GENDER, HEALTH AND HEALTH CARE IN GENERAL PRACTICE

A comparison between women's health care and regular health care

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Voor allen die mij lief zijn

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PREFACE

This thesis describes the results of a research into differences between female and male general practitioners in their contacts with female and male patients. The innovatory element of this study is the additional comparison between women's health care and regular health care.
During the course of my study I became even more acutely aware of the importance of gender differences in health and health care. I also became increasingly interested in doctor-patient communication, to which an important part of my study has been devoted. It was, is and will be intriguing to witness contacts between patients and their doctors.

The study was subsidized by the then Ministry of Welfare, Public Health and Culture (WVC) and was carried out at NIVEL (Netherlands institute of primary health care).

The Advisory Committee consisted of:

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I would like to thank the members of the Advisory Committee for their enthusiastic, stimulating and constructive contributions.

Atie van den Brink-Muinen
Utrecht, September 1996

1 INTRODUCTION

This thesis concerns the relation between gender, health and health care in general practice.
The attention paid to gender differences was initially aimed at patients and has revealed important differences in health problems of women and men. Women have a higher morbidity and men a higher mortality; women get sick, men die[1]. But, the difference in the life expectancy of women and men has decreased since 1980. The decrease in the gender difference in mortality in cardio-vascular diseases, for example, is ascribed to changing socioeconomic and psychosocial factors[2]. Women report both more somatic and mental health problems, and have a higher medical consumption, partly explained by health restrictive (but non life threatening) chronic problems, especially at older ages[2]. Gender differences in medical consumption are also partly explained by differences in symptom perception between women and men[3].

Later, gender differences in health care provided by female and male general practitioners to female and male patients received specific attention, and various studies have revealed major differences among the four gender dyads: female-female, female-male, male-female, male-male. Female patients are often said to prefer a female doctor, especially for women's health problems, and men often seem to prefer a man, although to a lesser extent. Also, gender differences were found in morbidity pattern presented to female and male general practitioners. Female doctors are more often visited for gender-specific problems and preventive procedures, for embarrassing, private and behavioural problems[4]. Male doctors see more patients with musculoskeletal and respiratory problems. There are also differences in communication style. Female doctors talk more, are more empathic and open to a patient's feelings, pay more attention to psychosocial issues, and have a more egalitarian relationship with their patients. The consultations of female doctors are longer than those of their male colleagues.

At about the same time, the Women's Health Movement gained support, leading to the establishment of self-help groups and independent Women's Health Centres in various Western countries. These centres were based on the philosophy of feminist health care, with emphasis on self-help and self-determination. They organized group consultations and discussions to provide support for women and to exchange relevant information and knowledge about women's health problems. In the Netherlands, a specific type of health

care has resulted; women's health care, provided by female general practitioners in a single general practice Aletta, named after Aletta Jacobs, the first Dutch woman feminist physician. This is the only general practice known to provide women's health care, either in the Netherlands or elsewhere in the Western world.

The study describes this specific type of health care and the attitudes of the general practitioners of Aletta, comparing them with both female and male general practitioners providing regular health care. Before elaborating on the aim of the study, the general criticism of health care in the 20th century which led to feminism and the history of women's health care is reviewed. The different types of development of the women's health movement in Western countries, resulting in different types of care, are also considered, putting women's health care in place both nationally and internationally. Policy concerning women's health care as performed in the Netherlands during the last few decades is summarized. The research questions which follow are formulated to answer the general question 'What differences in care provision exist between female general practitioners providing women's health care and female and male general practitioners providing regular health care?'

1.1 The origin of feminism: the first feminist wave

The twentieth century was initially characterized by hierarchical relations, medicalization and a strong emphasis on cure. People began to express their discontent with the traditional, hierarchical model of the treatment offered by the medical profession, dominated as it was by male doctors. The asymmetric relationships became particularly clear in consultations between opposite genders.
At the same time, attention was also being paid to the medicalization of people's life. This is defined as *erroneously regarding daily and life problems as biomedical problems*. The medical regime deprived people of their capacity for self-care and determination of their own life circumstances.
Lastly, there was a shift from 'cure' to 'care'[5]. The idea that people could be cured of every illness was replaced by another perception of health and well-being. Health was no longer defined as *the absence of diseases*, but as *the presence of well-being*[6]. There was an emphasis on a healthy lifestyle with respect to feeding, exercise and stress management. Attention given to the influence of social and psychological factors on well-being has increased. The biopsychosocial approach emphasizes the strong interweaving of body and mind in both illness and health, and the necessity of considering somatic and

mental health problems as a whole. Body and mind continuously influence one another in circular processes[7].

People from various sides objected to the prevailing views[8], but women emphasized specific aspects, or had additional criticism of the prevailing behaviour and attitudes of medical professionals and societal situations, as described below.

Over the centuries, at both individual and group levels, women have resisted their inferior position in society[9]. The first feminist wave arose in America and Europe at the end of the last century. Feminism was defined as *the women's movement striving for equality of norms and values for women and men* [10]. Women aimed mainly at the formal aspects of emancipation, such as equal rights for women and men, women's suffrage, employment, and access to professional education[11]. They also campaigned on such issues as social abuses in the workplace, health care for mother and child, and prostitution[12]. The women's movement was not homogeneous. In different ways, women tried to counter oppression, to extend their scope. The feminist movement developed many initiatives for the improvement of the positions of women in such areas as health care, social work, employment and education[13]. Women also resisted the growing interference of doctors in various aspects of people's lives caused by the professionalization of health care. For instance, prescriptions by the (at that time exclusively male) medical profession for the behaviour of women as housewife, mother, wife and lover, reflected the authority of medical science[14].

Aletta Jacobs was a famous advocate of feminism. She was the first Dutch female student, physician, and Doctor of Medicine. She fought for a higher quality of health care for women and the availability of contraceptives. She also sought to improve women's health and working conditions, for instance, by advocating that prostitutes should be examined regularly for sexually transmitted diseases. Aletta Jacobs was also an advocate of women's suffrage and a promoter of world peace.

1.2 The origin and history of women's health care: the second feminist wave

At the end of the 1960s, a revival of the feminist movement resulted in the second feminist wave in America and Europe, part of which was the women's health movement. Women challenged the women-unfriendly attitudes of (in

particular male) doctors towards women, the unnecessary medicalization of women's lives imposed by doctors, and the appropriateness of medical practise to women's health problems, arguing that the social position of women was not taken into account. The feminists fought for freedom of reproduction and for legal and safe abortion[15-17]. They realized that the health care system was sexist and contributed to the continuation of the unequal social relationships of the sexes[18]. In addition, women became conscious of the medicalization of women's lives. A primary goal of the women's health movement was to induce changes in the organization and nature of regular health services[19].

Another social movement during the second feminist wave was the women's emancipation movement[20]. This movement strove for the development and increase of individual autonomy and the right to self-determination. Patients had become more mature and they asked for tailor-made care adapted to their individual wishes. The women's emancipation was represented in such groups as the feminist women groups, patients' associations, self-help groups, health centres, and so forth. In the United States, the aim was for women's power of decision over their own bodies and reproduction[15], and the legalization of abortion[16]. In the Netherlands, the women's emancipation movement became manifest in such groups as *Man, Woman, Society* and *Dolle Mina* ['Crazy Mina'], which aimed to break through the established role patterns within society[17], and in self-help groups where women learned to know their own bodies[21].

Within the women's emancipation movement, radical women groups acted as women liberation agents. They strove for the preservation of female identity and the feminist culture[9]. These women departed from the assumption that women form a distinctive social class and aimed at political power. They were chiefly to be found in Germany, Spain and Italy.
Probably as a result of the different norms and values, women's health care has developed in the various countries in different ways.

1.3 Women's health care in Western countries

The study *Women's health care in international perspective*[8] showed that the World Health Organization (WHO) had not developed specific programs based on women's health care principles, addressing instead the health problems of women in general. The WHO has worked on the improvement of women's health by aiming at such specific subjects as family planning,

mortality from pregnancy and abortion, women and children with AIDS, and female genital circumcision.

The involvement of Ministries of Health in Western countries in the development of programs and education aimed at the improvement of women's health has differed per country. In addition to private initiatives, the Ministries of the United States and Canada are involved in information and training centres. In Europe the governments of Italy and Spain have been initiators in improving women's health but the governments of Denmark, Sweden, Germany and Switzerland have not. The Ministries of Health in the United Kingdom and the Netherlands have been partly involved. Most of the women's health centres cooperate with other (regular) health care institutions. In America and Europe, most women's health care institutions (19 women's health centres or training and education centres) adhere to a feminist approach to health. Exceptions were the centres in Italy and Spain, which do not have a feminist background. In all countries a social approach played an important part. About half of these institutions do not cooperate with regular health care, especially in Germany. The extent of cooperation in the other countries varies.

1.4 Women's health centres

Women's health centres, giving information about women's health and forming discussion groups and self-help groups, were manifestations of the women's health movement. Established in 1969, the women's health centre in Boston was one of the first initiatives of the women's health movement in the United States. Women of different socio-cultural background visited this centre, which gathered information on various aspects of women's bodies, such as contraception, the menopause and sexual power. The centre was one of the thousands of feminist health organizations emerging during the 1970s as part of the women's health movements[22]. A significant percentage of these organizations were organized as alternative health services[19]. These organizations sought to empower women by organizing health care services that would foster women's control of their bodies and reproductive lives. In recent years, women's health care centres have evolved that offer many services at a single site as a new model for comprehensive health care[23]. In imitation of these, the first European women's health centres were established in Berlin and Geneva in the early seventies. In the Netherlands, women's health centres are spread all over the country. The women's health centre Aletta in Utrecht, established in 1980, is the only Centre in the Nether-

lands allied to a general practice, also named Aletta. This centre also has divisions for education and research.

In the study mentioned, three women's health centres were explored in more detail. These centres, in Frankfurt am Main, Germany, in Manchester, the United Kingdom, and in Utrecht, the Netherlands, showed both similarities and differences[8]. They are similar in that they originated from women's dissatisfaction with health care in the 1970s. The three centres practise from a feminist perception of health, based on a holistic approach. All of them are national centres for education and development of women's health care.

The most remarkable differences concern the women using the centres. In Germany and the Netherlands in particular, young, employed women visit the women's health care centres, whereas in the United Kingdom women of ethnic minority groups are more likely to come to such a centre instead of to regular health care.
A second difference is the wish to cooperate with or to integrate into regular care. The British women's health team wants to be totally a part of regular care. The German centre definitely does not wish to integrate into regular care, whereas the Dutch centre Aletta desires integration of women's health care principles into regular health care while remaining an independent training and development centre for women's health care.
Third, the centres differ in their delivery of medical care. In each centre information-giving is an important task, but in the British and Dutch centres medical care is provided in addition to other activities regarding women's health. Only in the Dutch centre is there a general practice that delivers care for all health problems, whereas in the British centre medial care is restricted to specific women's health problems, such as a PAP smear or breast examination.
A final difference is the place of volunteers in women's health care. Their involvement is common in the United Kingdom and the Netherlands, but not in Germany.

To summarize, in most of the Western countries studied, women's health care has been mainly restricted to health care for specific women's health problems, based on the body of ideas concerning women's health care such as a gender-specific approach and consideration of the patient's personal and social situation. Information-giving is generally considered of paramount importance. Women's health care has however been further developed in the Netherlands than in other countries.

