LETTERS TO THE EDITOR

Influence of gender of physicians and patients on guideline-recommended treatment of chronic heart failure in a cross-sectional study

We read with interest the study by Baumhakel et al.1 regarding the influence of gender of physicians and gender of patients on treatment decisions in the care of congestive heart failure. This study takes the issue of gender disparities in clinical settings an important step forward, indicating that not only physician’s behaviour, such as time spent per patient, is different, as shown previously,2 but also that a gender effect may actually translate into differences in medical treatment.

In this study, the authors conclude that female patients are receiving inferior therapy, especially when treated by a male cardiologist. We believe that such a strong conclusion cannot decisively be made from the data presented. In observational studies such as the one presented here, it is difficult to distinguish between a direct relationship and a statistical association mediated by confounding factors. No doubt, controlled trials would not apply, randomization would be difficult to perform, and blinding even impossible. However, alternative analytical approaches for observational studies such as propensity score or instrumental variable-based analyses3 could further reduce potential confounding and may have shown different results.

The authors show that fewer female patients were receiving beta-blockers compared with men. However, such a difference was present independent of the gender of the treating physician. Why is that? Aetiologies for HF and co-morbidities differ significantly between male and female patients. Coronary artery disease (CAD) prevalence was significantly higher in men, whereas diastolic heart failure may have been more prevalent in women. This ‘double indication’ of CAD and HF likely explains, at least in part, the higher rate of beta-blocker treatment in male patients.

The authors also observed that patients treated by male physicians received beta-blockers less frequently. However, the proportion of patients with CAD treated by male physicians was somewhat lower in general, which may explain part of that phenomenon.

Most critically, this study makes no assertions regarding clinical outcomes of patients as stratified by gender. In fact, as the authors mention, several studies have shown that female patients with congestive heart failure actually have more favourable outcomes than male patients.4,5 Given this reality, it becomes difficult to assert, as the authors do, that female patients are receiving inferior treatment—if that were the case, would their survival really be superior?

Certainly, there is room for confounding in this study with regard to the influence of patient or physician gender on treatment, and with regard to a gender interaction effect. Given all of these issues, we consider the statement by the authors that ‘A female patient was likely to receive the worst medical treatment from a male physician…’ to be inflammatory and unsupported by the evidence presented in this manuscript.

Conflicts of interest: none declared.

References