The Need for Female General Practitioners
- their patients, their health problems, their professional care

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The classic dyad in the medical encounter consists of a male doctor and a female patient. Of all patients who visit primary care about 60 % is female, a number that is known from many studies in many countries. The male/female ratio of general practitioners shows the opposite picture, and - at least in the Netherlands - an even more unbalanced one: at the beginning of this year 87 % of the Dutch general pratitioners was male, and only 13 % was female. While many female medical students enter the GP's vocational training, their entrance in the profession is hampered by all kind of impediments, social as well as formal ones: insufficient formal regulations in case of pregnancy or parent leave, difficulties in combining domestic and family tasks with a full-time job as a general practitioner, difficulties in getting a part-time job as a general practitioner, etcetera.
This has resulted in a feminist movement among GP's and even within the professional association of general practitioners in the Netherlands. There is a general call for more female general practitioners in order to enable patients to choose between a male and a female general practitioner.

From a scientific point of view it is interesting to test the legitimacy of such a call: Is there really a need for more female general practitioners, apart from gratifying the personal needs of this particular group of doctors or doctors-to-be:

1: is there really a preference for female G.P's among female patients?
2: are female GP's really confronted with other types of health problems as compared to their male colleagues?
3. is their professional care really different from the professional care that is delivered by male GP's?

These are the topics that will be adressed in my paper. It is a paper about the often subtle selection mechanisms that do play a role in the contacts between doctors and patients, and about the way this is influenced by doctor-patient communication patterns.

I shall start with the first research question: is there a preference among female patients for female GP's?

Our data stem from the National Study of Morbidity and Interventions in Dutch General Practice. This is a large nationwide study among 161 general practitioners and 340.000 patients. The GP's have

registered much detailed information on each encounter during a three-month-period, together covering a whole year's period. A sample of their practice population (all in all about 13.000 patients) have answered an extensive health and medical consumption questionnaire, and the GP's an equally large attitudinal questionnaire. This has resulted in a huge amount of data which are a goldmine for curious researchers such as I am.

For this project I made a selection of the data. It is clear - from the general distribution of male and female GP's, that many patients in the Netherlands do not have the opportunity to choose a female GP, for the simple reason that in many places there is none. And if you cannot choose a female GP, you cannot show your preference for one. For this reason, I have restricted my analysis to group practices with both male and female GP's; in these group practices, patients have the opportunity to choose between a male and a female GP.
So the sample of my first research question consists of 23 group practices with 39 male and 30 female GP's; together they have seen a large amount of patients, as you can see on this slide (47.000 consultations versus nearly 24.000 consultations).
If there had been no gender preferences, the male/female patient ration would have been equal for male and female GP's. As you can see on the next slide, in most group practices this is not the case. In only five group practices (the open bars) there is no gender preference; and, what is equally important: in none of the group practices there is an over-representation of female patients with male doctors; in 19 of 23 group practices there is a significant over-representation of female patients with female doctors; most of the relationships significant at a .001 level. Female patients tend to choose a female GP.

This becomes even more clear when we group the practices according to the involvement of the female GP's in the practice, as is shown on the next slide: the left group consists of group practices in which the female GP's don't have listed patient and have a very limited involvement in practice, mostly one or two afternoons a week; in these practices there is virtually no gender preference by the patients; the next group consists of group practices in which the female GP's do have listed patients but have a limited involvement in practice; that is to say half-time, at most. The group to the right consists of group practices in which the female and male GP's have an equal share in the care for their patients, and - as a result - the patients have the most realistic opportunity to choose between a male and a female GP. In these 10 group practices the gender preferences are all significant and very large. There is one instance in which the patient population of the female GP consists of 81 % female patients, while her male colleague only had 48 % female patients.

So our first conclusion can be, that female patients indeed tend to choose a female GP if and when they have the opportunity to do so; and that this tendency is stronger, as the opportunity gets more realistic. This finding in its own is enough to promote female general practitioners.