1.5 Women's health care in the Netherlands

In the general practice 'Aletta' the principles of women's health care are the guidelines of the general practitioners in their everyday practising, providing both female and male patients with care for all health problems presented. Women's health care is defined as *consciously providing care from the perspective that patients' problems may be related to their socialization and their situation in society, and encouraging patients to map out strategies aimed at the realization of self-determination and self-responsibility with regard to both body and lifestyle*[24]. In this definition, women's socialization and their social position are considered as important determinants of psychological and social problems. Gender-specific complaints, power relations, and patterns of care in the lives of women and men are, according to this vision, indications of the interactions between women's individual histories and their social-cultural position[25]. The solution to these problems is aimed at increased autonomy and decreased power inequality, and in this respect it is emancipatory. The definition has been elaborated in a number of principles, which are described below.

1.6 Principles of women's health care

The most important and distinctive characteristics of women's health care are:
(1) consideration of the patients' gender identity and gender roles;
(2) consideration of the patient's personal and social situation.

Other principles also common to regular health care include:
(3) encouragement of patients to cope with health problems and to stimulate self-responsibility;
(4) treatment of patients with respect;
(5) prevention of medicalization (erroneous regarding of daily life and their body problems as biomedical problems)[26].

The three last mentioned principles already form part of the body of concepts propagated by the Dutch College of General Practitioners, but they are given specific emphasis in women's health care, which also requires a specific knowledge of and attitude to women's health problems. Specific attention is being payed to information-giving, an important means for realizing the principles. Good information provision requires such preconditions as good information material and a social chart of other care givers and specialists kindly disposed towards women.

The specific attention given by women's health care to women's socialization is based on such socialization theories as Freud's psychoanalysis; social-learning theory; cognitive-development theory; and Chodorow's theory about *the reproduction of mothering*[27 28]. These theories depart from the idea that women and men have been educated with the values and norms prevalent in their culture. These often gender-specific norms and values are thought to be desirable and necessary for participation in society, and they influence people's behaviour, skills and characteristics[11]. Women therefore present and express their health problems to the doctor different from men, and they also have different feelings about health problems. The aim of women's health care is to enhance the quality of care by using a gender-specific approach to the analysis of health problems, seeking solutions and giving treatments.

The influence of the women's movement on the participation of women with respect to decision-making processes as well as the role of the Dutch government with respect to women's health care is described below.

1.7 Women's influences on decision-making in health care

In the Netherlands women's striving for more influence and power with respect to the decision making in health care has only benefited from the feminist waves to a limited extent. In health care, as in politics and society, women still play an inferior role in decision making. In the sector Health Care and Welfare, at 80% the over representation of female employees in the lower ranks is considerable[29], while at the same time women occupy only 27% of the executive functions[30]. The higher the function, the lower the proportion of women[31]. In the Dutch Universities, including the Health Sciences faculties, the relationship between female and male employees is also asymmetric. Only 2% of professors and about a quarter of the teachers and researchers are women[32].

1.8 Policy on women's health care in the Netherlands

The Dutch government took advantage of the developments that had arisen from the second feminist wave, including the women's health movement and women's emancipation movement.
In 1983, a Project Group *Women's Health Care* was established, charged to advise the Minister of State about the integration of women's health care into the established, regular health care, so that this type of care would be

available for all women. Some health care projects (including Aletta) were provided with grants. A specialist journal of women' health care published by the Ministry of Welfare, Health and Culture (WVC) was established. The final conclusions and recommendations of the Project group *Women's health care* [24] have served as guidelines for government policy with regard to the integration of women's health care into regular health care[33]. At the beginning of 1988 a new *Advice Group on Women's Health Care* was convened by the Minister of Welfare, Health and Culture. In their Advisory Memorandum *The Position of Women's Health Care* the Advice group recommends the government to encourage the development of a more client-oriented, job-oriented organization of health care to which policy with regard to women's health care provision should be attuned[34]. Some policy recommendations were:

- the principles of women's health care should form a complete part of health care policy;
- the development and integration of women's health care should be encouraged by means of a function-oriented model;
- in the progress policy of women's health care the importance of the supply of women's health care should be the basic policy with regard to the entire health care.

In order to stimulate the integration of women's health care into regular health care the *Workprogramme Women's Health Care* of the Ministry of Welfare, Health, and Culture was started in 1992. The programme includes six spearheads of policy[35].

(1) giving women's health care an integrated place in the education of general practitioners and the promotion of their expertise;
(2) integration of women's health care into the standards of the Dutch College of General Practitioners;
(3) care programme for victims of sexual violence and the maltreatment of women;
(4) integration of women's health care into intramural and semimural psychiatry;
(5) integration of experience expertise into hospitals;
(6) regular financing of self-help in women's health care.

One of the most important objectives of the Work Programme is to involve the various parties of health in actual performance. The Ministry of Health, Welfare and Sports therefore installed a national Steering Committee of representatives in March 1996 which bears responsibility concerning content with respect to the further performance of the Work Programme Women's health care until the end of 1997[36].

The policy towards women's health care and the integration of the principles into regular health care could be depicted as positive. The grant of the Ministry of Welfare, Health and Culture to perform the present study was in line with policy. The aim of this study has been formulated as *to describe the specific type of health care and the attitudes of the general practitioners of Aletta and to compare them with both female and male general practitioners providing 'regular health care.* The research problem and the related topics investigated are described in the next paragraph.

1.9 Research problem

The general research question of this study, based on its aim is:
What differences in care provision are there between female general practitioners providing women's health care, and female and male general practitioners providing regular health care?

The related subsidiary research subquestions are answered in seven chapters in which the theoretical background, the relevant literature and the research methods are described and discussed. In this introduction a brief overview is given of the study design to make the general outline of the study clear.

The first research topic is the practice of female and male general practitioners providing regular health care to female and male patients. In Chapter 2, *Gender differences in practice style: a Dutch study of general practitioners*, a general impression is given of the differences in consultation characteristics, health problems presented, and services provided by female and male general practitioners.
In Chapter 3, *Consultations for women's health problems: factors influencing women's choice of sex of general practitioner*, the variation in the ways such specific women's health problems as vaginal discharge, breast examination and menstruation problems are treated by female and male doctors is studied in more detail. The factors contributing to the choice of presenting these specific health problems to a female or a male doctor was also investigated.
These two chapters give an insight into the relationship between doctor's and patient's gender and health as well as health care in a regular care setting. Next, women's health care is included in the study. Since the patients of the women's health care practice Aletta consist for the greater part of women aged between 20 and 45 years, the comparison of women's health care and regular health care is restricted to this age.

In Chapter 4, *Gender, health and health care: differences in female practice populations of general practitioners providing women's health care and regular health care*, the relationship between the characteristics of the practice populations of general practitioners and health and health care is investigated. Since the Aletta practice population is selective, this population cannot be compared with other doctors' populations without accounting for the differences in characteristics of the practice populations of the three groups of general practitioners, namely women's health care doctors, and female and male regular health care doctors. In relation to the selectivity of the Aletta population, the question: *Why women have chosen for women's health care* arises. Knowledge about their motives may improve insight into the backgrounds underlying the need for this specific type of health care. Chapter 4 also focuses on this issue.

In Chapter 5, *Factors influencing the type of health problems presented by women in general practice: differences between women's health care and regular health care*, the number and type of health problems female patients actually present to their general practitioners are related to such patients' characteristics as educational level and the role of worker, partner and parent. The influence is investigated of the type of health care, including the doctor's gender, on the type of problems presented. On the basis of its principles, one might expect more attention to be paid in women's health care to psychological and social problems than in regular health care.

In Chapter 6, *Differences in treatment: a comparison between general practitioners providing women's health care and regular health care*, with respect to the diagnoses made the relationship between the type of health care and general practitioner's gender on the one hand, and the interventions provided on the other are explored. The extent to which the women's health care principles *demedicalization* and *encouraging the patient to cope with health problems and stimulating self-responsibility* may be reflected in such interventions as giving prescriptions, ordering diagnostic tests, or referring patients to secondary care or mental health care is assessed.

In Chapter 7, *Gender and communication style in medical encounters: differences between general practitioners providing women's health care and regular health care*, the communication style of general practitioners (the verbal and nonverbal treatment of patients) is studied. Differences between the two types of health care, based on the different perception of health care, as well as between female and male general practitioners, are hypothesized. Additionally, it is argued that the communication style of patients is influenced by the doctors' communication style and gender. Patients' characteristics that

might be important in doctor-patient communication are also included in the exploration of the differences.

Chapter 8, *Women's health care: principles and practice*, discusses the five principles of women's health care on which general practice in Aletta is based. The principles are operationalized into several items in the *Women's Health Care Analysis System*', an observation scheme used to assess how the principles are applied in the 'Aletta' doctors' everyday consultations. Again, a comparison is made with female and male general practitioners providing regular health care.

In Chapter 9 the research results are summarized and a critical review of certain aspects is given. Certain recommendations with respect to health care, education and research are proposed and implications for future health care policy discussed.

This thesis *Gender, health and health care in general practice* seeks to enhance insight into differences between female and male general practitioners as well as between women's health care and regular health care. Since each of the Chapters 2-8 was originally written as a journal article and must be capable of standing alone, inevitably parts of the chapters overlap.

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2 GENDER DIFFERENCES IN PRACTICE STYLE: A DUTCH STUDY OF GENERAL PRACTITIONERS

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2.1 Abstract

The differences between female and male general practitioners were studied regarding three different factors: 1) Do female GPs see more female patients than their male colleagues in the same practice?; 2) Are female GPs confronted with different types of health problems from their male colleagues?; and 3) Do female GPs provide different services to their patients? Data from the Dutch National Study on Morbidity and Intervention in General Practice were used. All practices in this study with both female (n=23) and male (n=27) GPs were selected. This resulted in detailed data on 47,254 consultations, 62% of which were with female patients. The three research questions all received an affirmative response: 1) female patients tend to choose female general practitioners; 2) female GPs see different health problems from their male colleagues, and that is only partly because the patient so chooses; and 3) besides the expected differences in female-specific health problems, there is a clear GP-gender effect in the presence of 'social' and 'metabolic' problems in the female GP's consultations. Some differences in the provision of services between male and female GPs occurred, with female GPs spending more time to their patients and having a stronger tendency to provide continuity of care. In addition to a gender-effect (both physician and patient) a part-time effect in most issues studied was observed.

2.2 Introduction

The classic dyad in the medical encounter consists of a male physician and a female patient. Approximately 60% of all patients who visit Dutch primary health care practitioners are women[1]. This seems to be a fairly universal phenomenon[2-7]. The male/female ratio for general practitioners (GPs) shows a completely different picture, and - in the Netherlands at least - an even more unbalanced one: in 1991, 87% of independently established Dutch GPs were men, and only 13% were women[8]. A greater participation of female doctors in

general practice can be expected as a result of the sharp increase of female medical students in the last 10 years - a recognised phenomenon in the western world[9-16].

Because the number of female medical students is growing, gender issues have attracted attention in the medical field. Nowadays, there is a general call for more female GPs to enable patients to choose between a male and a female GP and to enhance the quality of care for specific health problems[17-19]. The underlying assumption is that women prefer a female GP and that some health problems are more easily presented to and differently cared for by a female GP. It is interesting to test the legitimacy of such a call from a scientific point of view. An examination of the literature shows that for each of these points some questions are still left unanswered and some results still have to be confirmed.

