Patient choice in a practice with men and women general practitioners

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SUMMARY. This study investigated the distribution of workload between men and women doctors in a south London practice. Of 909 attending patients aged 15 years and over, 611 were women and 48% of these consulted a woman doctor. In comparison, only 27% of the 298 men consulted a woman doctor. Twenty nine per cent of the 105 women who gave a reason for choosing a woman doctor said they had done so because of her sex.

Multiple logistic regression was used to assess the relative importance of having a general preference for a woman doctor or of consulting about a problem related to sex in predicting the likelihood of a woman consulting a woman doctor. This showed that preference was 2.3 times as important as problem type in predicting this. This suggests that women's demand for women doctors in general practice extends beyond family planning and well woman clinics. The implications of this for practice organization are discussed.

Introduction

GENERAL practice has traditionally been a male domain. In 1968,[1] just under 10% of principals were women but by 1986, this had doubled to almost 20%.[2] As 40% of vocational trainees are now women,[2] this can be expected to rise further and the implications of this change for general practice need to be understood.

The nature of general practice is also changing. A comparison of the second and third national morbidity surveys revealed that in 1981–82, women consulted general practitioners for contraceptive advice almost twice as frequently as they had done in 1971–72.[3,4] Significant increases also occurred in the consultation rate for vaginal candidiasis and cervical cytology testing.

In a study of Manchester general practitioners, Cooke and Ronalds[5] found that women were more likely to consult women doctors about a range of sex related conditions, particularly those likely to require a vaginal examination. They felt that the fact that only 33% of practices included a woman doctor might represent a significant barrier to preventive health care.

Two studies[6,7] have reported the pattern of morbidity seen in practices offering the choice of men or women doctors. Both found that the women doctors saw more of the women patients and although the differences were greatest when the problem was sex related, women also consulted a woman doctor more often for other problems. This suggests that women's preferences for doctors of their own sex are based on more than simply an aversion to examination by a man. Preston-Whyte and colleagues noted that women doctors followed up their women patients more often and suggested that they might be more popular because their patients preferred the care they provided. There may or may not be differences in the attitudes of men and women doctors to their women patients, but there is evidence that those women who prefer women doctors believe that they are more understanding and easier to talk to.[8,9]

This study was designed to investigate the extent to which patients determine the distribution of workload between men and women doctors. Of particular interest was whether any differences observed were due to women having a general preference for a doctor of their own sex or a specific wish to consult a woman about sex related problems.

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Submitted: 20 October 1988; accepted: 17 August 1989.

© *British Journal of General Practice,* 1990, **40**, 13-15.

Method

The study was conducted in a south London group practice with four male partners, two female partners and two trainees, one of each sex. Three of the partners (two of the men and one of the women) and the two trainees recorded their consultations during three specific weeks in March, May and August of 1984. While patients with appointments could consult the doctor of their choice, 'extras' were fitted in with any doctor who was free at the end of surgery. All patients aged 15 years or over seen at the surgery during the three weeks, apart from those attending the baby clinic, were included in the study. At each consultation, the general practitioner recorded the main diagnosis, using the Royal College of General Practitioners' morbidity classification.[10] Diagnosis for sex related conditions were analysed separately and were defined as the following RCGP codes: intrauterine contraceptive device, cap, cervical smear: 6340, 6350, 6365–6400, 7220; genital disorders, infections: 0165, 0205, 0210, 0230, 0470–0480, 0495–0560, 3035, 3095, 3160; menstrual, pre-menstrual and other symptoms: 3100, 3105, 3115–3150; oral contraception: 6355, 6360; pregnancy care: 3200–3490, 6275–6335, 6500–6650, 7150.

Before patients saw the doctor, the receptionists asked them to complete a short questionnaire about whether they had chosen the doctor that they saw, whether they knew the doctor's sex beforehand, and whether they preferred a male or female doctor.

The likelihood of a woman aged 15 years or over consulting a doctor of her own sex was compared with expressed preference for female doctors and the presence of a sex related problem, other than pregnancy, by multiple logistic regression using the GLIM package.[11]

Results

During the study weeks 909 patients aged 15 years or over consulted: 611 women and 298 men. Of the women 48% (296) consulted a woman doctor, compared with 27% (79) of the men (chi-squared = 37.5, 1 df, $P<0.001$).

The questionnaire about why patients chose particular doctors was completed by 639 patients (70%); although only 199 of the men responded (67%), this was not significantly less than the response rate for the women (72%, 440). Uncertainty about which doctor they would see may have been a factor for those who were seen without an appointment as fewer patients with respiratory, gastrointestinal, musculoskeletal problems or injuries responded (65%, 194/298).

Patient preferences and choice of doctor

Patients were asked, 'In general, would you prefer to see a male doctor, a female doctor, or does it make no difference to you?' This revealed that more than half the women wanted to see a female doctor for at least some problems, but that a majority of men did not feel the doctor's sex mattered to them (Table 1).

When asked, 'Did you choose to see the doctor you are seeing today, or was this the first convenient appointment?' 62% (155/250) of patients seeing a female doctor said they had chosen her, whereas only 50% (194/387) of those seeing a male doctor had chosen him (χ^2 = 8.17, 1 df, $P<0.01$).

