (Todd, 1989). Women's health problems are sometimes trivialized and discounted (McCandless & Conner, 1999). Their symptoms are more likely to be labelled psychosomatic, and physicians are more likely to prescribe sedatives and tranquilizers to women than to male patients presenting with similar symptoms (Currie, 2003). Women are more likely than men to be diagnosed with anxiety and depression (Malatesta, 2007). Women with symptoms of coronary heart disease are not treated as aggressively as male patients (Feldman et al., 2013).

Although prevalence of arthritis is greater in women than men, and they are affected with greater severity, women are not offered the same treatment options as men (Godfrey & Felson, 2008). For a long time, women were ignored in health and medical research, even though conditions studied affected both women and men (Gochfeld, 2010; Greaves, 2009). Gender has been shown to influence patient–physician interaction, and there is evidence physicians may be making medical decisions based on gender-related considerations and even gender stereotypes (Fisher & Groce, 1985; Hamberg, Risberg, & Johansson, 2004). Compounding sexism, there is evidence of ageism in older women's medical care. More likely to be diagnosed with breast cancer than younger women, for example, older women are less likely to be screened for breast cancer, and to receive the same level of care as younger women (Pritchard, 2007; Silliman, 2009). Physicians are less likely to discuss sexual health with older than younger female patients (Nusbaum, Singh, & Pyles, 2004).

The few studies that have investigated older women's health care experiences indicate that issues pertinent to patient–physician interaction are a predominant concern. Older women experience and are concerned about ageism (Henderson, 1997). They believe their symptoms and concerns may not be taken as seriously as those of younger patients, and that they may receive inferior treatment because of their age (Tannenbaum, Nasmith, & Mayo, 2003). They complain that doctors do not always treat them with respect, and they are not given enough information, especially about prevention (Evans & Robertson, 2009; Tannenbaum & Mayo, 2003). They report that their emotional and psychological needs are not adequately addressed (Tannenbaum et al., 2003). In addition, older women are often dissatisfied with the quality of physician communication (Maly et al., 2004). Liang, Kasman, Wang, Yuan, and Mandelblatt (2006) found, for example, that physicians failed to adequately inform older women patients about the use of mammography; importantly, satisfaction with physician communication influenced older women's intention to obtain a mammogram. In another study, Sidell (1992) found that older women were highly critical of physicians: they felt doctors were not willing to listen to the information they had to give about their bodies and health problems. Ageism, over-prescribing, and sexism were also areas of dissatisfaction.

Although the literature reveals much about patient dissatisfaction, few studies have directly investigated patient preferences and what patients want from physicians. Relevant studies indicate patients emphasize characteristics associated with effective communication and interpersonal skills more than competence (Noori & Weseley, 2011; Miles & Leinster, 2010). Patients, women in particular, are most satisfied with physicians who listen, are respectful, warm and friendly, have good communication skills, and are empathic and caring (Bylund & Makoul, 2002: Derose, Hays, McCaffrey, & Baker, 2001; Mast, Hall, & Roter, 2007). There is increasing emphasis on patient-centred care: "healthcare that is respectful and responsive to patient needs, values, and preferences and encourages shared clinical decision-making" (Bertakis & Azari, 2012, p. 326). However, as previously noted, research indicates that older patients are less likely than younger patients to want to be involved in medical decision-making (Adams et al., 2012). In one of the few studies to directly ask women what they want from physicians, Houle, Harwood, Watkins, and Baum (2007) found that women believed trust was vital to a successful doctor–patient relationship. They expected doctors to be respectful, caring, and friendly, to listen, do follow-up, and make prompt referrals. The researchers did not indicate whether age influenced patient preference. Focussing specifically on older women, Tannenbaum and Mayo (2003) found they wanted physicians who would spend adequate time with them, see them as whole persons, and provide reassurance, especially around concerns related to memory loss.

A number of studies have indicated that women prefer female physicians, especially for intimate health problems (Derose et al., 2001; Roter & Hall, 2004; Van Til, MacQuarrie, & Herbert, 2003; Shah & Ogden, 2006). However, findings are inconsistent. Mast et al. (2007) found physician sex affected patient satisfaction; however, "sometimes satisfaction was higher for male physicians, sometimes the reverse, and sometimes there was no difference" (p. 19). Furnham, Petrides, and Temple

(2006) found both women and men favoured a same-sex physician; however, women did not show a stronger preference for female physicians than male patients did for male physicians. A number of studies have indicated significance of gender concordance, reporting male and female patients show preference for same-sex practitioners (Bertakis & Azari, 2012; Mast et al., 2007). Two studies focusing on older women found no preference for female physicians (Sidell, 1992; Tannenbaum & Mayo, 2003).

In sum, although older women interact with physicians frequently, their preferences and perceptions of their experiences have received little attention. Most studies examining patient preferences, or providing information about what patients want from physicians, are quantitative and patient age is rarely taken into account.

With the exception of the Tannenbaum et al. (2003) study of older Canadian women, the majority of the relevant research has been American or European thus far. Moreover, many existing studies focus on one dimension of the patient–physician relationship (e.g., decision-making or physician communication); few researchers have investigated in detail the older-female-patient–physician relationship overall. Inasmuch as the doctor–patient relationship is a cornerstone of the health care system (Freidson, 1989), a more fully developed understanding of this relationship is important. Research shows that the quality of patient–physician interaction can affect important patient outcomes such as health status (Ditto, Moore, Hilton, & Kalish, 1995; Matusitz & Spear, 2014). Furthermore, patients who are not satisfied with their interactions with physicians are less likely to cooperate with their medical advice (Weitzman & Weitzman, 2003). In the study described in this article, the focus is older women's voices. Two primary objectives of this study were (1) to investigate older women's perceptions of their interactions with physicians, and (2) to identify what older women want from physicians.