Patients' preference for a specific type of physician is generally measured by asking for the patients preference in a questionnaire[20-24]. In most of these studies, patients seem to have a preference for a physician of the same sex[22-25], although in one study a general preference for female physicians has been reported[26]. However, some studies also suggest that, until recently, there was a general preference for male physicians among male and female patients[19 22]. Female patients often report that they prefer female doctors for sex-specific health problems[20 22 26] for embarrassing or intimate problems[23 27], or for behavioral problems[22]; at this moment it is unclear whether female patients prefer female doctors for other types of health problems, or perhaps, more generally, regardless of the specific types of health problems. Sometimes the validity of these questionnaire-based measures of preference as measures of the real preference for male or female physicians is questioned, and it is suggested that they are more likely measures of a general sex bias[22 28]. This validity problem is not encountered in studies in which patients preference is measured by looking at the patient's actual consultation behavior. In such studies, it is assumed that the patient shows his or her preference for a male or female physician by making an appointment with a physician of his or her choice. In these studies, female patients generally chose female physicians[2 7 17 28 30]. The generalizibility of the results of most of these studies is dubious however, because the study took place in only one general practice with male and female physicians[7 17], or because data from larger data-sets are analyzed, without being corrected for the availability of female and male physicians[11]. The latter is a problem because of the uneven distribution of female and male GPs, while the most important factor in choosing a GP is geographical accessibility[19]. A new study is necessary with the participation of an equal, available and sufficient number of female and male GPs.

The literature on *the prevalence of various problems* presented to male and female GPs, or the type of diagnoses made by male and female GPs is much

more scarce. There is some evidence from morbidity surveys that female physicians are more often visited for genitourinary problems and preventive procedures[2 7]; female physicians also seem to perform better in certain preventive procedures (breast examination and pap smears), but worse for urinary tract infections in children. In one British study[2], some differences in morbidity pattern were found between male and female GPs, but the overall conclusion of this study was that "there seems to be no recognizable pattern in differences in morbidity seen by women and men doctors other than for gender associated conditions" [2 (p 755)]. However, this conclusion is based on one study only; more research on different data sets is necessary to confirm this conclusion.
Still less knowledge exists on *gender differences in the services provided*. In a recent American study, female doctors were shown to spend more time with their patients, especially with their female patients[31], a result that was not confirmed in a British study[11]; female doctors seem to have a more favorable attitude to psychosocial factors in patient care, patient education and health counseling[9], although it is not yet clear whether this attitude is also reflected in actual practice behavior. One recent Canadian study, after adjustment for other factors, demonstrated that women provided more counseling and psychotherapy[16], and also ordered more laboratory tests, a result that was also found in England[11]. In this study, however, we concluded that the percentage of women in the 15-to-44 age group accounted for most of the differences between men and women doctors rather than the sex of the doctor. Again, it would seem desirable to find out if these results can be replicated.
Accordingly, the present study has been designed, taking into account what is known from literature. Three research questions have been formulated:

1. Do female patients have a preference for female GPs?;
2. Are female GPs confronted with other types of health problems when compared with their male colleagues?;
3. Are female physicians different from their male colleagues with respect to the services that they provide to their patients?

2.3 Methods

We used data from the NIVEL National Study of Morbidity and Interventions in General Practice, a large nationwide study among 161 general practitioners working in 103 practices[32-34]. We based selection of participating GPs on a stratified (according to region, urbanization and distance to a general hospital), random sample of all Dutch GPs. The GPs registered detailed

information about all patient contacts in a 3-months period, with four groups (together) covering 1 year (April 1987 to April 1988). Data recorded included patient characteristics, characteristics of the consultation (e.g. first or repeat consultation, length of consultation, time of the day), problems presented and physician's diagnoses (classified in the International Classification of Primary Care), and services provided (diagnostic services, treatment, prescriptions, referrals). To ensure maximal uniformity in the data-collection process, all participating doctors were trained in the use of the classification systems. A written instruction with definitions was provided to keep at hand during the consultation[32]. Before the registration period started, all elements of the registration form were tested in each individual practice while a research assistant was present. During the registration period, a research assistant visited each practice to check the data for completeness and irregularities and to discuss problems that might have arisen. The doctors received feedback on their practice profile compared to the 'average' practice profile in the National Study on Morbidity and Interventions in General Practice, a service that was highly appreciated by the doctors and provided an extra opportunity for data control.

For this study we used select portions of the National Study's data set. We selected all group practices with male and female GPs (21 group practices with 27 male and 23 female GPs) to equalize patients' opportunity to choose between a male and a female GP. In this way, distance to the practice location can be ruled out as a possible explanation for differences between male and female GPs, as well as other relevant factors such as the composition of the practice population, the particular characteristics of the neighborhood and the availability of other health services in the surroundings. There was no significant difference between the age-distribution of male and female GPs; the mean age was 38.2 years for male GPs, and 41.8 years for female GPs. As part-time jobs are common for female physicians but can also be an alternative explanation for differences found between male and female physicians, the group practices grouped into practices with female partners working less than a 0,6 full-time equivalent (n=10) and practices with female partners working more than a 0,6 full-time-equivalent (n=11). For reasons of intelligibility these groups are called "part-time working", respectively "full-time working".

In this article (which is part of a larger study) we used only the routine consultation data for the analyses; home visits, emergencies and special consultations were excluded. Altogether 47,254 patients from the selected group practices were examined by the doctors; 29,322 of these patients were women (62.0%). To distinguish between GP and patient gender effects, the results are presented for both patient sexes. In this way it is also possible to study the different types of dyads (male-male, male-female, female-male,

female-female). The age-sex register of the patients consulting male and female GPs is presented in Table 2.1. As there are some differences in the age-sex register between male and female GPs and as age is an important factor in morbidity figures, a direct standardization for age was performed for all analyses presented. Furthermore, an additional standardization for morbidity was performed in analyzing the last research question. The influence of GPs gender will be analyzed under different conditions: 1) with part-time versus full-time working female physicians; and 2) with male versus female patients.

Table 2.1 Age Distribution of Consulting Patients, by GP's and patients' Sex and Female GP's Involvement in Practice

	♀ GP < 0.6 FTE				♀ GP ≥ 0.6 FTE			
	♂ Patient		♀ Patient		♂ Patient		♀ Patient	
Age (years)	♂ GP	♀ GP	♂ GP	♀ GP	♂ GP	♀ GP	♂ GP	♀ GP
0 - 14	11.8	14.9*	6.5	6.6	13.6	20.4**	11.3**	9.1
15 - 44	43.2	48.4*	52.0	57.7**	48.7*	45.8	50.4**	59.0
45 - 54	13.9*	10.8	11.9	11.6	12.6	12.3	11.8	11.3
55 - 64	15.9**	9.9	13.1**	10.2	11.6	10.6	12.1**	9.0
≥ 65	15.2	16.0	16.5**	13.9	13.5**	10.8	14.4**	11.6
N	5157	1310	7701	3360	7621	3844	8887	9374

♀, female; ♂, male
* p < .01
** p < .001
FTE, full-time equivalents

2.4 Results

2.4.1 Gender preferences in patient contacts

Contacts with female patients comprise 55.3% of the total workload of male physicians and 71.1% of the female physician's workload. In Figure 2.1 the result of gender preferences in terms of the sex distribution of patient contacts is presented for each of the 21 group practices with male and female GPs. If there had been no gender preferences, the male/female patient ratio would have been equal for male and female GPs and as a consequence, each bar in Figure 2.1 would have had zero length. In none of the group practices is there an over-representation of female patients with male doctors;

in contrast, in all but one of the 21 practices, the female GPs examine significantly higher proportion of female patients as compared with their male colleagues in the same practice. In the only practice where there is no such difference, the female GP works only 1 day per week. The differences are larger in those practices where the female GP works 0.6 full-time equivalent or more. Female patients more often choose a female GP than do male patients if and when they have the opportunity to choose one; this tendency is stronger, as there is more opportunity.

Figure 2.1 Over-representation of female patients with female doctors in 21 group practices

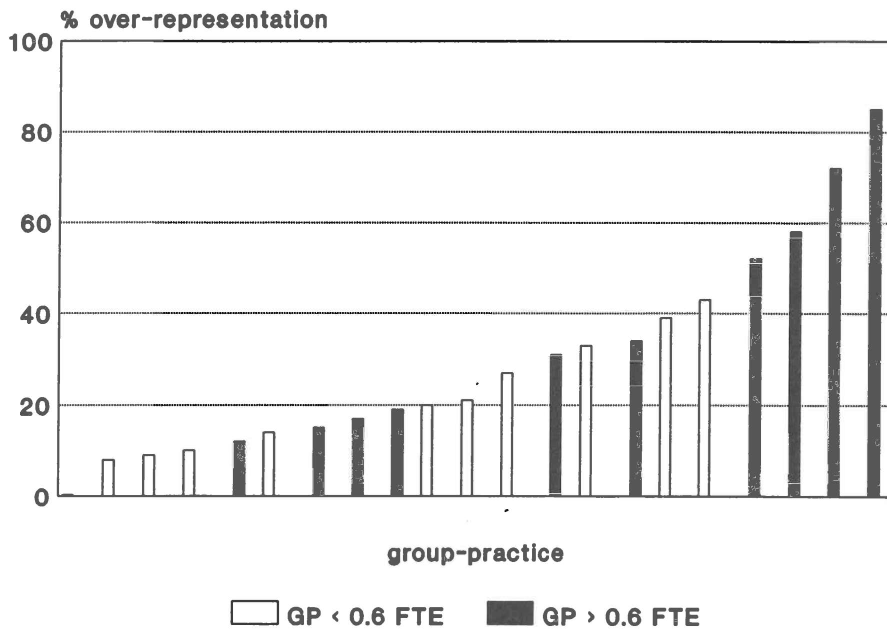
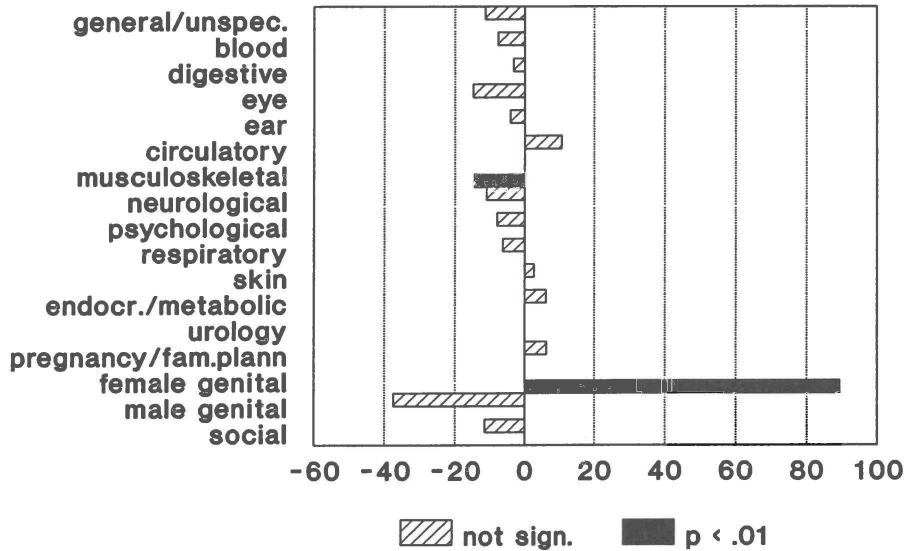
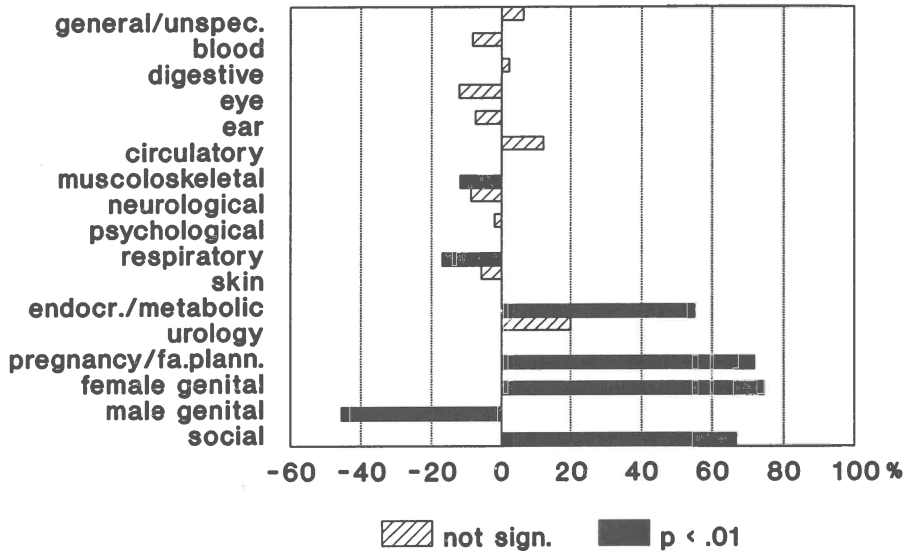