Women seeing a female doctor were significantly more likely to have chosen whom they consulted (64%, 131/206) than those seeing a male doctor (50%, 116/233) (χ^2 = 7.91, $P<0.01$). In contrast, there was no significant difference between the proportions of men who had chosen to see a man or men who had chosen to see a woman doctor. It was interesting that 29% (30/105) of women who gave a reason for choosing a woman doctor said they had done so because of her sex. Other reasons given by both men and women included satisfaction with previous care or a more neutral statement that they usually saw that doctor.

Table 1. Patients' preferences for male or female doctor.

	Number (%) of patients	
	Men (n = 198)	Women (n = 438)
Prefer a doctor of opposite sex	8 *(4)*	29 *(7)*
Prefer a doctor of the same sex	33 *(17)*	95 *(22)*
It depends on the problem	32 *(16)*	142 *(32)*
It makes no difference	125 *(63)*	172 *(39)*

NB Three patients did not answer this question.

Choice of doctor by women with sex related problems

Data from the main diagnosis made by the doctor revealed that 65% (75/115) of women who had a sex related condition apart from pregnancy consulted a female doctor, whereas only 44% (215/493) of women with other problems did so (χ^2 = 16.60, 1 df, $P<0.001$).

When the consulting behaviour of women with different conditions was compared (Table 2), it was apparent that those attending for preventive procedures or conditions likely to require a vaginal examination were significantly more likely to consult a female doctor. However, this was not the case among those attending for oral contraception or with problems less likely to need an examination. It is perhaps worth commenting that one of the male partners had a particular interest in antenatal care which may explain why more of the women saw a man for their antenatal care.

Overall, women with sex related problems apart from pregnancy accounted for 20% (75/375) of the patients of the women doctors and 7.5% (40/534) of patients seen by their male colleagues. Interestingly, 64% of those who saw a man and 77% of those who saw a woman about these problems said they had chosen that doctor, reflecting the importance women attach to these intimate problems.

Choice of women doctors by women

The likelihood of women consulting a woman doctor was analysed further by multiple logistic regression.

There was no interaction between expressed preference for a female doctor and problem type (Table 3). Women who said they normally preferred to see a female doctor were 6.3 times more likely to do so (95% confidence intervals 3.63, 10.87, $P<0.001$), while those with sex related problems were 2.8 times more likely to consult a woman (95% CI 1.65, 4.73, $P<0.001$). The difference between these estimates is significant, the effect of preference being 2.3 times more important than problem type in predicting the sex of the doctor consulted (95% CI 1.05, 4.80, $P<0.05$).

Table 3. Women consulting male and female doctors by preference and problem type.

		Number (%) of women consulting:	
Prefers female doctors	Sex related problem	Male doctor (n = 233)	Female doctor (n = 205)
No	No	186 *(80)*	95 *(46)*
No	Yes	27 *(12)*	35 *(17)*
Yes	No	19 *(8)*	55 *(27)*
Yes	Yes	1 *(<1)*	20 *(10)*

n = total number of women.
NB Women who said 'it depends on the problem' are included with those who did not express a general preference for female doctors.

Discussion

This study investigated the effects of patient choice on the pattern of morbidity presented in one practice. A minority of women always preferred to consult a woman doctor and as a result, appointments for these doctors were in greater demand.

Table 2. Women consulting male and female doctors for sex related conditions.

	Number of women with problem	Number (%) consulting:		Significance: χ^2 (1 df)	
		Male doctor	Female doctor		
Problems related to sex					
IUCD, cap, cervical smear	25	5 *(20)*	20 *(80)*	11.04	P<0.01
Genital disorders, vaginal discharge	30	8 *(27)*	22 *(73)*	8.69	P<0.01
Menstrual, premenstrual and other symptoms	30	13 *(43)*	17 *(57)*	1.38	NS
Oral contraception	30	14 *(47)*	16 *(53)*	0.67	NS
Pregnancy care	64	37 *(58)*	27 *(42)*	0.01	NS
Problems unrelated to sex	429	241 *(56)*	188 *(44)*	8.25	P<0.01
All problems	608	318 *(52)*	290 *(48)*		

NB Three women had no diagnosis recorded. IUCD = intrauterine contraceptive device.

While patients with chronic problems were able to choose whom they saw, those with acute problems were more likely to take the first available appointment, which was usually with a man.

The majority of women (77%) who saw a woman doctor for sex related problems had chosen the doctor they saw; however, 64% of women who consulted a man about sex related problems had also chosen to see him. Overall, women who normally preferred a doctor of their own sex contributed more to the additional numbers of women the female doctors saw than did those with sex related problems.

The extent to which these observations may apply in other practices depends partly on the consulting time available with male and female doctors. A single female doctor in a predominately male practice might find she saw more women with sex related problems, whereas practices with equal numbers of men and women might find their workload more evenly distributed.

Practices need to be aware of these differences, but how they should respond to them may be more controversial. In this practice, one of the women avoided antenatal care and asked patients to book with a colleague for this. Although this was partly because she had other interests, it also reflected her wish to see more men patients. Some practices operate individual list systems and if these are inflexible, they may prevent patients choosing a doctor of their own sex for potentially embarrassing conditions.

Finally, the observation that women's preferences for women doctors are not limited to sex related problems suggests that merely providing more family planning and well woman clinics, even if they are staffed by women doctors, will not be enough to satisfy the demand for more women in general practice.

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Acknowledgements

I would like to thank all the patients, doctors and reception staff of the practice for their help with this study. I am also grateful to Dr IC McManus for his help with the statistical analyses and to Mrs P Lochrie for help coding the questionnaires.

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