Theoretical Framework and Methodology

With its focus on women's subjective experience, this study was guided by a *symbolic interactionist perspective* and insights derived from feminist theory. Symbolic interaction emphasizes significance of meaning and social interaction in the study of human behaviour (Mead, 1934). The subjective standpoint of individual actors is of central concern, based on the premise that "human beings act toward things on the basis of the meanings that the things have for them" (Blumer, 1969, p. 2). Agency is emphasized; humans are conceptualized as having the capacity to modify and construct meaning, and to make choices among alternative lines of action (Blumer, 1969; Hewitt, 1991). Subjective experience is also central to feminist theory, a key premise being that women's situations and experience must be the focus of attention if their interests and concerns are to be adequately investigated and understood (Calasanti, 2008). Viewing gender as a fundamental element of social organization, feminist theorists focus on the effects of gender stereotyping and on gender as a basis of inequality (Calasanti). Feminist analyses of health have focused on gender disparity, gender-based inequalities, and issues such as the exclusion of women from medical research (Alspach, 2012; Greaves, 2009). Critical of the dominance of the biomedical model, feminist theorists have called for a holistic model of health, and they have emphasized the significance of structural issues and the need to incorporate social and cultural context to understandings of women's health (Kuhlmann & Babitsch, 2002). Feminist research illuminates how health care institutions, particularly medicine, have neglected many of women's health care needs (Armstrong, 2006). Until recently, feminist analysis has emphasized issues pertinent to younger women. Apart from the medicalization of menopause, older women's issues and concerns have received less attention (Calasanti & Slevin, 2006).

Sociologically, the patient–physician relationship is conceptualized as inherently asymmetrical; possessing special technical knowledge, the physician has power and occupies a position of dominance (Freidson, 1989; Fisher, 1986; Waitzkin, 1991). Lacking this kind of knowledge, the patient occupies a position of relative dependency and subordination. Patients are not, however, wholly without influence in the medical encounter. Well-informed, highly educated patients are more likely to challenge physicians and insist on playing an active role in their care (Freidson). Individuals living with chronic illness for years, knowing a great deal about the treatment and management of their condition, may also be less willing to accept the physician's absolute authority (Freidson). Social changes and movements, such as the patients' rights movement, medical consumerism, and women's health movement, have altered the patient–physician relationship, with the result that patients are less likely to unquestioningly accept physicians' right to dominance (Rodwin, 1994). Younger women, particularly well-educated middle-class women, are less likely to accept patriarchal elements of domination in the relationship (Freidson). There has been a shift away from "a paternalistic doctor-centred model of the clinical encounter" to a more democratic, patient-centred encounter where patients are less likely to be passive recipients of care and more likely to expect to be "negotiators" of their own health care (May, Rapley, Moreira, Finch, & Heaven, 2006, p. 1024). Older patients, however, may still prefer a more traditional model (Bastiaens et al., 2007).

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In adopting a theoretical framework that emphasizes subjective meaning, this study examined women's perceptions and beliefs about their interactions with physicians, and the meanings they gave to their experiences. The study's primary aim was to develop a comprehensive, in-depth understanding of older women's medical encounters as they defined them: the in-depth, face-to-face interview was the research instrument of choice. Audio-recorded interviews were conducted with 30 older women, ranging in age from 55 to 89 years; average age was 69. All were White and of European descent. Eleven (37%) had a university degree; seven of these, a master's degree. Almost half (47%) had completed high school, some having additional training; five had less than high school education. All lived in the province of Nova Scotia, all but six residing in urban locations. Twenty participants (67%) had female physicians; 10 (33%) had male doctors. Generally speaking, the sample included women of both middle and working class status. Assuming younger women might be more assertive in articulating health care needs and concerns, expect more from physicians, and be more willing to challenge them, one objective of the study was to compare the experiences and views of younger-older women (ages 55–74) and older-older women (age 75 and up). Since recruiting older-older women was more difficult than anticipated, only 7 participants were 75 years or older; 23 (77%) fell within the age 55-to-74 range.

An interview guide focussed the conversation (Rubin & Rubin, 1995) and ensured that certain topics were covered; however, most questions were open-ended so that participants could describe their experience in their own words. Moreover, the women were given ample opportunity to talk about aspects of their experience and issues they deemed significant. I conducted all interviews. The sample was recruited primarily through a notice placed in a local newspaper, and a snowball technique, whereby some women suggested others who might be willing to participate. Two women were recruited through local senior organizations. After brief discussion of its content to ensure that the women knew what was expected of them, and their rights as participants, each was asked to sign two consent forms: one for the interview, the other granting formal permission to record it. All but two of the interviews were conducted in participants' homes; the two exceptions were conducted in the researcher's home. Ethics approval was obtained from the University Research Ethics Committee.

Following principles of qualitative data analysis outlined by Coffey and Atkinson (1996), Lofland and Lofland (1995), and Charmaz (2006), I analysed the data inductively. The analysis was guided by the initial research questions, concepts, and insights derived from the theoretical framework guiding the study, and the relevant body of literature (Marshall & Rossman, 2011). Some codes and themes were based on interactionist concepts such as agency and negotiation which served as "sensitizing concepts" directing the researcher towards particular lines of inquiry (Van den Hoonard, 1997). In adopting the general principles of grounded theory (e.g., memoing and generating concepts and properties of categories through the constant comparative method), however, I focussed primarily on categories emerging directly from the data, identifying their properties and the relationships among them (Charmaz, 2006; Glaser & Strauss, 1967). Interview transcripts were read and re-read, as I tested initial understandings of the data and carefully investigated contradictions and inconsistencies. Analytical memos were written as I developed conceptual categories and identified connections among them (Charmaz, 2006).

Findings

Several themes, central to understanding older women's experiences with their physicians and what they want from them, emerged from the study data. These can be categorized as follows: (a) high level of satisfaction with the patient–physician relationship; (b) what older women want and do not want; (c) patient assertiveness and compromise; and (d) physician gender and age. As evident in the subsequent discussion, these categories overlap and interact.