Figure 2.2 Over-representation of Reasons for Encounter presented to female and male GPs by female GP's involvement in practice





2.4.2 Gender differences in the problems presented

The morbidity pattern of the International Classification of Primary Care (ICPC) chapters for male and female GPs is presented in Figure 2.2. A detailed Table is presented in Appendix 2.A. Part-time working female physicians see nearly twice as many gynecologic problems compared with their male colleagues (8.9% vs. 4.7%); musculoskeletal problems are seen less frequently by these female GPs (20.6% against 24.1%). The other differences between the morbidity patterns of male and female GPs from this group are not statistically significant. When we look at the morbidity pattern presented to full-time working female GPs compared with that presented to their male colleagues, some considerable differences can be noted: female GPs see more gynecologic problems (7.5% vs. 4.3%), pregnancy/family planning (6.7% vs. 3.9%), social problems (3.0% vs. 1.8%), and endocrinologic/metabolic problems (3.1% vs. 2.0%). Conversely, female GPs see fewer musculoskeletal problems (23.8% vs. 27.0%), respiratory problems (13.2% vs. 15.9%), and problems of the male genital system (0.6% vs. 1.1%). The over-representation of gynecologic and pregnancy/family planning reasons for encounter can be ascribed to the higher percentage of female patients with female physicians, but social problems are presented more often to female physicians by both male (2.8% vs. 1.9%) and female (3.1% vs. 1.8%) patients. The same can be said of the endocrinologic/metabolic problems (2.9% vs. 1.7% for the male patients; 3.1% vs. 2.4% for the female patients).

2.4.3 Gender effects in provided services

In Table 2.2 some consultation characteristics are presented for female and male GPs under two conditions (full-time and part-time; male and female patients). Despite a direct standardization for patients' age, and morbidity, some differences remain in the consultation characteristics. On average, female physicians spend more time with their patients than their male colleagues (not presented in table): 32.7% (vs. 25.7%) of their consultations last longer than 10 minutes (Note: the average consultation length in the Netherlands is 8.1 minutes[35]). In group practices with part-time working female physicians there are also more long consultations than in group practices with full-time working female GPs (34.0% against 24.8%). In addition, female patients also have longer consultations than men (30.8% vs. 23.2%). As a combined effect consultations of more than 10 minutes occur 2.3 as often among part-time working female GPs with female patients as compared with full-time working male GPs with male patients.

Table 2.2 Consultation's Characteristics by GP's and Patients' Sex and Female GP's Involvement in Practice (%)

	♀ GP < 0.6 FTE				♀ GP ≥ 0.6 FTE				
	♂ Patient		♀ Patient		♂ Patient		♀ Patient		overall
	♂ GP	♀ GP	♂ GP	♀ GP	♂ GP	♀ GP	♂ GP	♀ GP	%
Time of Consultation > 10 min.	28.2	29.6	34.6	41.8**	17.9	24.5**	21.9	33.4**	28.0
First Consultation	44.6	45.2	41.9	43.8	49.6**	45.8	48.4**	44.9	45.6
Patient-initiated	62.7	71.1**	63.1	70.6**	74.1**	69.6	75.7**	73.3	69.1
Further Appointment	69.5	68.2	72.6*	70.2	58.6	66.8**	57.7	66.0**	65.7
Psychological aspect	23.9	35.8**	29.0	41.1**	31.6	31.5	33.8	33.8	31.2
Unsure/doubt	9.3	16.4**	9.6	15.9**	10.7	14.8**	10.3	14.0**	15.4
N	5157	1310	7701	3360	7621	3844	8887	9374	47254

♀, female; ♂, male
* $p < .01$
** $p < .001$
FTE, full-time equivalents

The way a GP manages his of her consultations is indicated by three variables: 1) who took the initiative for the consultation?; 2) is it a first or a repeat consultation of a problem presented in earlier consultations?; and 3) is the consultation concluded with a new appointment? In the full-time group a consistent picture emerges: male GPs have more first consultations, more consultations on the patient's initiative, and fewer consultations that end in a new appointment. These results pertain to both male and female patients. In the part-time group no such picture is seen: there is only a difference between male and female physicians in the amount of consultations on the patient's initiative; this is higher among female physicians, regardless of the sex of the patient.

Female physicians are less sure about the diagnosis than their male colleagues, regardless of their involvement in practice and regardless of the

sex of their patient; part-time working female GPs consider more complaints in their psychosocial context as their male colleagues, a result that is not found among full-time working GPs.

Table 2.3 Provided Services by GP's and Patients' Sex and Female GP's Involvement in Practice (%)

	♀ GP < 0.6 FTE				♀ GP ≥ 0.6 FTE				
	♂ Patient		♀ Patient		♂ Patient		♀ Patient		overall
	♂ GP	♀ GP	♂ GP	♀ GP	♂ GP	♀ GP	♂ GP	♀ GP	%
internal diagnostics	76.2	74.0	73.2	72.1	77.2	76.1	75.6	74.2	75.0
external diagnostics	6.1	6.6	8.8	11.7**	5.6	7.3**	7.5	8.9**	7.8
counseling:									
passive/listening	14.2	18.9**	16.6	18.7*	9.7	17.4	10.4	15.9**	14.2
active/exploring	17.4	15.5	20.1**	15.5	12.9	20.5	13.5	17.3**	16.4
reassuring	15.7	13.4	17.6**	13.0	17.5	10.4	18.4**	11.0	15.3
information about:									
health problems/ treatment	38.6	51.4**	38.3	45.6**	49.4**	38.6	46.6**	34.3	41.8
general health education	3.2	5.3**	3.5	5.6**	4.3	3.8	4.1	4.3	4.1
wait and see	5.1	4.9	4.2	4.2	5.9	5.0	5.6*	4.7	5.0
lifestyle advice	3.0	5.2*	2.4	4.1*	3.3	2.7	1.8	2.4*	2.7
med. techn. treatments	9.5**	6.3	5.6	4.9	8.9	7.6	6.6**	4.9	6.7
prescription	41.2	41.0	44.0**	39.3	42.5*	39.7	46.6**	43.2	43.1
medication without prescription	1.3	4.5**	1.9	4.3**	3.7	2.8	3.1	2.9	2.9
referral primary care	4.4	4.3	3.6	2.9	3.9	4.7	3.4	4.0	3.8
referral medical specialist	6.5	5.7	4.9	5.3	6.2	5.8	4.6	5.1	5.4
consultation	1.6	2.9*	1.2	2.3**	1.5	1.7	0.8	1.1	1.3
N	5157	1310	7701	3360	7621	3844	8887	9374	47254

♀, female; ♂, male
* p < .01
** p < .001
FTE, full-time equivalents

Table 2.3 presents an overview of services provided by male and female GPs for their male and female patients. Regardless of the sex of the patient, full-time working women doctors ordered more laboratory tests, wrote down fewer prescriptions, and performed fewer technical-medical interventions. They did more passive and active counseling, but registered fewer reassurances as compared with their male colleagues. They also gave less information. Generally the same picture emerges when we compare part-time working female GPs with their male colleagues, with one notable exception: this particular group of female physicians is in general much more active in providing information, general health education, and lifestyle advice as compared with their male colleagues.

2.5 Discussion

This study has some limitations. Because of the study's design, only group practices with male and female physicians have taken part in the study. It is possible that a self-selecting group of physicians is drawn to such group practices; the majority of Dutch GPs work in single-handed practices. This limits the generalizibility of the study. It is also possible that some of the differences that we found are the result of an agreement between the partners in the group practices (for instance agreements on antenatal care). One final warning is necessary about the validity of some of the measures for the services provided, especially the "softer" services: information giving, counseling, and general health education. While, in general, there is little doubt whether a GP has taped a patient's ankle or not, in some instances no such clear distinction can be made in case of (for instance) information giving. Despite the training, the written definitions provided, and the very careful process of data collection, some physician-specific inaccuracies are possible. An observational study is better equipped to measure these kind of variables.
Despite these limitations, this study reveals some interesting results. To start with the main conclusion, gender issues indeed seem important in general practice.
First, it is clear from our data that compared with male patients female patients tend to choose a female GP if and when they have the opportunity to do so; this tendency is strongest with patients of full-time working female GPs.
Second, female GPs see a different morbidity pattern from their male colleagues; for part-time working female GPs this is mainly to be found in the disproportionate amount of gynecologic problems; for the full-time GPs there is a much more variegated picture. In addition to the expected over-representation of female-specific health problems (family planning/pregnancy,

gynecology) and under-representation of male-specific health problems (male genital system), these female physicians also see more social problems and endocrine problems and less musculoskeletal and respiratory problems. Moreover, these differences pertain to both patient sexes. Male patients as well as female patients tend to present more social problems and endocrine problems when confronted with a female GP. The former is interesting, because it includes relational problems; the latter category is interesting because it includes metabolic and eating disorders. It is not clear from our data which is the cause and which is the result of this phenomenon. Perhaps male patients who are willing to discuss their social and/or metabolic problems with a GP tend to choose a female GP rather than a male GP. Conversely female GPs by their attitude and questions stimulate patients to discuss social and metabolic problems. In all probability, both situations occur as doctor and patient tend to socialize each other. Of course the same can be said about the underrepresentation of musculoskeletal and respiratory problems with female physicians; these types of health problems are more popular in the male physician's consultation room. The GP's gender is important in general practice; GPs seem to attract not only patients of the same sex, but also specific types of health problems, regardless of the sex of the patient. These types of health problems correspond with the existing sex-biases or stereotypes: "masculine" health problems (around the male genital system and the musculoskeletal system, which incorporates health problems arising from sports-related accidents, job injuries, and so on) are overrepresented with the male GPs; "feminine" health problems (around gynecology and family planning/pregnancy, but also around human relationships, food habits, and so on) are overrepresented with the female GPs. With part-time working female GPs only the differences in sex-specific morbidity become apparent; with full-time working GPs there also seems to be a more subtle or indirect gender effect. This may explain why only marginal differences around these types of health problems are found in earlier studies, where no distinction was made between full-time and part-time working female GPs [7 11] .

The third conclusion that can be drawn from this study is that female GPs and male GPs seem to develop a different working-style. As noted in previous studies[31], the female GPs from this study tend to have longer consultations, especially when they have a part-time job, and when confronted with female patients.