But, are these female GP's confronted with other health problems, too? Or do they see the same morbidity pattern as their male colleagues?
For this research question I used the data from those ten group practices in which the male and female GP's have an equal share in the care for their patients; for in those practices the patient's opportunity to show their gender preference is the most real. Our sample consists of 14 male and 12 female GP's confronted with 23.000 respectively nearly 19.000 health problems. The figures about the morbidity pattern are corrected for age, because there are slight differences in the age-distribution between male and female GP's. The health problems are classified according to the International Classification of Primary Care.

On the next slide we have indexed the male GP's health problems at 100, and made a graphical display of the over- or underrepresentation of different health problems at the female GP's office. We see some remarkable results:
Female GP's are confronted with more problems of the endocrine and metabolic system, including weight problems and eating disorders. They see more problems of the female genital system, such as menstrual problems, menopause problems and sexual dysfunctioning. Pregnant women also show a strong preference for female GP's; and - to conclude - female GP's are much more confronted with all kinds of social problems. And it is interesting to see that this over-representation is not entirely to ascribe to the patient's gender: male patients, too, present more metabolic and social problems when they meet a female GP!
Male doctors -at the other hand - also have a very typical morbidity pattern: they see more problems of the male genital system, more musculoskeletal problems, such as shoulder complaints, backpain and sport-injuries and more respiratory problems.
Psychological problems are equally registered by male and female GP's, all be it in a different form: male GP's mostly register either a medication request by the patient or a psychiatric diagnosis as the reason for encounter, while the female GP's mostly register psychological symptoms, such as restlessness, stress, general anxiety, and so on.

Formally spoken, the patient's reason for encounter is registered by the GP, who had the task to register the patient's reason for encounter apart from his own diagnosis. But it is not very likely that it is only the patient who determines what is registered as the reason for encounter. Therefore, the two lists of health problems are a too perfect mirror of the type of health problems that belong to the own sexe: eating disorders with the female GP's; breathing disorders with the male GP's; health problems around procreation with female GP's; health problems around recreation (sports for instance) with male GP's; it is a bit: "tell me the gender of your GP and I will tell you what your health problem is"!

It seems that both the patient's gender and the doctor's gender are important in the distinguished morbidity patterns. Their relative contribution to the differences in morbiditypattern can be shown for each type of health problem. To test the differences' significance, we have calculated chi-squares,

controlling for the GP's respectively the patient's gender, and we have done logistic regression analyses to test for interaction-effects.

On the next slide we see the over/ respectively underrepresentation of social problems in each dyad: male GP-male patient, male GP-female patient, female GP-male patient and female GP-female patient. In this case, it is the GP's gender that contributes to the differences in morbidity pattern between male and female GP's: male and female patients present more social problems in consultations with a female GP; when confronted with a male GP, social problems are less presented by both types of patients.
In the case of the metabolic problems (the eating disorders and so on), the situation is a bit more complicated; there is a clear GP-gender effect; but there is also a patient-gender effect, at least in the male-male dyad. In this dyad there is a clear under-representation of health problems of the endocrine and metabolic system. In terms of the logistic regression analysis: there is a GP-effect, and an GP-patient interaction effect.
The two types of health problems with an over-representation in the male doctors' consultation room: respiratory problems, and muskulo-skeletal problems both show the same pattern: it is mainly the patient's gender that contributes to the differences in morbidity-pattern that we found (twee dia's).

Our second conclusion is that, indeed, female GP's are confronted with a different morbidity-pattern as compared to their male colleagues. In this selection process there appear to be both GP and patient gender effects.

Now I will turn to the last research question: is there a gender effect in the provision of care: in the modern terminology: is the product that is delivered by female practitioners essentially different from the product of male practitioners?
To start with: female GP's spend more time with their patients than their male colleagues: in the studied sample, 26 % of the female GP's consultations had a total length of more than 10 minutes, against 16 % of the male GP's consultations (the difference is significant on the .001 level). But, female patients also tend to consume more time in their GP's office (23 % consultations with a total length of more than 10 minutes, against 16 % among the male patients; this is also a significant difference on the .001 level). The combined gender-effects show the following picture: the male-male dyad gets the least time; de female-female dyad the most. In the female-female dyad twice as many consultations last longer than 10 minutes, as compared to the male-male dyad.
But what else is there, besides time?