"I Really, Really Like my Family Doctor"

The most salient theme to emerge from participants' replies to questions about the patient–physician relationship and perceptions of their interactions with their physicians was a *high level of patient satisfaction*. To investigate overall satisfaction with the patient–physician relationship, participants were asked, "How satisfied are you with the relationship you have with your doctor?" They were later asked questions designed to elicit their perceptions about specific qualities and behaviours of their physicians. They were asked whether their doctor encouraged them to ask as many questions as they wanted to ask, whether they were satisfied with the amount of time their doctor spent with them, and whether they believed their physician was a good communicator. They were asked whether they agreed with these statements: "My doctor always makes me feel comfortable and at ease"; "My doctor always treats me with respect"; and "My doctor is always empathetic." Indicating a very high level of satisfaction with the patient–physician relationship, half of the women (50%) said they were "very satisfied" or "totally satisfied"; 14 (47%) said they were "satisfied" or "pretty satisfied". Only one participant, who had a

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number of complex health problems, said she was not satisfied. Moreover, all rated their physicians as respectful and good communicators. A large majority (93%) agreed with the statement, "My doctor always makes me feel comfortable and at ease." Similarly, 90 per cent were satisfied with the amount of time their doctor spent with them, and 93 per cent believed their physician tried to understand their perspective on their health problems. Most participants (78%) said their doctor encouraged them to ask as many questions as they wanted to ask. Most (76%) agreed with the statement, "My doctor is always empathetic."

A high level of satisfaction suggests that older women who participated in this study were, for the most part, getting what they wanted from their physicians. However, as further analysis indicates, a high level of patient satisfaction does not preclude complaints and perceived physician shortcomings.

What Older Women Want and Do Not Want from Physicians

To gain a more in-depth understanding of older women's perceptions of their interactions with physicians and patient preferences, I asked participants: "What do you like most about your doctor? Is there anything you do not like?" Their replies, and comments made elsewhere during the interviews, illuminate *what older women want and do not want* from physicians, and what they are or are not willing to tolerate. The predominant theme to emerge was that *personal attributes and "bedside manner"* – or the manner in which the physician interacts with the patient – *have priority over technical skill and competence*. Most frequently cited, older women want a physician who "listens": female physicians were more often described as good listeners: "She listens to anything I have to say." They want physicians who are "approachable" and with whom they "feel comfortable" enough that they feel they can "tell [them] anything". All physicians described this way were female. Older women want a physician who is "warm and friendly", "interested in [them]", and has "empathy". Again, female physicians were more often described in this manner. The second most frequently cited characteristic – older women want respect from physicians – had many study participants asserting that a lack of respect is something they are not willing to tolerate. Indicating that respect was non-negotiable, Margaret[1] said, for example: "That would be very important. I left one because of lack of respect." Similarly, Irene said, "Oh, [respect] is very important, I wouldn't go back if they didn't [show respect]." They want a physician "who looks at you as a whole person" and, important to some, acknowledges limitations: "She doesn't mind admitting that she doesn't know something, but she will check it out." Cited less often was competence, but those who did mention it said they want physicians who "are thorough", "refer", and "follow up" on test results.

Consistent with the level of satisfaction reported, a majority of participants (63%) claimed there was not anything they could think of that they did not like about their physicians. Among those who reported dislikes, the most frequently noted dislikes were related to time ("I don't like the length of time in the waiting room") or accessibility ("[I didn't like] when he did not have appointments past 2:30 p.m."). Initially stating there was nothing they disliked, as the interview progressed and the participants were asked about specific aspects of the patient–physician relationship, importantly, many made comments that contradicted earlier statements. Indeed, many reporting a high level of satisfaction with their physician were among those later expressing complaints, their comments providing insight into what older women do not want from physicians. Reporting that she was "very satisfied" with her physician, Rhonda, for example, when later asked whether she believed her emotional and psychological needs were being met, stated, "I don't actually, in retrospect, when I think of it, I don't feel that my doctor looks at me as a whole person. I think he addresses the issue at the moment, but I don't think he's ever taken the time to say kind of 'who are you?'" Lorraine was "satisfied" with her doctor, but later complained that her physician sometimes needed "prodding": "If I don't tell him what's wrong, he won't [investigate]. I have to ask him for the internal." Judy, who initially indicated satisfaction, when later asked whether she thought her doctor tried to understand her perspective on her health concerns, stated, "The process is technical, it has nothing to do with easing my mind." Participants also frequently proffered complaints about "other doctors" who were "rude", "arrogant", "abrupt", "too quick to prescribe", or did not show a "genuine interest" in the patient. This sampling of complaints indicates preference for physicians who look at the patient as a "whole person"; physicians who are, as some stated, "proactive"; address emotional needs; are friendly, and not "dismissive" or too "ready to hand you a pill".

To further explore what older women want from physicians, participants were asked, "What, in your opinion, are the basic ingredients of an ideal doctor–patient relationship?" To ascertain the extent to which they perceived they were getting what they hoped to get from their physicians, responses were compared to replies to an earlier question: "How would you describe the type of relationship you have with your doctor?" Consistent with what was said when asked how satisfied they were with the relationship they had with their physicians, and what they liked most about them, the central theme in descriptions of an ideal

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doctor-patient relationship, and the relationship they had with their own physician, was *personal attributes of the physician and behaviour towards the patient*. As the women described it, an ideal doctor–patient relationship is one in which the patient feels comfortable with the physician. Liz, for example, said the ideal doctor "would be somebody very comfortable to be with and you can tell them anything and everything." It is one in which the physician is "caring", "warm and friendly", "empathic", "approachable", and "honest". The ideal physician shows "respect", and "is interested in", the patient. For Francis, an ideal physician is "a warm person who you feel that you can truly open up to in order to receive the best health care for yourself." Vivian stated that "empathy is big on my list." "Honesty" was "really important" to Maureen. For Heather, ideally a "doctor … is genuinely interested [in the patient] … compassionate, and willing to have a conversation about the person's life." The words "trust" and "respect" appeared frequently. Particularly important, the ideal physician "listens to the patient", or as one woman put it, the ideal doctor "listens *and* hears". Five women believed they already had, or almost had, an ideal doctor-patient relationship. One said, "The one that I have now [is ideal]"; another said: "I've got almost the ideal [doctor-patient relationship]". Of these five study participants, four had female physicians. Among those who noted competence as desirable, an ideal doctor–patient relationship is one in which the patient "trust[s] that the physician has the skills and the competence" or a relationship in which the patient has "confidence in the doctor's abilities". "Good" and "open" communication and "a doctor who is prepared to refer" were also regarded as ideal.