The service profile of female GPs is similar to what is known from other studies[11,16], with female GPs doing more counseling and ordering more laboratory tests, but writing fewer prescriptions and doing fewer technical-medical interventions. The situation of information giving is a bit complicated: part-time working female GPs seem to be more active in a variety of

information-giving activities than full-time female GPs; the full-time female GPs in our study registered even less information giving than their male colleagues. Why this is is not clear at the moment. Results from other studies indicate that female GPs have a higher number of information-giving utterances[31,36]. One possible explanation is that, in these studies, no distinction was made between full-time and part-time working female GPs. Our study clearly indicates some important differences within the group of female physicians between those with a full-time and those with a part-time job. As many women doctors prefer a part-time job, it is possible that in those studies the part-time effect is measured instead of the gender effect. Another possible explanation is that there could be a trade-off effect between information giving and counseling, which becomes most prominent under time pressure (of all subgroups studied, the full-time working female physicians proved to have -by choice or by force- the tightest appointment schedule). Information giving is considered active and instrumental behavior, whereas counseling is considered passive and affective behavior. This is consistent with feminist literature in which male behavior is dominated by active and instrumental types of behavior, whereas female behavior is dominated by passive and affective behavior. A last explanation that cannot be ruled out pertains to the validity of the registered communication variables as has been stated before. Because of the puzzling results, more research on this issue is necessary, partly with other research methods (preferably observation methods) [31 36].
From the way they manage their consultations it seems that full-time female GPs have a special interest in the continuity of care (relatively many repeat consultations visits, many visits on the GP's initiative, and many follow-up appointments). This tendency towards continuity of care can also be interpreted as a consequence of the female GP's greater uncertainty about the exact diagnosis of the patient's health problems, or of course, the female GP's greater willingness to admit such uncertainty. This is similar to the female GP's stronger tendency to order laboratory tests. All in all, a picture emerges of a female GP who is or admits more often than her male colleague that she is not sure about what exactly is wrong with the patient, and consequently orders laboratory tests and asks the patient to come back for a repeat visit (with which the patient complies). Whether this particular work style must be considered as precise and quality enhancing, or instead as insecure and medicalizing, can not be determined from this data, but is an interesting topic for further research.
A last result that has to be discussed is the unexpected but highly relevant distinction between part-time and full-time working female physicians. Part-time working female GPs seem to spend more time on their patients, time that seems to be largely spent on information giving and counseling, two

important types of behavior in preventive and psychosocial care. Possibly as a result, they are more sensitive to the psychosocial aspects of the patient's health problems. Conversely, with part-time working female GPs, patient's preferences are a bit less marked as compared with their full-time working colleagues, possibly because of their restricted availability; there is also less continuity in care, as expressed in proportion of repeat visits, contacts on GP's initiative and further appointments. This study clearly demonstrates the relevance of part-time versus full-time working as a research topic in itself.

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Appendix 2.A Percentage[a] of total number of consultations with reason for encounter[b], by GP's sex and female GP's involvement in practice

	♀ GP < 0.6 FTE			♀ GP ≥ 0.6 FTE		
	♂ GP	♀ GP	ratio ♀/♂	♂ GP	♀ GP	ratio ♀/♂
general and unspecified	11.5	10.2	.89	9.5	10.1	1.06
blood	1.3	1.2	.92	1.2	1.1	.92
digestive	8.3	8.0	.97	8.9	9.1	1.02
eye	2.7	2.3	.85	3.3	2.9	.88
ear	4.9	4.7	.96	5.3	4.9	.92
circulatory	12.0	13.3	.11	9.2	10.3*	1.12
musculoskeletal	24.1**	20.6	.85	27.0**	23.8	.88
neurological	5.5	4.9	.89	5.7	5.2	.91
psychological	6.3	5.8	.92	4.9	4.8	.98
respiratory	14.3	13.4	.94	15.9**	13.2	.83
skin	11.2	11.5	1.03	13.9	13.1	.94
endocrine, metabolic	3.3	3.5	1.06	2.0	3.1**	1.55
urology	2.2	2.2	1.00	1.5	1.8	1.20
pregnancy, family planning	6.4	6.8	1.06	3.9	6.7**	1.72
female genital system	4.7	8.9**	1.89	4.3	7.5**	1.74
male genital system	0.8	0.5	.62	1.1**	0.6	.54
social	2.6	2.3	.88	1.8	3.0**	.67
N	12858	4670		16508	13218	

♀, female; ♂, male
FTE, full time equivalent
* $p < .01$
** $p < .001$
a as one consultation can have more than one reason for encounter the total adds up to more than 100%
b Classified in the International Classification of Primary Care (ICPC)

3 CONSULTATIONS FOR WOMEN'S HEALTH PROBLEMS: FACTORS INFLUENCING WOMEN'S CHOICE OF SEX OF GENERAL PRACTITIONER

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3.1 Summary

Aim. This study is set out to examine the degree to which women choose to visit a female doctor for women's health problems and the determinants of this choice. The differences between women and men doctors with regard to treating women's health problems were also studied.
Method. Data from the Dutch National Survey of General Practice were used. All group practices with both women and men general practitioners were selected. Analyses were restricted to consultations among women aged 15-65 years about menstruation, the menopause, vaginal discharge, breast examination and cervical smear tests.
Results. Given the size of their female practice population, women doctors saw considerably more women with women's health problems than did their male colleagues. Women were more likely to consult a woman general practitioner if she was more available (that is, working longer hours), and younger women were more likely than older women to choose women general practitioners. Sex differences in the treatment of women's health problems were small and mainly related to the verbal part of the consultation: counselling and providing information. The doctors' availability and their certainty about the working diagnosis explained differences in the verbal aspects of consultations. Women general practitioners had longer consultations than their male colleagues mainly because more health problems were presented per consultation.
Conclusion. In order to increase the possibility of patients choosing women general practitioners, policy should be directed towards the education of more women general practitioners and women general practitioners should be encouraged to work more days a week.

3.2 Introduction

All women are affected by menstruation and the menopause; some of them have problems with these physiological processes and consult their physician.

Many women undergo a vaginal examination in connection with these problems and other problems involving the genital system. Women also consult their doctor for sex-specific examinations such as breast examination and cervical smear tests, and for contraception and other sex-related issues. Earlier studies found that female patients, in general, have a preference for a doctor of their own sex[1-3] and that they actually tend to choose a doctor of their own sex[4-8]. When consulting with problems of the female genital system, this preference is even stronger[1 9 10]. In one study, the preference for doctors of the same sex was strongest for items in which the complaint involved a sexual dysfunction and a thorough physical examination, for complaints of an intimate nature or where complete undressing was required[2].
Why do women choose to visit a woman doctor for women's health problems? Women find it easier, or less embarrassing, to talk to a woman because of feelings of shame and fear, and taboos about genital problems[1 9-11]. Further, women are thought to have a better understanding of women's problems and are therefore easier to talk to[10]. Women doctors are also said to be more gentle when performing gynaecological examinations than men doctors[11 12].
Patients' preference for a woman doctor could also be influenced by other factors, such as the general practitioner's experience and the patient's age and education. However, patient choice could be limited by the availability of women doctors. Women general practitioners are still in the minority, though their number has been increasing over recent years[13-18]. In addition, many of them work part-time and are therefore less frequently available than their mostly full-time male colleagues in the same group practices[19].
Although much attention has been paid to women's health problems in the literature,[20-23] so far no data have been published about differences between women and men general practitioners in their treatment of these problems. Some studies indicate that counselling is an important factor in consultations[14 24], particularly for gynaecological problems[25 26]. In consultations relating to women's health problems techniques such as reassurance and explanation have been advocated to reduce anxiety and to help patients relax[27].
As regards health problems in general, differences have been found in the treatment provided by women and men general practitioners[19]. Women doctors provided more counselling and advice on health education and lifestyle than male colleagues in the same group practices, while men more often gave information on health problems and treatment and offered more reassurance. The same study shows that women general practitioners admit to more uncertainty about their diagnoses than men general practitioners.

One could hypothesize that women and men general practitioners differ from each other in treating women's health problems. One reason could be that women doctors are more inclined to follow the two main principles of women's

health care - consideration of the socialization and sexual identity of women and consideration of their social context[28]. Other principles of women's health care are showing respect for patients and encouraging them to cope with health problems and to take personal responsibility[28]. Following these principles can avoid medicalization of a problem. Advice on the integration of these principles into normal health are has been issued to the government[29-31].

The number of women general practitioners is likely to increase in the future and this will have consequences for the accessibility and quality of care for women. The aims of this study were, therefore, to determine to what degree women choose women general practitioners for women's health problems and the determinants of this choice, and whether women and men general practitioners differ in treating women's health problems and, if so, how this can be explained.

3.3 Method

The data were derived from the Dutch National Survey of General Practice[32], a large scale study of morbidity and interventions in general practice. The study was conducted among 161 general practitioners working in 103 practices. Selection of participating general practitioners was based on a stratified random sample of all Dutch general practitioners (according to region, urbanization and distance to a general hospital). The general practitioners recorded detailed information about all patient contacts in a three-month-period, with four groups covering one year (April 1987 until April 1988). The data recorded included patient characteristics, characteristics of the consultation (such as first or repeat consultation, length of consultation), problems presented and doctor's diagnoses (classified using *International Classification of Primary Care*[33]), and services provided (diagnostic services, treatment, prescriptions, referrals). Counselling and information provided were recorded using the following categories: counselling passive/listening; counselling active/exploring; reassuring; information on health problems/disease; information about treatment/medication/referral/operation/ diet. The extent to which general practitioners were certain of their working diagnosis was recorded on a five-point scale for each problem presented (one, very certain to five, very certain). Data on the general practitioners' characteristics - sex, availability and experience - were obtained by written enquiry. Patients' characteristics, such as age, education and length of acquaintance with the doctor, were derived from national survey data[32].

To ensure maximal uniformity in the data collection process all participating doctors were trained in the use of the classification systems. Written

instructions with definitions were provided to keep at hand during the consultation[34]. Before the recording period started all the elements of the registration form were tested in each practice while a research assistant was present. During the recording period each practice was visited once a week by a research assistant to check the data as regards completeness and irregularities and to discuss problems that might have arisen. During the recording period the doctors were asked to formulate a diagnosis on the basis of a clinical vignette in order to get an idea of the extent to which participating general practitioners assign and name similar diagnoses. There was a reasonable degree of conformity (approximately 90%) indicating that this was a reasonably reliable method of registration. The services provided by the doctors were not validated.
For this study only data from group practices with both women and men general practitioners were considered (21 practices with 27 men and 23 women doctors) in order to balance patients' opportunity of choosing between a man and a woman general practitioner. This allowed distance to the practice to be excluded as a possible explanation for differences between women and men doctors, as well as the composition of the patient population, the characteristics of the area and the availability of other health services in the area.

3.3.1 Analysis

The analyses were restricted to women's health problems most commonly presented - consultations about menstruation, the menopause and vaginal discharge, and for breast examination and cervical smears. Only consultations with women patients aged 15-65 years (1654 consultations) were included, because women's health problems mainly arose in this age group (96.2% in this study).
Only health problems presented on the initiative of the patient alone or the patient and doctor together were selected in order to exclude screening an consultations (5.3% of 1654 consultations were excluded) from the logistic regression analysis concerning preferences for a woman or man general practitioner. The two dependent variables were the general practitioner's sex and treatment provided - counselling (active or passive), information (on health problems or treatment), reassurance, vaginal examination, prescription and referral (to secondary care or to other primary health care professionals). the independent variables were general practitioner's sex, availability, experience and certainty about working diagnoses; and the patient's health problem, age, education and length of acquaintance with her doctor. The availability of the doctors was defined as the number of full time equivalents which they worked in the practice per week (0.1 full time equivalent is a morning or an afternoon). Experience was defined as the number of years a

general practitioner had been working in general practice. Certainty about the working diagnoses was calculated for each general practitioner by taking the means of certainty for all the problems presented. Patient education was divided into three categories by the level at which full-time education was finished: low (primary education), middle (secondary education) and higher (higher vocational training and university). The length of acquaintance of a patient with her doctor (and vice versa) was the number of years she had been registered with her present doctor.

In order to compare the numbers of women consulting a woman or a man general practitioner for women's health problems the consultations with each general practitioner were expressed both as numbers and as percentages of the listed women patients because the female patient population of men general practitioners was bigger than that of women general practitioners (60.4% versus 39.6% of women patients). However, not all consultations in the group practices studied were with the doctor with whom the patient was registered; it is quite possible for a woman listed with a man general practitioner to go to a woman general practitioner in the same group practice. Differences in patient ages[19] were taken into account by performing a direct standardization for the age distribution of all women aged 15-65 years in the practice population of the participating general practitioners (in five categories of 10 years).

