sophical scholarship with clinical expertise. Dr. Brody today is one of the bright lights in the field. Let us hope that family medicine gives us many more like him.

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References

1. Orr RD, Moss R. The family physician and ethics at the bedside. J Am Board Fam Pract 1993; 6:49-54

Why Can't A Man Be More Like A Woman?

The medical interview is the family physician's principal tool for both diagnosis and treatment. Residency-trained family physicians have already received more detailed instruction and feedback regarding interview skills than have most other specialists, but we must nevertheless continue to explore ways in which we can enhance the therapeutic potential of the interview. Two recently presented studies are therefore of great interest to family physicians. The first suggests that women physicians display certain valuable interviewing skills more frequently than men. The second suggests that practicing physicians can enhance these sorts of skills following a brief and focused intervention and that measurable patient improvement results.

Charon and colleagues[1] have developed a narrative model of medical encounters that fundamentally looks at the medical interview as an example of reading the meaning of a text (i.e., the patient's story). Previous work on gender differences in the reading of literary texts suggests that women read differently from men — specifically, women more readily enter into the world of the text and identify emotionally with it, while men remain more distant from the text and see it as a source of facts to be abstracted. Applying this model to the medical interview, the authors elaborated some hypotheses: women physicians would demonstrate more interest in the patient's life narrative, would exercise less control over the interview content or process, would provide more comprehensive information to the patient, would show more receptivity toward the patient, and would spend more time and display more mutual behavior. (All of these interviewing behaviors have been shown in other research to be positively linked to improved therapeutic outcomes.[2])

Using a comprehensive and previously validated instrument that combines features of both quantitative and qualitative research methods, the authors studied 5 women and 6 men internists in the outpatient clinic of an Eastern, urban tertiary-care hospital. The results confirmed all hypotheses but one: women exercised as much control as men did over the structure of the interview. In the other four areas, women displayed the predicted behavior more frequently and at a statistically significant level.

Contrary to the assumptions of those who are suspicious of feminist agendas, Charon and colleagues have no interest in using their research as a club with which angry women can beat men physicians. Instead, they wish to use a novel research approach to focus attention upon behaviors that could have been neglected in earlier studies and that could readily be used by all physicians regardless of gender. How this approach might work is suggested in a separate study by Roter and Hall.[3]

Roter and Hall wished to demonstrate how primary care physicians could better respond to patients' psychosocial distress. They randomized to three groups 69 Baltimore-area primary care physicians representing a wide variety of practice settings. Two groups received 8 hours of continuing education on responding to emotional problems; in one group, training focused upon skills in handling emotion during the interview, while in the other group, training focused more on cognitive problem-solving skills. The third group served as a control. Approximately 10 patient encounters were then audiotaped for each physician; one-half the encounters were with patients who showed emotional distress on the General Health Questionnaire, and the other half were with nondistressed patients. Both

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physicians and patients completed a questionnaire following the visit, and patients were contacted by telephone at 2 weeks, 3 months, and 6 months.

Audiotape analysis revealed that the educational intervention did significantly increase the frequency of the targeted behaviors in practice. Moreover, there was a substantial spillover effect — those who had been trained in problem solving also showed improvement in emotion handling, and vice versa. Notably, these skills did not substantially increase the length of the office visits.

Both trained groups did significantly better in recognizing emotional distress. All distressed patients, on follow-up telephone interviews, displayed decreased distress as measured by the questionnaire; but patients seen by either group of trained physicians showed significantly greater reduction in distress, and this difference could be demonstrated even after 6 months.

While these two studies used very different theoretical models, it appears that the sorts of behaviors taught in the Roter and Hall intervention overlapped a great deal with the behaviors Charon and colleagues had identified as occurring more frequently in their women physicians. This overlap suggests that those skills of "reading the patient's story" are not biologically innate in women and can indeed be learned and practiced by both men and women — as soon as the dominant culture chooses to recognize and reinforce them.

Today, the dominant medical culture in our country is sending several messages — it devalues women, it devalues primary care, it devalues attention to psychosocial distress and instead focuses on objectively measurable biological variables, and it has evolved a style of approaching illness that is so prohibitively expensive that our society can no longer afford it. We who are committed to excellence in primary care know that the most cost-effective way of providing humane care for all patients is to respond to psychosocial distress (which often masquerades as physical symptoms) with a sensitive interview instead of with a battery of diagnostic tests and with polypharmacy. Studies such as those summarized here point the way to improving our skills in offering this care and thereby continuing to lead in the direction in which all health care in the United States must eventually follow.

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References

1. Charon R, Greene M, Adelman R. Women readers, women doctors: a feminist reader response theory for medicine. Paper presented at the working conference on Empathic Expertise: Gender, Ethics, and the Woman Physician. Galveston, TX: March 6-7. 1992.
2. Novack DH. Therapeutic aspects of the clinical encounter. J Gen Intern Med 1987;2:346-55.
3. Roter D, Hall J. Improving psychosocial problem address in primary care: is it possible and what difference does it make? Paper presented at the 1991 International Working Conference on Doctor-Patient Communication. Toronto, Nov. 14-16, 1991.

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