A number of women made it very clear they did not want physicians who would "talk down to them" or treat them "like a child". Describing her relationship with her physician, Maureen said, "It's very much almost an equal situation, not being talked down to and 'do as you're told' kind of thing, 'I know best.'" Comparing her doctor to other physicians, Emily said, "Some doctors can be a little condescending; don't talk down to me." Another, pleased with her doctor, compared her to a physician she had previously seen and whom she did not like, stating that "She made me feel like a child." Although few claimed to have personally experienced it, ageism was something that many, especially the younger-older women, indicated they were not willing to tolerate. Anita was emphatic that she would not allow a physician to treat her the way physicians had treated her mother, physicians who "were overprescribing" and "using language Mother did not understand". Comparing interactions with her own physician with what she had observed while accompanying her mother on medical visits, Laura was critical of what she saw as ageist physician behaviour: "No, she [her doctor] would not be dismissive, but my mother's doctor – he turns to *me* and asks the questions." Intolerant of ageism, Loraine's ideal physician "investigates and does not simply diagnose [a condition] as sciatica or osteoarthritis, or [something that inevitably] "happens as you age."

Another prominent theme that emerged in the data pertinent to understanding what older women want from physicians, and how they respond when they do not receive it, is patient agency and assertiveness. It was very apparent that most of the participants were unwilling to be passive recipients of medical care; they wanted to be involved patients, some using the word "partner" to describe their preferred role in the patient–physician relationship. There was also evidence that although some women were not getting what they wanted, they had chosen to compromise, or make do with less.

Assertiveness and Compromise

Patient assertiveness as a prominent theme permeated the data. Describing their interactions with their own and other physicians, almost all of the women often vigorously expressed the view that a patient has the right to, and should, question the physician, demand input, and refuse to tolerate unacceptable physician behaviour. The salience of this theme first appeared in replies to the question, "How satisfied are you with the relationship you have with your doctor?" Many asserted if they were not satisfied they would leave: "Oh I'm happy, otherwise I'd leave." It was evident when participants were asked if they agreed with the statement that "The doctor knows what is best for the patient." A large majority (87%) disagreed, acknowledging their own agency:

> Oh no, I don't think that, the doctor can provide you with information but you know a lot of things. Ultimately, it's your decision … you know your own body and have a right to make those decisions.

> No, because I think you know your own body best, or you should.

Asked whether they agreed with the statement, "A patient should always follow the doctor's recommendations," agency and assertiveness were salient themes again. A majority (60%) disagreed, more of the younger-older than older-older women disagreeing definitively:

> No, because I have to make up my own mind what is good and best for me.

> No, I mean … you may not agree with him. I mean it's your body, it's up to you.

Agency and assertiveness were strikingly apparent as the women expressed their views about and described

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their interactions with physicians. Comments such as the following were very common: "I'm very comfortable … telling a doctor what I need"; "I just didn't take the prescription and I told him so"; "I'm not gonna let anybody talk to me like that … I'm not afraid to speak my mind"; and, "If I see any sense of dismissiveness … I have my skills."

Older women's confidence in their agency and right to assert themselves was evident when they were asked how involved they wanted to be in their medical care. Only one said she wanted little input: "I want in and out; I give him the bare facts of my illness and he takes it from there." All the others wanted to be involved, many vigorously asserting that involvement was a necessity and a right:

> Totally, it's my body, my future.
>
> Well, I want input. It's my body, my decisions.

Although all but one wanted to be involved, *involvement* not meaning the same thing to everyone, desire for involvement ranged along a continuum. Many were adamant that they had to be involved ("I want to be totally in charge of my health") and would not settle for less ("I wouldn't put up with anything else"). Others wanted involvement but added qualifications. Most commonly, that meant seriousness of the condition: "Well certainly, if it was something serious like cancer or something like that, I would want options." Although often indicating they wanted "information" and "options", older-older women (age 75 and older) tended to be less certain how to answer the question, more likely to add specifications, and to view the physician as "the expert". For example, one older-older woman replied: "To tell you the truth, I don't know. I'm not unhappy; perhaps if I had a major illness, it would be different." Another thought "the patient should participate", especially if the condition were "serious", but added: "I don't know if I have the knowledge for medical decision-making." Edna wanted to be involved, "in some sense, because we know our bodies and what is right for us." However, she considered the physician to be the "expert": "But, he is the expert, so he should know…."

Some suggested that having a say in one's medical care contributes to patient satisfaction. Maureen, for example, when asked how satisfied she was with her relationship with her physician, stated, "I'm pretty satisfied largely because I feel much of the time that I'm in control. I feel that I can negotiate." Others emphatically asserted they would not tolerate an unsatisfactory patient–physician relationship ("If I didn't like him, I wouldn't go back"), some indicating they had in fact not returned to physicians they did not like. However, although many asserted they would seek another physician if they were not getting what they wanted from the relationship, it was evident that compromises were being made. As noted earlier, along with claims of satisfaction were complaints and descriptions of physician shortcomings, indicating that many of the participants had physicians perceived as not always meeting their expectations.

Although compromises had been made, no doubt for various reasons (e.g., likes outweighed dislikes), two conditions under which compromise was less of a choice were (a) rural location and (b) distance to a physician's office. Edna, for example, was only somewhat satisfied with her physician ("Some days I like him, some days, I don't") and found it difficult to say what she liked about him ("No, I can't say, I don't know what I'd like about him, I mean … he's nice to me"). Living in a small town with few physicians, some of whom were not accepting new patients, she compromised: "Oh yeah, that's important [a good relationship] because if I didn't like him *at all*, I wouldn't go back." She rationalized her compromise through a favourable comparison of her physician to "stories" she had heard about "other doctors": "I hear so much from other women about their doctors … You do hear people complaining about doctors, and I tell them I have nothing to complain about, my doctor's fine, you know."