The consultation length was recorded by the general practitioners using six categories. In the analysis the midmarks of these categories were used in order to calculate the mean consultation length.

The percentages and mean values presented were tested for statistical significance by a difference of proportions test and by a t-test; both tests for independent random samples[35]. Multiple and logistic regression analyses were performed in order to explain differences between women and men general practitioners.

3.4 Results

Comparison of the two groups of general practitioners revealed no significant difference in their ages: the mean age of the 2 women doctors was 38.2 years and of their 27 male colleagues 41.8 years. Women and men general practitioners differed significantly in availability and certainty, but not in experience. Women general practitioners were less available (mean 6.1 versus 8.9 full time equivalents, $P<0.001$) and less certain about working diagnoses (mean 4.4 versus 4.6, $P<0.01$) than their male colleagues.

3.4.1 Preference for a women general practitioner

Women general practitioners were more often consulted for women's health problems than their male colleagues: 53.8% of all such consultations were with a woman general practitioner (Table 3.1). Given the size of their personal female practice population women doctors saw considerably more women's health problems, especially consultations about menopause problems and involving a cervical smear, than men doctors.

Table 3.1 Number of consultations for women's health problems and age standardized rate of consultation among women patients

	Women GPs		Men GPs		
Type of problem	Number of consultations	Number per 1000 women patients (n=10.566)	Number of consultations	Number per 1000 women patients (n=16.112)	Ratio of rate women:men
Menstruation	380	34.7***	321	20.3	1.7:1
Menopause	51	5.4***	37	2.1	2.6:1
Vaginal discharge	208	18.8***	195	12.5	1.5:1
Cervical smear	177	16.9***	132	8.2	2.1:1
Breast examination	74	7.0**	79	4.9	1.4:1
Total	890	82.7	764	48.0	1.7:1

n = number of women patients aged 15-65 years on GPs' personal lists. ** P<0.01; *** P<0.001.

Women presented additional health problems in more of the consultations with women doctors than with men doctors (46.1% of 890 versus 40.9 of 763). More than half of the patients consulting their woman doctor about menopause complaints (60.8%) and for a breast examination (55.4%) presented one or more other health problems in the same consultation; this was significantly more than in consultations with men doctors (37.8% and 42.3%, respectively; both p <.001). In two thirds of the consultations for a cervical smear other health problems were presented, (65.5% to women doctors and 64.4% to men); for menstruation problems the figures were 35.8% and 31.5%, respectively, and for problems concerning vaginal discharge 41.3% and 40.5%.

Logistic regression analysis was performed to find the determinants for the preference for a woman doctor. The chance a woman will visit a woman doctor about women's health problems is higher if the general practitioner is more available (odds ratio 1.08, P<0.001, for a doctor working 0.1 full time equivalents more). Younger women patients (in 10 years age bands) will more often choose a women doctor than older patients (odds ratio 0.82, P<0.001).

3.4.2 Treatment

The services provided by women and men general practitioners for women's health problems are presented in Table 3.2. Women doctors spent time listening to their patients in significantly more consultations for a cervical smear and breast examination than men doctors. Active counselling was provided in significantly more consultations for menstruation problems with men doctors than women doctors while the reverse was true for consultations for a cervical smear. In most cases, men general practitioners provided reassurance in consultations more often than women general practitioners did. Information on health problems and their treatment was generally provided more often by men doctors than their female colleagues. No significant sex differences were found for performing vaginal examinations and referring patients, although overall more referrals to medical specialists were made in consultations with men doctors. Finally, men general practitioners prescribed medication in more consultations about menopause problems than women general practitioners, but no significant differences in prescribing were found for the other women's health problems.

Table 3.2 Services provided in consultations for women's health problems

	% of consultations									
	Menstruation		Menopause		Vaginal discharge		Cervical smear		Breast examination	
Service	Women GPs (n=380)	Men GPs (n=321)	Women GPs (n=51)	Men GPs (n=37)	Women GPs (n=208)	Men GPs (n=195)	Women GPs (n=177)	Men GPs (n=132)	Women GPs (n=74)	Men GPs (n=79)
Counselling										
Passive/listening	12.4	16.8	27.5	13.5	9.6	6.7	14.1***	4.5	17.6**	5.1
Active/exploring	16.8	25.5**	27.5	35.1	12.5	12.3	13.6***	4.5	17.6	12.7
Information										
Health problems/disease	40.0	41.4	31.4	43.2	37.0	49.7***	14.1	12.9	29.7	35.4
Treatment/medication/referral/operation/diet	30.5	39.9***	21.6	40.5	37.5	44.1	12.4	9.8	23.0	21.5
Reassurance	16.1	24.3***	11.8	10.8	10.1	21.0***	7.3	15.2**	28.4	38.0
Vaginal examination	36.8	34.0	15.7	13.5	51.0	56.9	52.5	47.0	32.4	40.5
Prescription	44.7	43.9	45.1	73.0***	69.2	67.7	12.4	7.6	13.5	25.3
Referral	7.4	8.1	3.9	5.4	1.4	3.1	0.6	0.8	6.8	3.8

n=total number of consultations. ** $P<0.01$; *** $P<0.001$.

In order to explain these differences logistic regression analysis was performed (Table 3.3). The chance of a patient receiving information or reassurance was higher when she visited a man doctor for women's health problems than when she saw a women general practitioner. Although the provision of information seems to be explained by patients' characteristics and health problems (column two), when the data are also controlled for the characteristics of the doctor another picture emerges (column three). Women general practitioners were more likely to provide counselling. The sexes did not differ significantly in terms of prescribing, referring or performing vaginal examinations.

Table 3.3 Odds ratios of the chance that a service will be provided by a woman general practitioner

	Odds ratio		
	Uncontrolled	Controlled for health problem and patient's characteristics	Controlled for health problem and patient's and GP's characteristics
Counselling[a]	0.97	1.11	1.54**
Information[b]	0.76**	0.78	0.58***
Reassurance	0.53***	0.48***	0.38***
Vaginal examination	0.99	0.89	0.84
Prescription	0.87	0.90	1.06
Referral	1.08	1.33	0.76

[a] Passive/listening and/or active/exploring.
[b] Health problems/disease and/of treatment/medication/referral/operation/diet.
** P<0.01; *** P<0.001.

The contribution of the various characteristics of the general practitioner is shown in Table 3.4. General practitioners who were more certain about the working diagnosis were more likely to provide counselling and information; doctors who were more available were less likely to provide information. More experienced doctors were more likely to provide counselling but less likely to provide information. However, experience is unlikely to be of great relevance because the odds rations were all about 1.0. It should be noted that the strength of relationships with general practitioner characteristics will be overestimated, because the number of consultations per doctor is high and therefore standard errors will be smaller and as a result, relationships are more likely to achieve statistical significance.

Table 3.4 Odds ratios of the chance that a service will be provided, by characteristics of general practitioner

	Odds ratio by GP characteristic		
Service	Availability	Experience	Certainty
Counselling[a]	0.97	1.03**	6.74***
Information[b]	0.85***	0.97***	3.39***
Reassurance	0.90	0.98	1.71
Vaginal examination	0.95	0.99	1.59
Prescription	1.03	1.01	1.63
Referral	0.90	0.94	0.41

[a] Passive/listening and/or active/exploring.
[b] Health problems/disease and/of treatment/medication/referral/operation/diet.
** P<0.01; *** P<0.001.

3.4.3 Consultation length

The mean consultation time for women's health problems was 10.3 minutes with women doctors and 9.7 minutes with men doctors (P<0.01). This difference can mainly be ascribed to problems concerning the menopause and vaginal discharge: with women general practitioners consultations for these problems lasted a mean of 12.1 and 10.8 minutes, respectively, while for men general practitioners the mean times were 8.5 and 9.5 minutes, respectively (both P<0.01). There was no significant difference between the sexes for length of consultations for menstruation, breast examination and a cervical smear. Women seeing their doctor with menopause problems had the longest consultations (mean for all women 10.6 minutes), those attending for a breast examination the shortest (mean 9.6 minutes).
The general practitioner's sex alone makes only a small contribution to explaining the longer consultation time with women general practitioners (0.5% of variance explained, P<0.01). If patient characteristics, type of health problems and the number of health problems presented in one consultation are taken into account 17.8% of the variance explained (P<0.001).

The availability and experience of the general practitioner, the length of acquaintance between doctor and patient and the number of problems presents patient presents explain 20.0% of the variance in consultation length (Table 3.5). However, the general practitioner's sex and patient's education do not contribute to this explanation, nor do the general practitioner's certainty and patient's age. Part-time doctors had longer consultations, as did less experienced doctors. The less doctors were acquainted with the patient, the

more time they took for the consultation. However, the strongest explanatory factor remains the number of problems presented by the patient.

Table 3.5 Standardized and unstandardized regression coefficients (beta and ß) for length of consultation

	Beta	ß
GP characteristics		
Sex	-0.01	-0.08
Availability	-0.12***	-0.24
Experience	-0.09**	-0.05
Certainty	-0.03	-0.64
Patient characteristics		
Age	0.05	0.02
Education	0.05	0.39
Length of acquaintance	-0.11***	-0.73
Number of problems mentioned	0.35***	2.52

** P<0.01; *** P<0.001.

3.5 Discussion

The system of data collection used in this study has advantages and disadvantages. On one hand, a great deal of accurate information is produced but, on the other hand, certain areas such as counselling and provision of information and reassurance allow room for interpretation on the part of the doctors. Whether counselling is recorded as active/exploratory or passive/listening will depend in part on the assessment of the doctor; provision of information may be so much part of their routine that it may not be recorded. These verbal and non-verbal aspects of communication need further investigation by means of independent observation methods, which ensure the validity of the recording.

Another restriction is imposed by the group of general practitioners selected for this study. Only group practices with women and men general practitioners were investigated, so that, in theory, patients have the chance of consulting a woman doctor. General practitioners in such practices may differ from other colleagues in practice style and hence the generalizibility of the result may be limited. This applies particularly to men general practitioners, because while fewer than half of all Dutch men general practitioners (42%) belong to a group

practice, 80% of women general practitioners work in group practice[36].
These limitations should be borne in mind when considering the results of the study. More than half of the women studied visited a woman general practitioner for women's health problems (54%). This percentage is considerably higher than the figure of 43% for all health problems[19]. When the number of women in the practice population is taken into account, women doctors sam many more women with women's health problems than their male colleagues.. The embarrassing nature of these health problems did seem to influence the choice of sex of general practitioner. Consulting a woman doctor seemed to diminish women's reserve about mentioning health problems in general; more women presented additional problems in consultations with women doctors than with men doctors.
Determinants of the preference for a woman doctor were the availability of the doctor and the age of the patient: women are more likely to consult a woman doctor if the doctor is more available, and younger women patients were more likely to choose a woman general practitioner than older patients. The issue of availability is an important finding. Only 14% of all Dutch general practitioners are women, many working part time and women's preference in general practice is for part-time work[36]. The demand for women general practitioners is likely to increase among the future generation, given the preference of younger women for a doctor of their won sex. The implications for health policy are clear. To enable women to consult a women doctor more women medical students have to be encouraged to become general practitioners. Additionally, vocational retraining should be organized for women general practitioners returning to work after raising a family.
Small sex differences were found in the treatment of women's health problems by general practitioners, mainly relating to the verbal part of the consultation. The small numbers of consultations, especially for menopause problems and breast examination, may explain why some differences did not reach statistical significance. In general, women doctors listened more often to their patients than men doctors (passive counselling); This was especially true with women who had problems with the menopause and with women undergoing an examination for breast or cervical cancer. Men general practitioners undertook more active counselling than women doctors with women consulting them for menstruation problems, while women general practitioners undertook more active counselling with women undergoing an examination for breast or cervical cancer. Information seemed to be more commonly provided by men than women doctors, as did reassurance. Communication and information are important issues, particularly from the point of view of women's health care, but it cannot be concluded from these findings that the principles of women's health care with regard to communication and provision of information are better met by women than by