Registration is not the best method to measure the subtle differences in patient care that are supposed to exist between female and male GP's, according to the feminist movement. Observation of real-practice behavior is a better method, but a rather time-consuming and therefore costly one. At this moment we are preparing a large observation study into gender differences in general practice.

We do not have the results as yet. But we can present the results of a pilot-study from our collection videotaped consultations. NIVEL has a large store of about 3000 videotaped consultations, that are neatly catalogued and computerized, and therefore accessible for further research, without the need for new observations. From this databank of 3000 consultations I have made a selection of all female GP's (n=5) and all male GP's of the same age and generation (n=14). The latter is done, because the female GP's are on average younger than the male GP's and - as a consequence - have all followed the special vocational training for GP's that exists in the Netherlands for only the last twenty years, and is obligatory since. By matching on age and generation we therefore hope to have rather homogenuous GP-groups.

On the next slide it is shown in which respect female GPs can be discriminated from their male colleagues. From our databank I have chosen those kind of variables that are mentioned in the feminist literature about feminist health care:

1. one important concept in this literature is the amount of influence the patient has in the diagnostic process and the choice of the most appropriate treatment. Female GP's are more patient-centered in this respect than male GP's
2. Female GP's do not assess their patient's health problems more often than theire male colleagues as psychological in nature, but, if they do, they are more active in exploring the psychosocial context: As a consequence, in nearly half of all female GP's consultations there is explicit attention to the psychosocial context of the patient's health problems against in one third of the male GP's consultations. Psychosocial aspects are seldom ignored, when the doctor is aware of these aspects.
3. The female GP's consultations are a bit longer than those of their male colleagues (in this sample, the difference is not significant), but more important is the finding that female GP's have much more eye-contact (stopwatch-clocked): in more than 40 % of the time, the female GP looks directly at the patient. From other research (for instance my thesis) it is known that stopwatch-clocked eye-contact has a very hihg correlation with panel-assessed quality of care.
4. Coherently with this last result is the observer's assessment of the GP's interest and warmth towards the patient: in both respects, female GP's get higher marks than male GP's.

To end with, I will point to some verbal-communicative aspects. It is important to note that for most verbal categories (I have used the internationally accepted Roter's Interaction Analysis System) there are no differences between male and female GP's, at least no differences that reach significance. Yet, I will present those categories that fit within the feminist literature, because these show a trend that can be confirmed or falsified in the main study that we have started.

With this warning in head, we may notice, that in our pilot-study patients are more often encouraged to talk freely by their female GP's than by male GP's; female GP's also show more verbal empathy (reflections, paraphrases, and supportive statements). There are no differences in the amount of

interuptions between male and female GP's. It seems that female GP's are more often trying to create an egalitarian relationship with their patients by showing partnership ("if I were you, I would be worrying, too"), by legitimizing ("it is very wise of you to come back, now your complaints won't vanish"), by showing agreement and asking the patient if she had understood the patient's message.

We may conclude, that here too we find some differences between male and female GP's that are in concordance with the feminist literature. We have just started a large project into gender differences in general practice and hope to publish more results in the year to come. At this moment the following conclusions seem valid:

1. Women choose a female GP, if and when they have the opportunity to do so.
2. in female general practice we can see a morbidity pattern that is different from the male GP's morbidity pattern; for instance, they see more "female" complaints, but also more metabolic problems and social problems. There seem to be both GP and patient gender effects.
3. Female GP's tend to have a more egalitarian relationship with their patients, give them more influence in the course of the consultation and pay more attention to the psychosocial context of the patient's health problems.

So the main conclusion is warranted that - indeed - there is a need for more female General Practitioners. Besides, more research is needed into the subtle mechanisms in the doctor-patient interaction, that must be held responsible for the results that we found.

Thank you.