In many instances justifications and rationalizations were employed to explain acceptance of physician shortcomings. If a doctor was "a little abrupt", for example, or the patient "felt rushed", it was because "the waiting room was full of patients". Even in urban locations, distance can limit choice of physician. Seeking a new doctor after moving, Maureen said "there is another doctor that I thought about going to. I liked him very much [and "heard he was good"] but he's too far away, it's a good ride from here on the bus … especially in the winter, and it would be expensive to take a taxi there." Although respect was non- negotiable for most, some indicated a willingness to compromise, competence trumping respect, especially if the physician were a specialist: "I think it's [respect] important, but I would say, it depends on the circumstances – a surgeon or specialist, you are looking for excellent skills." Although Vicki thought having a good relationship with one's physician was important, she added a qualification: "Now that being said, if I had a choice between a close, personal relationship with a doctor, and a comfortable relationship with a doctor who I knew was top notch in terms of their clinical skills, I would go with the clinical skill." As indicated in the next section, sadly, some study participants – more often, older-older women – were going without medical care for conditions they were not comfortable discussing with their male physicians.

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"It's a Delight Having a Woman": Physician and Gender

Many participants showed a *preference for female physicians*, the majority who had them indicating how pleased they were to have a female ("I don't want to ever have to go to a male doctor"). Asked "Does it matter to you whether your doctor is a man or a woman?" 17 (56.7%) said it did not; 13 (43.3%) said it did, all of these indicating preference for a female physician. When those preferring a woman were asked to explain their preference, the most common explanation given was they were more comfortable with a woman:

> Well, I've never had a woman, but now that I am getting older, I kinda think I'd like to have a woman, you know. I mean you can talk to a woman about things that you can't talk to a man, you feel embarrassed you know … apart from having the Pap test and having babies, like a doctor has never seen any other part of me, you know. Like, a doctor has never examined my breasts.

Susan, whose previous physician was male, commented, "It began to matter a lot as I got older, even into my forties. I found a woman doctor more comfortable and easier to talk to." A woman was especially likely to be preferred for intimate physical exams and discussion of "female problems". For example, Hannah said, "I would prefer a female for some things like certain female problems or whatever; I'd feel more comfortable." Neither Susan, Hannah, nor an additional, third participant who remarked that the gender of their doctor mattered more now that they were older, explicitly indicated why this was the case. However, as indicated in these comments, for some, especially older-older women, modesty was an issue. Asked if there was any health problem she would not be comfortable discussing with her doctor, Edna (age 85) said, "Well, you know I have trouble with my bladder…. And he knows I have trouble with my bladder, but I don't want to talk to him about it … like if it was a lady doctor I would tell her, you know, 'cause she's probably suffering with the same thing." The problem persists even though her doctor continues to ask "how's your bladder?" because she is too embarrassed to have her male physician investigate it. When Charlotte (age 89), who previously had a female doctor, was asked if there was anything she did not like about her physician she replied: "No, other than the fact that I probably don't feel as comfortable with him … [discussing] women's problems, especially when you're old like I am." Later asked if there was any problem she would not be comfortable discussing with her physician, she replied, "Maybe a woman's issue, like for instance a breast exam; so far I just let it go."

The second most common explanation given for preferring a female physician was the belief that a woman better understands "women's problems." Asked why she preferred a woman, Elizabeth replied: "Well, she's a woman, she understands women's problems better." Shirley preferred a woman because "Well, hopefully we have the same wavelength. Yeah, we have the same kind of bodies, same kind of problems. We know what a period is. We know what having a child is." Mary, who had a female doctor for many years, preferred a woman because: "Well, women understand women. They don't put them aside, you know," suggesting women are less likely to be dismissive of women's health concerns than are male physicians. Explaining her preference, Laura stated, "Well, I think it's the sense that they may have experienced life in the same way that I have." She, like many others, also believed women were more likely to be "caring" and "better listeners" than male doctors: "I think my assumption is that a female is going to be more ... compassionate, or more apt to be a listener."

Among the comments of those who said it did not matter whether their doctor was a man or a woman were some interesting observations. Two study participants for whom physician gender did not matter later indicated they were more comfortable seeing a woman for intimate problems. One whose male physician was part of a group practice saw his female colleague for her Pap test, and said if she wanted to discuss sexual health, she would make an appointment with *her* for this. The other participant, whose physician was also male, said: "If it's a woman's issue, I would go to a nurse practitioner." "Uncomfortable" talking to her doctor about a "bowel area" problem, she said, "I feel more at ease with the nurse practitioner." For some who had had a male physician for years, it seemed that having a male doctor was something they had simply gotten "used to": "It doesn't matter, I'm more used to a man." For a few, competence and personality mattered more than gender. Blanche, for example, said physician gender did not matter: "if somebody told me someone was a good doctor, I'd be satisfied." Another, seeking a replacement for her retired physician, had seen two different women doctors but did not like either of them: "So I tried a couple of them and I didn't really like them. I didn't like their personality or the way they were with me – you know, how they treated me. It doesn't matter whether it's a male or female really, as long as they pay attention to me."

Female physicians were generally described differently than male physicians. Although males were sometimes described as "warm and friendly", for example, this was a more frequent description of female physicians. One woman, very pleased with her physician, said

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"and I almost feel that she's a friend". Some referred to their female physicians by their first names. Women were more frequently described as "more caring", "good listeners", and "empathic". Bemoaning the loss of her female doctor, Charlotte, whose physician was now male, said: "The female doctor I had before, she would listen to everything, you know. Female doctors seem to be more caring." Some recounted instances where their female doctors, providing empathy and support, helped them through emotionally difficult situations. First saying "It never used to" matter whether her doctor was a man or a woman, Maureen, added, "but as I get older, I'm faced with some situations where it's mostly frustrating [coping with her husband's many health problems]. [physician's first name] hears more about those things than another doctor would." In lamenting the loss of her physician, Vicki said, "I had no hesitation in talking to her about anything. We've had a few challenging years.... my elderly parents, my father was chronically ill and passed away this spring, and I found she was a good sounding board. She suggested that I take some time off work when things were really bad, and also set me up with a personal therapist who I could talk with, all positive."