men general practitioners in the group practices investigated.
Another factor seen to be important in women's health care is the avoidance of medicalization where possible[28]. This would be apparent in prescribing and referring. With the exception of prescriptions for menopause problems, which were provided in significantly more consultations with men doctors than women, there were no sex differences in prescribing and referring. However, this exception is an interesting one, because women's health care emphasizes the menopause (and menstruation) as a normal physiological phenomenon that needs no medication in most cases[28]. It seems that women doctors support this idea more than men doctors. Men doctors more often gave information than women doctors, but because the content of the information was not investigated it cannot be assumed that this led to less medicalization.
How can these differences between women and men general practitioners in the treatment of women with women's health problems be explained? Counselling appears to be related to certainty about the working diagnosis: for both sexes combined more certainty coincided with more counselling. However, women doctors provided more counselling, especially passive counselling, but were less certain about their diagnoses, or were more willing to admit such uncertainty. This uncertainty is also demonstrated by a greater tendency to order laboratory tests and to ask the patient to make a repeat visit[19]. Whether this uncertainty should be considered as enhancing quality of care, or as increasing medicalization, cannot be determined from these data.
Provision of information about health problems and their treatment is also related to more certainty. The more certain doctors are about the diagnosis, the more specific information they can provide. Less involvement in the practice also influences the extent of provision of information. This is probably a matter of time: part-time general practitioners plan and take more time per consultation and therefore they have more time to provide information to their patients. Another possible explanation is that counselling and provision of information are sex-related behaviours. Counselling can be considered as passive and affective behaviour, and may therefore be a specific characteristic of women[28]. Provision of information is regarded as active and instrumental behaviour and hence can be ascribed to men. Finally, reassurance was only related to sex: men general practitioners tried to reassure their women patients more often then their female colleagues. Perhaps this can be ascribed to the opposite sex of doctor and patient or it may indicate that reassurance is a typically male characteristic. Another explanation may be that women only reassure their patients if they are certain about the diagnosis. It can be concluded that to some degree certainty about the diagnosis and availability explain differences in the verbal aspects of consultations for women's health problems. However, the results do not imply

that men or women supply a higher quality of care.
The length of consultation also deserves attention: women general practitioners had longer consultations for women's health problems than men general practitioners. In trying to find an explanation for this it was ascertained that the number of problems presented, in particular, influenced the consultation length. Since women general practitioners were more often consulted by patients presenting more than one health problem, this partly explains the sex difference. However, it also can be argued that women general practitioners encourage their patients to present additional problems.
Other factors relevant to the length of consultation were the availability and experience of the general practitioner and the length of acquaintance between doctor and patient. The less general practitioners were involved in the practice, the less experienced they were and the less acquainted with a patient, the longer the consultation was. These factors explain only 20% of the variance in consultation length. Other factors must have contributed to the length of consultation time, for instance the content of communication, information and examination but these were not investigated in this study.
Women more often consulted a woman than a man general practitioner for women's health problems and, in view of this preference, these problems especially should be a task for women general practitioners. However, once in the consultation room there were few differences in the treatment of these problems, except in terms of consultations. More detailed studies, particularly of the verbal and non-verbal aspects of consultations, are needed to determine whether there are differences between women and men general practitioners in the quality of care provided.

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4 GENDER, HEALTH AND HEALTH CARE: DIFFERENCES IN FEMALE PRACTICE POPULATIONS OF GENERAL PRACTITIONERS PROVIDING WOMEN'S HEALTH CARE AND REGULAR HEALTH CARE

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4.1 Abstract

Differences are investigated between female practice populations of general practitioners providing women's health care (in the practice 'Aletta') and of women and men general practitioners providing regular health care. In an extensive health interview with women patients (15 years or older), data are gathered about socio-demographic characteristics, gender-role, attitudes, somatic and mental health status, and medical consumption. The Aletta patients were also asked about their motives to choose for women's health care. 'The Aletta patient' can be characterized as a young, urban, single, highly educated, working, and childless woman, who deliberately choose for women's health care. She is more androgynous than women of other doctors, less inclined to seek help with the GP, she suffers more from psychosomatic and psychosocial problems, and she has a poorer mental health. It results in a higher use of mental health care, and also of alternative health care. Implications for future health policy are discussed.

4.2 Introduction

During the 'second feminist wave', back in the late 1960s, women's groups rebelled against the established health care, because they were discontented with the attitudes of - in particular men - doctors towards women and the medicalization of women's lives[1]. They challenged the appropriateness of medical practice to their health problems and they fought for freedom of reproduction and for legal and safe abortion. Women's health centres were established providing care based on the philosophy of feminist health care: self-help and self-determination were important criteria.

In the Netherlands, a Centre for Women's Health Care was established in 1980 in the city of Utrecht[2]. It was called "Aletta", after Aletta Jacobs, the first Dutch feminist physician and the first Dutch woman to receive a doctorate (1854-1929). She fought for higher quality of women's health care. In 1984 a general practice was added to the Centre. In the practice three 'ordinary'

women general practitioners are practising from a feministic point of view. The patients who choose for a 'women health care doctor' have to visit her for all their health problems, not only for their 'female' health problems. The knowledge and working-methods that are developed in the Centre are shaped and implemented in the work of the general practitioners; the aim is improvement of the quality of care[2 3].
Women's health care has been defined as 'to work consciously in care-giving to women from the viewpoint that women's problems can be related to their socialization and their position as women in this society, and to help women to develop strategies in order to get more authority over and responsibility for their own bodies and lives'[4].
The principles of women's health care can be summarized as[5]: consideration of the patient's gender-identity and gender-roles; consideration of the patient's personal and social factors; respect for the patient; encouragement of the patient's self-responsibility and self-determination; demedicalization (prevention of labelling normal physical processes as pathological). The two first principles are considered to be the most important and distinctive characteristics of women's health care; the
other three principles are already part of the ideology being propagated by the Dutch College of General Practitioners[6]. In addition, specific attention is paid to information-giving, which is an important means for realizing the principles. The principles of women's health care serve as guidelines for care-giving that are aimed at enhancing the quality of care for women. It must be emphasized that these general practitioners have qualified in the normal way and provide care for all the health problems of their patients, and not only for 'female' health problems. However, they place different emphases on certain aspects of care, in accordance with the principles of women's health care
Choosing for women's health care is partly also choosing for women general practitioners. Earlier research has shown an over-representation of women patients registered with women, as compared to men, doctors[7 8] . Many women prefer a doctor of their own sex[7 9-17] especially for women's health problems and problems involving extensive handling, probing and undressing[10 11 13 18].
Because the general practitioners at Aletta provide 'women's health care', based on the philosophy of feminist health care, the question arises as to whether the Aletta practice attracts another population, compared to other general practices (of women and men general practitioners), with regard to social-demographic characteristics, attitudes towards help-seeking, health status, and resulting medical consumption. By addressing this question we can arrive at a description of 'the Aletta patient' and her motives for preferring women's health care.
It follows then that a logical question is whether and to what extent

differences between the practice populations of women and men general practitioners, providing regular health care, exist and how do the differences influence patients' medical consumption. For, earlier studies already showed important gender differences in the health problems presented and in the provided services[7 13].
In this article the question is restricted to women patients, because the majority of the Aletta patients is female (84.3%). Moreover, women's health care is aimed primarily at women.
The research questions which will be addressed in this paper are:
1. What are the differences between the female practice populations of general practitioners who provide women's health care and of women and men general practitioners who provide regular health care?
2. Are the female practice populations different from each other with respect to medical consumption, and if so, how can this difference be explained?
3. What women choose for women's health care and why?

4.3 Expectations

In view of the feminist basis of Aletta one could assume that the general practice attracts a specific group of women patients, with specific motives for choosing Aletta. In view of the relatively short history of feminism and women's health care as well as the fact that the Aletta practice is only ten years old, the population of Aletta could be expected to be younger than that of the other practices. One could also expect the Aletta patients to be more highly educated, because their motives to become registered with this specific practice are probably idealistic, well-considered and based on feminist principles - such as consideration of the patient's living and working circumstances and responsiveness to the patient's own opinions about health and health care. Following on from these differences in age and education, one could expect differences between Aletta women patients and other women in other socio-demographic characteristics, such as living single, without children, and being employed.
Further, one could assume that, because of the 'specificity' of women's health care, the female Aletta patients are more assertive, critical and independent, resulting in another gender-role than other women have. For, gender-role refers to the way women and men construct their femaleness and maleness within subjective assessment[19]. It follows that the Aletta patients might be less influenced by prevailing norms and values, and that this could be reflected in more androgynous gender-types and fewer feminine types among Aletta patients compared with other populations[20].
The specific 'Aletta characteristics', such as self-determination and self-

responsibility, also might influence their attitudes towards help-seeking for health problems. For example, their expectations of a doctor might be lower, and the extent to which they think that their health status can be influenced by themselves might be higher, whereas the influence by the doctor or by chance might be assessed as lower[21].

One could expect further that the Aletta women, being younger, more often having a high income and more highly educated, have a better somatic health than the other women[22]. However, Aletta women's mental health might be worse. Since they have had more education and possibly therefore more knowledge of medical issues, the Aletta women may be more 'proto-professionalized'. Protoprofessionalization is defined as the penetration of the culture of a professional group into the culture of the laity[23]. A strong relationship was found between education and professional level with a professionalization score[24]. Higher scores had the highly educated people, and professionals with a high status. A high score was related to more psychosocial problems.

Taking into consideration the expectations formulated above with respect to the first research question, one could further expect that the female Aletta patients have another medical consumption than the other women (question two). Firstly, their other help-seeking behaviour as well as their supposed better somatic health may result in less visits to the general practitioner. Secondly, one could assume that the Aletta women have a higher use of mental health care, because of more psychosocial problems. Lastly, as regards the use of alternative health care, it is known that the number of patients who visit an alternative practitioner is still rising, more women than men pay a visit to an alternative practitioner, especially those aged between 30 and 59, and the same applies to people with a higher education and those who are privately insured. Most important, however, is the health status: those who feel themselves less healthy and are ill for a long period, visit alternative practitioners more often[25]. Thus, because of the age, education and income of Aletta patients, is might be expected that they more often use alternative health care, but on the base of their health status, one might expect a lower use.

Answering the first two questions will result in a description of 'the Aletta patient'.

4.4 Data and methods

The present study compares the female patient population of Aletta with the female patient populations of other (women and men) general practitioners. The first information source is an extensive patient health interview which is

part of an extensive study of gender differences in health and health care, the general purpose of which is to describe and to compare care-giving and attitudes of Aletta general practitioners with those of other women and men general practitioners.

The data are partly derived from a study carried out in 1993 among the three women doctors of the Aletta practice and their 3740 patients. 253 female patients (all aged 15 years and older), who were selected by a random sample, were interviewed at home. The response rate amounted to 51.0%. The main reason for non-response (82.5%) was that the respondents were unable to be contacted, by telephone or letter, generally because they had moved and had not forwarded their new address to Aletta. 13.3% of the non-respondents refused an interview because of lack of time or personal choice. Illness and language problems were the other reasons for non-response (4.3%).
Non-response analysis yielded no significant differences between women patients in the response group and the non-response group with regard to age, education, type of health insurance, employment status, and whether they lived alone or had children. More women in the response group contacted their doctor or the practice secretary (during 3 months: 61.9% versus 53.2%, $P<0.05$). For the female patients who had contact with the practice there was no difference in the mean number of contacts between the two groups. No further differences were found. So, the interviewed female population is considered to be similar to the female practice population (patients enlisted with the general practice).