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Data:

National Study of Morbidity and Interventions in Dutch General Practice

(161 GP's - 340.000 consultations)

Sample 1:

All Group Practices with male ànd female General Practitioners

23 group practices

39 male GP's : 47.079 consultations

30 female GP's: 23.709 consultations

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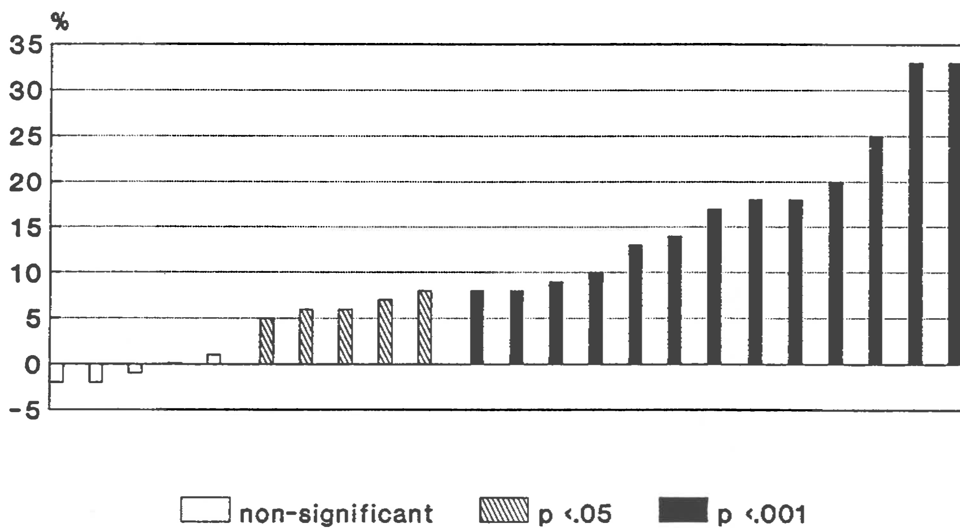
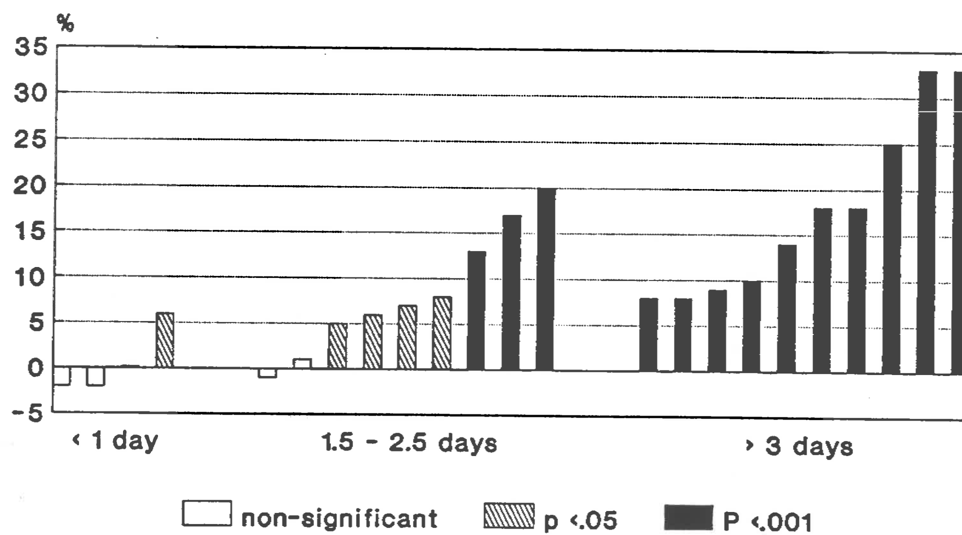
Over-representation of female patients consulting female GP's in group practices



Over-representation of female patients with female GP's grouped according to their involvement in practice



Sample 2:

Only those Group Practices with male ànd female GP's working 3 days or more a week

10 group practices

14 male GP's : 23.119 health problems

12 female GP's: 18.682 health problems