Female doctors were perceived as more respectful and less likely than male physicians to dismiss women's complaints. Heather, whose physician was a woman, stated, for example, "I think women doctors treat people with more respect." Asked if her doctor tries to understand her perspective on her health concerns, Mary replied, "Yes, because she's a woman." Others believed that women showed more interest in the patient. "She is very interested in me" appeared frequently in women's descriptions of what they liked about their female doctors. Discussing different styles of practice, a majority showed a preference for a style characterized by partnership and shared decision-making, and some believed they were more likely to have this preference met if the physician were a woman. Pleased that her physician encouraged her to actively participate, Sandra said, "And I believe it has something to do with the fact that she is a woman. I feel a bit more intimidated when the physician is a male." Willingness to admit limitations was more often associated with female physicians. Anita said her relationship with her doctor was "good, because she is one of the few who admits that she doesn't know everything." Describing what she liked about her physician, Mary said, "She's very interested in me. She's very thorough. She doesn't mind admitting that she doesn't know something, but will check it out." Others believed female doctors were more open to alternative forms of therapy, with some indicating that their female doctors had recommended therapies like homeopathy, osteopathy, and yoga.

Not Too Old, Not Too Young: Physician and Age

Many participants showed a *preference for younger physicians*. Further exploring patient preference, study participants were asked, "Does the age of your doctor matter to you?" Slightly more than half (53.3%) said it did not; 46.7 per cent said it did. Although four participants did not want a physician who was "too young", the majority for whom age mattered did not want an older one. By far the most common reason given for that was the belief that older physicians would be less "up to date" than younger ones:

> I think the younger the doctor, the more up to date he will be on procedures and techniques.

> I prefer not an older one, because I want one that is up to date with things.

Rarely mentioned, even when the potential benefit of experience was noted, *younger* was still sometimes preferred over *older*. First remarking that "I think in general I would be happier with an older doctor", Liz continued, "but, on the other hand, I think maybe younger doctors are up to date with certain things. Experience can sometimes go a long way [but] … you know, they can get stuck in their ways sometimes." Although most preferred younger doctors, for some, a doctor could be "too young". Describing her physician as "very young", Laura said age did not matter, then added, "But it's funny, because I look at this one, and I say, 'are you sure you're old enough to ...? Are you sure you know enough?' you know." Asked if her doctor was empathic, Sandra replied, "I'd say 'somewhat'. She tries to be, but she's so young. How much has she observed?" Asked if the age of a patient could influence a doctor's treatment of the patient, Janet replied, "Maybe they don't understand, especially when they are young." Among the few to prefer an older physician, and to mention experience, Mary thought an older physician might be a better match for an older patient: "I don't want some little thing just out of university ... experience [is important] ... you're on the downward slide at 59 years." Preferring a physician who was neither too old nor too young, Nora said, "An extreme either way would concern me." Doris believed there was an advantage to having a middle-aged physician: "It's delightful having a woman who has a mother my age …. She understands totally." Similarly, another participant believed her physician was more likely to be empathic and have insight into the health problems of older adults because he had an elderly father. Some for whom physician age did not matter believed things like "trust" or "faith in the doctor" were more important. Edna preferred older doctors; however, she said "it would depend on the personality of the doctor".

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Evidence of stereotyping older physicians as less knowledgeable, less competent, or less interested in learning occurred frequently in the data. Critical of her mother-in-law's and father's doctor, Bonnie saw age of the doctors as the problem: "I guess that is an age thing. I think, well my doctor's younger ... more knowledgeable ... and my mother-in-law's doctor, he's an older doctor that she would have went to for twenty years." Frustrated that it took so long to get her father to stop driving, she concluded, "But you know what the problem with my father's doctor is [is] that they were the same age: he was also elderly." Comparing younger to older physicians, Sharon said, "They're generally not like the old guys. They were the 'doctor knows best', like 'father knows best'. The new ones are better trained … and [are better] because they communicate." Asked if she thought a patient's age might influence the doctor's treatment of the patient, Maureen replied, "Yeah, I do, depending on the age of the doctor. Doctors who graduated 50 years ago are perhaps less well educated about aging and its effects. Younger doctors are getting a better education." For another, age of a physician mattered, "Because I make an assumption that the younger doctor is still interested in learning about stuff."

A significant theme to emerge relevant to physician age was loss of a physician and concerns associated with finding a replacement and establishing a relationship with a new one. Some wanted a younger doctor in part because they wished to avoid the need to replace a physician. Doris preferred a younger doctor "only in the respect that … She's young enough that she's going to outlive me. That's part of the criteria." For the same reason, age mattered to Connie: "Yes, I had to find someone younger than me." For many, their current doctor was one of several physicians they had seen over the years. Some physicians had moved, others had died or retired. Older-older women were more likely to have replaced their doctor a number of times. Noting she had gone "to the same office for over 50 years," Blanche (age 79) stated, "I've gone through four doctors … They died off." Vivian (age 79) had "gone through three in the past 10 years". Ruby (age 77) had been the patient of four different doctors in 15 years; her previous physician retired, the other three moved. The need to replace is especially difficult when the woman is older, has been with the physician for many years, and is fond of the doctor. Ruth, for example, who "really like[s]" her current doctor, "dread[s] the day that she retires." Fond of her previous doctor of many years, Connie said "it was heart-breaking to lose" him. Sometimes it is the older patient who must leave the physician. Doris was concerned about the day when, no longer able to drive, she would have to replace her current ("wonderful") physician with one located nearer to her. Nora hoped she would not lose her physician because "she has moved her office and she is further away, so I might [have] to consider changing, but I would like to stay with her." Stating, "We liked her so much that we kept going back," Laura and her husband, after moving to a relatively remote rural area, for nearly three years drove a long distance so they could continue to see their previous physician. Laura's comments illuminate one reason why losing one's physician later in life can be difficult: "I guess I'm ... grieving the fact that we had to leave her. I'm expecting to have as much of a relationship with this new person, and I know I probably won't." Pondering the possibility of ageism in a medical encounter, Laura suggested it was less likely in a long-term relationship, believing the doctor was more likely to see the patient as a person rather than an 'old person': "I am with this new person. How long will it take to get that relationship with this new person? So that 'It's Laura and Jack' coming in [rather than two older patients]."

