

## EDITORIAL

# Physician Sex and Practice Pattern Differences in the Emergency Department

Teva Brender, MD; Eve Rittenberg, MD, MA; Sharon K. Inouye, MD, MPH; Ishani Ganguli, MD, MPH

**There is a growing literature** on physician sex differences in patient care and outcomes that largely favor female physicians. Studies in the primary care setting find, for example, that female physicians spend more time in direct and indirect patient care,<sup>1</sup> use more patient-centered communication, and

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provide more evidence-based services,<sup>2</sup> although the evidence is more mixed on the provision of low-value care.<sup>3,4</sup> But one challenge of these studies is that it is difficult in the primary care setting to disentangle the effects of patient expectations, self-selection to their treating physician, and the dyadic interaction between patient and clinician on practice patterns and outcomes. Hospital-based studies that can leverage more random assignment of patients to physicians have found that patients treated by female physicians have better outcomes, such as lower mortality and hospital readmission rates,<sup>2,5</sup> but beyond this, little is understood about how practice patterns differ by sex in the acute care setting.

To better understand this, Ly et al<sup>6</sup> used the quasi-random nature of patient assignment in the Veterans Affairs emergency department to study how male and female emergency medicine physicians differ in their testing and admission patterns. As they report in this issue of *JAMA Internal Medicine*, Ly and colleagues found that female physicians ordered slightly more radiology and laboratory tests and were marginally more likely to admit patients than their male colleagues (45.7% vs 44.0%).

There was no difference in 30-day mortality or in potentially inappropriate admissions, as evidenced by short (<24-hour) inpatient stays. Finally, in a subanalysis of potentially low-value testing, the authors found that female physicians ordered slightly more computed tomography scans with contrast as the initial test for patients with chest pain or shortness of breath without a high pretest probability of pulmonary embolism.

The observed physician sex differences in test ordering and admission decisions in the emergency department are intriguing but small when compared, for instance, to previously reported differences in the ordering of preventive services.<sup>2,7</sup> What might explain the differences? Ly et al<sup>6</sup> posit that they may be driven by factors such as female physicians having, on average, greater aversion to risk and to judgment by their peers. In addition to intrinsic clinician factors, we note that case mix, responses by nursing and other health care professionals, gendered perceptions and expectations of physician behavior,<sup>8</sup> and patient-clinician dyadic interactions may contribute. It is also important to note that this study, like prior ones, has been constrained by data availability to examine biological sex rather than the likely more relevant social construct of gender. For future work, mixed-methods studies could help to explain such differences across outpatient, emergency, and acute care settings. Deeper dives will be essential to understand the pathways by which sex or gender lead to the observed differences, with the ultimate goal of helping physicians across sexes and genders deliver the best possible care to patients.

## ARTICLE INFORMATION

**Author Affiliations:** Department of Medicine, School of Medicine, University of California, San Francisco (Brender); Editorial Fellow, *JAMA Internal Medicine* (Brender); Department of Medicine, Brigham and Women's Hospital and Harvard Medical School, Boston, Massachusetts (Rittenberg, Ganguli); Viewpoints, Inside Story, and Online Editor, *JAMA Internal Medicine* (Rittenberg); Harvard Medical School, Boston, Massachusetts (Inouye); Editor in Chief, *JAMA Internal Medicine* (Inouye); Marcus Institute for Aging Research, Hebrew SeniorLife, Boston, Massachusetts (Inouye); Associate Editor, *JAMA Internal Medicine* (Ganguli).

**Corresponding Author:** Ishani Ganguli, MD, MPH, Harvard Medical School, 41 Ave Louis Pasteur, Boston, MA 02115 ([iganguli@bwh.harvard.edu](mailto:iganguli@bwh.harvard.edu)).

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