Some participants believed physicians preferred younger patients, and some were concerned about ageism in their search to replace a physician. Maureen, said, for example, "I'm thinking how many years is it going to be before she retires and then I'm … I have to find another doctor who would take little old ladies, no matter how healthy or not they are." Another concern, especially important to patients with serious chronic illness, was the need to establish trust within a new patient–physician relationship. Living with a serious illness for a number of years, Sharon was pleased to have a physician who treated her like a "peer" because she knew so much about her condition. Unhappy when told she would be seeing a new doctor, she wondered if she would be able to establish the same "mutual trust" she enjoyed with the old one: "My GP knew me very well, the new doctor ... is a nice young doctor [but he] doesn't yet trust me." Having had "three [doctors] in the past 10 years," Vivian, a very assertive patient, said it was difficult to start over with a new physician because, "As you get a new doctor, you basically have to train them."

Discussion and Conclusion

The findings of this study of older women's perceptions and preferences regarding physician interactions are consistent with the results of previous research also revealing a high level of patient satisfaction (Edwards, Staniszweska & Crichton, 2004). This is an important finding since satisfaction with the patient–physician relationship has been shown to affect important patient outcomes. Also consistent with previous research, the findings show patients can be satisfied yet still have complaints (Williams, Coyle, & Healy, 1998). In contrast with previous work, few women complained about their doctors not treating them with respect, not providing

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sufficient information (Houle et al., 2007; Sidell, 1992), or failing to address emotional and psychological needs (Tannenbaum et al., 2003). Also, consistent with previous findings, satisfaction and preferences were related more to personality traits and physician behaviour towards the patient than physician competence (Duberstein, Meldrum, Fiscella, Shields, & Epstein, 2007) – competence perhaps assumed to be a given (Miles & Leinster, 2010). Satisfaction with the patient–physician relationship may be related to participants' health status. A majority (83%) rated their health as "excellent", "very good", or "good". Chronic illness and complex health problems can negatively affect the patient–physician relationship and patient satisfaction (Campbell & McGauley, 2005; Poot, den Elzen, Blom, & Gussekloo, 2014). High satisfaction may also be related to participants' assertiveness. If, as some research suggests (Adler, McGraw, & McKinlay, 1998), physicians are inclined to view assertive patients more favourably, and respond to their treatment requests, older women who assert their needs and insist on having a say in their own care are more likely to receive the kind of care they want, resulting in a higher level of satisfaction with the patient–physician relationship.

Importantly, the findings contradict previous research that indicated older patients prefer a more traditional model of care wherein the physician is in control and takes responsibility for decision-making (Bastiaens et al., 2007). A majority of the women in the present study wanted to actively participate in their medical care. Paralleling Bastiaens et al.'s (2007) and Evans and Robertson's (2009) findings, they wanted to be able to ask questions and be listened to, to be given adequate information and options, and to be part of the decision-making process. Indicative of a "preference continuum" (Bastiaens et al., 2007), generally, older-older women were not as adamant about their desire for involvement as younger-older women. They wanted information and options, especially if the health problem was serious, but, viewing the physician as "the expert", they were more likely to want the doctor to be the primary decision maker. Weir, Kotecha, and Goel (2007) also found a much higher level of interest in patient choice among women aged 75 and older than the literature previously indicated. Involvement and patient satisfaction may be related, as research indicates physicians are more patient-centred with "actively involved" patients (Street, Gordon, & Haidet, 2007).

Consistent with other studies, many participants showed a preference for female physicians (Noori & Weseley, 2011; Shah & Ogden, 2006). This also likely contributed to a high level of satisfaction with the patient–physician relationship found since so many (67%) had female physicians. Those who had female physicians, almost without exception, liked them a lot, frequently expressing their satisfaction as they discussed aspects of the patient–physician relationship. Moreover, female physicians were preferred overall for many of the same reasons reported elsewhere, because of their personal manner and a practice style characteristic of patient-centred care (Bertakis & Azari, 2012; Roter & Hall, 2004). Paralleling other findings, a main reason for preferring a female doctor was because women felt more comfortable with a woman, especially when discussing intimate health problems (Van Til et al., 2003; Shah & Ogden, 2006). Female physicians were perceived as warm and friendly, caring and empathic, and willing to listen (Bylund & Makow, 2002; Nicolai & Demmel, 2007). Notably, what participants liked about female physicians closely matched qualities and behaviours they associated with an ideal physician.

An important finding of the present study is the preference for younger physicians and the belief that older physicians are less likely to be as up to date, knowledgeable, and well trained as younger ones. Despite the high status of their occupation, physicians, it appears, are not immune from age stereotyping. Participants seemingly giving priority to scientific technical knowledge (Cassell, 1986), clinical experience as a potential asset was rarely mentioned. One of a few studies to investigate patient preference concerning age of their general practitioner, McKinstry and Ying Yang (1994) found that positive attributes such as kindness, thoroughness, and willingness to listen were more often attributed to older doctors; however, the mean preferred physician age was 42. Although many of that study's participants indicated they would prefer younger physicians to older, similar to the findings of this study, they also did not want a physician who was "very young". McKinstry and Ying Yang concluded: "Patients appeared to want a balance with the doctor being experienced and being up to date" (p. 349). In that British study, they suggested "that patients start to lose confidence in doctors once they are over retirement age" (p. 351) which at that time in the United Kingdom was over the age of 65. Examining patients' judgements of general practitioners, Shah and Ogden (2006) found, overall, that both younger and female physicians were rated more positively than older and male physicians. Younger doctors were believed to have a better personal manner, better technical skills, and were deemed more likely to refer patients than older physicians. In contrast, Furnham et al. (2006) found age did not seem to matter as physician age did not significantly affect participant ratings of physicians. Studying older women's health priorities, Tannenbaum et al. (2003) also found physician age appeared not to matter to participants as long as their health concerns were adequately addressed.

The primary basis of physician authority being possession of expert scientific, technical knowledge (Freidson, 1989), stereotyping of older physicians as less knowledgeable and well trained than younger ones is interesting. Emphasizing and promoting medicine as science, even though much of everyday medical practice continues to be based equally on art, the medical profession has fostered the belief that patients should acknowledge and accept physician authority and omnipotence. Now that medical knowledge is more accessible to laypersons, physician authority is being challenged while, at the same time, physician experience appears to be counting for somewhat less (Cassell, 1986). Ironically, an emphasis on medicine as science and understating of medicine as art is detrimental to older physicians when being stereotyped as "out of date" takes precedence by patients over having years of clinical experience. Moreover, patients' belief that younger physicians know more, especially about the health problems of older adults, is somewhat misplaced as research indicates many general practitioners do not feel they are adequately trained in geriatric medicine, and report lacking confidence in their knowledge about the health problems and treatment of older patients (Adams et al., 2002; Thomas et al., 2006).

This study has a number of limitations. The findings are based on an ethnically homogeneous sample of women who volunteered to participate. A different recruitment method may have attracted older women less satisfied with their physicians, producing different results. Many of the women are well educated. Previous research indicates that patients from a higher social class, and with a higher level of education, are likely to receive more information from physicians, which, in turn, may influence patient satisfaction (Malat, 2001; Waitzkin, 1991). Race/ethnicity may also affect the medical encounter and patients' perceptions of care providers (Cooper-Patrick et al., 1999; Malat & Hamilton, 2006). Adler et al. (1998) found, for example, that Chinese American women were less assertive and, although they recognized the value of being assertive, were more likely to believe that patients should be polite and not "inappropriately assertive" with their physicians. Weitzman, Chang, and Reynoso (2004) found that middle-aged and older Latino American women were less likely to directly confront physicians when they were dissatisfied with their care.

The majority of the participants in this study had relatively good health; as previously noted, patients with poorer health are less likely to be satisfied with their care. The one participant who expressed dissatisfaction with her physician was among the least healthy of the participants, living with a number of complex chronic health problems. The number of rural participants was small. There are no doubt important urban-rural differences in the patient–physician relationship that could not be addressed in this research. The self-advocacy strategy of changing doctors when dissatisfied with one's physician, for example, is not so easily implemented in a rural area, an exigency noted by some of the rural participants.

The findings point to important directions for future research. There is need for further study of older women's health care experiences and what the women want from physicians. Importantly, further research is needed to ascertain how older women's desire for "negotiated health care" might be facilitated, and how less-assertive older women might be empowered to make decisions about their health (Evans & Robertson, 2009). Building on the concept of "preference continuum" (Bastiaens et al., 2007) – and this study's finding suggestive of a possible cohort difference in desire for involvement – research examining the subjective meaning of involvement, and the conditions associated with it, would provide insight to understanding how to encourage older patients' active participation in their own care. Gender differences in desire for and interpretation of involvement need to be explored. Existing research suggests women are more likely than men to want to actively participate in their care (Arora & McHorney, 2000); however, little is known about older men's health care experiences and what they want from physicians.

Most research investigating patient preference and physician gender has looked exclusively at women's preferences, and studies of patient preferences have generally not considered the influence of patient age. The findings of this study offer insight into why older women might prefer a female doctor; however, more work is needed to illuminate why both men and women might prefer gender concordance. Some participants suggested that what patients want from physicians may vary in relation to patient age, some saying physician age and/or gender mattered more as they aged. This important finding requires further detailed investigation. Researchers need to examine the extent to which older women's health may be impaired by their modesty and the discomfort some experience being examined by and discussing intimate health problems with a male physician. That some of the older-older women had chosen to live with an intimate health problem rather than endure the embarrassment of pursuing it with their male physician is a troubling finding. Knowing how commonly older women go without medical treatment because of modesty or shame in revealing an "old female body" to a physician is essential to ensuring older women's health care needs are adequately addressed.

Given the scarcity of research on the topic, and inconsistent findings, there is a need for further research

examining physician age and whether and how it influences the patient–physician relationship and older adults' satisfaction with their care. Significance of length of the patient–physician relationship is a potentially fruitful direction for further research. These findings suggest possible advantages associated with a long-term patient–physician relationship, some participants believing that mutual trust and understanding are more likely to be found in a relationship of long standing. A participant who had the same doctor for a number of years, for example, believed her physician was better able to understand her perspective: "Well, she's been through lots of events with me, so she can relate." Adams et al. (2002) found some older physicians felt closer to their older patients, and "a complex medical situation that occurred within the context of a long-term doctor-patient relationship was perceived differently from a complex medical situation in the context of a new relationship" (p. 840). In long-term relationships, physicians are likely to know more about their patients, the conditions of their lives, preferences, and limitations, all significant to continuity of care and holistic, patient-centred care that many patients today are seeking. Stereotyping of older physicians calls for further study. How widespread is it? Are older physicians aware they may be the objects of age stereotyping? What might they do to prevent and/or counter it?

An important practical implication of this research is that it points to the need for more physician training in geriatric medicine, especially psychosocial dimensions of aging and health, to better prepare physicians to encourage and facilitate the negotiated care many older women say they want. Many younger-older women vehemently indicated they were not willing to be passive patients, adamant that participation is their right. Physicians need to be prepared to respond appropriately to this new generation of assertive older women.

Note

1 All names are pseudonyms.

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