In the health interviews the Aletta patients were asked about socio-demographic characteristics, such as age, education and living circumstances. They were questioned about opinions and attitudes towards help seeking (help seeking for common health problems and Health Locus of Control[21]), subjective morbidity, their mental and psychosocial condition and medical consumption. They were also asked about the motives they had for their decision to choose for Aletta and for a woman doctor (since in the Aletta general practice there are only women doctors), and for which health problems they especially preferred a doctor of their own sex.
The Aletta women also completed the Bem's Sex Role Inventory, a self-report instrument that asks the respondent to indicate on a 7-point scale how well each of 40 attributes describes her- or himself[26]. The instrument identifies both gender-typed individuals - feminine or masculine - and androgynous and undifferentiated persons. It was designed for empirical research on psychological androgyny, a term that denotes the integration of femininity and masculinity within a single individual. The items were selected on the basis of

cultural definitions of gender-typed social desirability. Half of the attributes reflect the culture's definition of 'femininity', such as gentle and understanding, and half reflect the culture's definition of masculinity, for example assertive and independent. The items were translated into Dutch in order to meet the Dutch cultural definitions of the items. The Aletta patients were also asked to report whether they considered themselves to be feminist and emancipated.
The other source of information was the Dutch national survey of general practice: a large-scale study of morbidity and interventions in general practice (1987-1988)[27]. The study was conducted on 161 general practitioners working in 103 practices, with a total of 340,000 patients. Selection of doctors was based on a stratified random sample of all Dutch general practitioners according to region, urbanization and distance to a general hospital. This selection procedure allowed distance from the practice, differences between women and men doctors, composition of the patient population (women and men together), characteristics of the area and the availability of other health services in the area to be controlled for. The response rate for the health interview was 76.6%.
Only group practices with both women and men general practitioners were considered (21 practices with 23 women and 27 men doctors), in order to balance patients' opportunity for choosing between a man and a woman general practitioner[11]. Further, only those women patients (15 years and older) were selected for whom it was known on which doctor's (woman or man) list they were registered. This yielded reference groups composed of 391 women patients of 22 women doctors (one doctor did not participate), and 628 women patients of 27 men doctors.
Scores from members of the 'Dutch Health Care Consumer Panel' were used as reference group for BEM's Sex Role Inventory[17]. This panel resulted from a random sample of Dutch households and is managed by the Dutch Consumers Union and the Netherlands Institute of Primary Care (NIVEL). Four hundred and seventy-six women from the panel (87%) completed the inventory. This can be assumed to be representative of the Dutch female population.

Patients' socio-demographic characteristics, attitudes towards help-seeking, health status, being an Aletta patient or not, as well as sex of the general practitioner are the independent variables. Gender-role is assumed to be included in the variable 'being an Aletta patient or not'.

Figure 4.1 Dependent and independent variables

<u>Women patients' socio-demographic characteristics:</u>
* age, in 6 categories of 10 years: 15-24, 25-34, 35-44, 45-54, 55-64, 65 or more
* low or high education: high means higher educational training and university
* employed no/yes
* single no/yes
* childless no/yes
* private or public insured
* income: low (< Hfl 2000 pm), middle (Hfl 2000-4000 pm), high (>Hfl 4000 pm)

<u>Women patients' health status:</u>
* perceived health status: a Likert scale of 5 categories; (very) healthy or not good/not bad and (very) unhealthy
* symptoms of ill health (43 items): number of symptoms which patients reported they had during the two weeks before the health interview
* number of chronic health problems
* mental health problems, measured by the General Health Questionnaire, an indicator of psychological distress or neuroticism (30 items): number of problems patients suffered of during the past 4 weeks
* number of psychosocial problems: 22 items concerning problems on several areas
* number of stressful life events: 35 items

<u>Women patients' attitudes towards help seeking:</u>
* General Practitioner orientation for common health problems (12 items): number of items patients agreed with: a higher score means a higher expectation of the doctor in case of common health problems
* health locus of control: patients' opinion about to what extent their health is controlled by themselves, by the general practitioner or by chance (each 6 items); a higher score means a greater orientation

<u>Aletta characteristics:</u> patient of Aletta or not

<u>Sex of general practitioner</u>

<u>Medical consumption:</u> the percentage of women patients who:
* consulted general practitioner past 2 months before the interview
* consulted mental health care past 5 years before the interview
* consulted alternative practitioner past 5 years before the interview

The indicators used are presented in figure 4.1 along with the three dependent variables - the measures of medical consumption. In the analysis of the characteristics of the women patients who choose for women's health care, the same independent variables are used, with the exception of 'being an Aletta patient', which is the dependent variable.
In the analyses of attitudes, health status and medical consumption,

differences in patient age were taken into account by performing a direct standardization of the age distribution (in six categories of 10 years). The means and percentages were tested for significance using a difference of proportions test and a t-test, both for independent random samples[28]. In order to explain differences in medical consumption and in order to examine the characteristics of women who choose for women's health care, logistic regression analyses were performed.

4.5 Results

4.5.1 Differences in characteristics between female practice populations

Socio-demographic characteristics

The Aletta population consists of 84.3% women. In the population of the other women doctors 62.7% are women, and of the men doctors 50.7%.

Table 4.1 Socio-demographic characteristics of female practice populations (≥ 15 years) by general practitioner's gender

	patients Aletta GPs	patients women GPs	patients men GPs
mean age	31.7 [1]	38.8 [2,3]	42.6
% high education	62.3 [1]	11.6 [2]	8.2
% employed	69.0 [1]	35.1 [2]	35.2
% single	60.1 [1]	21.0 [2]	16.1
% with children	15.4 [1]	64.1 [2]	72.8
% public insured	61.0	70.9	72.0
% low income	45.7	42.3	37.2
% high income	20.2 [1]	10.7 [2]	12.7
N	253	391	628

[1] P≤0.001 Aletta GP's patients compared to women GPs' patients
[2] P≤0.001 Aletta GP's patients compared to men GPs' patients
[3] P≤0.001 women GP's patients compared to men GPs' patients

The socio-demographic characteristics of the women patients of Aletta and of the other (women and men) general practitioners are shown in table 4.1. It can be seen that the Aletta women are on the average younger, more highly educated and are more likely to be employed than the women patients of the other practices. They live alone more often, fewer of them have children and more have a high income. It is notable that there are no significant

differences between the female practice populations of the other general practitioners, except for an age difference.

Gender-role

It appears from table 4.2, that the Aletta women more often perceive themselves as androgynous than the reference group. This suggests that the Aletta patients feel are less attuned to the prevailing cultural definitions of 'femininity' and more to those of 'masculinity'. Consequently, they are likely to adjust their behaviour less in accordance with feminine properties and more in accordance with masculine properties.

Table 4.2 Gender-role of the female Aletta patients and of the female members of the Consumerpanel (%)

	Aletta	Panel
androgynous	31.6	23.0*
feminine	35.2	42.0
masculine	19.4	14.6
undifferentiated	13.8	20.5
feminine properties:		
gentle	30.7	32.4
understanding	59.4	69.3*
tender	38.5	36.4
compassionate	57.9	70.3*
sympathetic	72.5	72.8
masculine properties:		
independent	63.2	46.5*
assertive	32.8	26.5
ambitious	44.1	31.6*
individualistic	41.3	28.6*
competitive	40.5	28.9*
N	253	479

* $P \leq 0.01$

In order to illustrate this, some items of the BEM-inventory are singled out (table 4.2). The Aletta women consider themselves as less understanding and compassionate than the other women (although equally tender and gentle), properties which are ascribed particularly to women. They feel more independent, ambitious, individualistic and competitive - masculine characteristics according to the prevailing cultural definition. However, they

consider themselves equally assertive. Three quarters of the Aletta patients feel emancipated, and one third thinks that the attribute 'feminist' fits her.

Attitudes towards help seeking

The Aletta women patients show a lower score on the attitude scale for help-seeking behaviour for common health problems than the other women (table 4.3). This suggests that their confidence in doctors is lower in regard to solving health problems. They are less inclined to ask for help for complaints such as tiredness and listlessness, a cold, headache and the flu. Instead, they take the view that treating these problems is their own responsibility. Women patients of women general practitioners do in fact rely more on their doctor than do women patients of men doctors.

Table 4.3 Health status, attitudes towards help seeking and medical consumption of female practice populations, by general practitioner's gender

	patients Aletta Gps	patients women GPs	patients men GPs
Health status:			
perceived health status (% good)	84.6	88.8	85.9
mean number of:			
- symptoms of ill health	7.5 [1]	5.0 [2]	5.0
- chronic health problems	1.2	0.9	1.1
- mental health problems	5.0 [1]	2.5 [2]	2.6
- psychosocial problems	3.7 [1]	1.8 [2]	1.8
- stressful life events	2.9 [1]	2.2 [2]	2.2
Attitudes towards help seeking (mean score)			
GP orientation for common health problems	0.8 [1]	2.4 [2,3]	3.1
health locus of control:			
- internal orientation	1.9	1.8	1.8
- GP orientation	0.1 [1]	0.7 [2]	0.9
- chance orientation	0.7 [1]	1.3 [2]	1.4
Medical consumption: (% who visited)			
general practitioner (past 2 months)	51.8	55.2	50.8
mental health care (past 5 years)	32.4 [1]	9.8 [2]	13.2
alternative health care (past 5 years)	39.6 [1]	19.7 [2]	21.2
N	253	391	628

[1] $P \leq 0.001$ Aletta GP's patients compared to women GPs' patients
[2] $P \leq 0.001$ Aletta GP's patients compared to men GPs' patients
[3] $P \leq 0.001$ women GP's patients compared to men GPs' patients

It appears that the Aletta women patients assign a less important role to their doctor or to mere chance than do the other women (Health Locus of Control). They are of the opinion that it is not the general practitioner who influences health and recovery, and that keeping healthy or becoming ill is not a matter of chance. The extent to which they think that they can influence their own health does not differ between them. The women of the two reference groups do not differ between each other.

Health status

Most women assessed their own health status as excellent or good and only a few reported poor or very poor health (table 4.3).

The Aletta patients reported having had significantly more symptoms of ill health (acute complaints) during the two weeks before the interview than both the other groups. Most of the Aletta women cited tiredness and headaches as the most common complaints, about a third of them said they had been nervous, apathetic or had had sleeping problems (table 4.4). The women patients of the other doctors reported these problems too, but less often than the Aletta patients.

Table 4.4 Women patients with symptoms of ill health (%) during the past two weeks before the interview

	patients Aletta GPs	patients women GPs	patients men GPs
tiredness	82.7 [1]	50.7 [2]	47.1
headache	61.6 [1]	49.3	45.8
nervousness	39.1 [1]	21.8 [2]	24.5
listlessness	35.0 [1]	21.6 [2]	14.1
sleeplessness	34.3 [1]	17.2 [2]	19.1
N	253	391	628

[1] $P \leq 0.001$ Aletta GP's patients compared to women GPs' patients

[2] $P \leq 0.001$ Aletta GP's patients compared to men GPs' patients

The mean number of chronic health problems yielded no significant differences (table 4.3). The most frequently cited complaints by women respondents were eczema, migraine and backpain and - for the Aletta women - problems with menstruation and menopause.

The mean score for GHQ is by far the highest for the Aletta patients. In all groups of patients the most frequently mentioned problems occurring during

the previous four weeks were feeling under pressure more than usual, sleeping badly and feeling unhappy. However, the Aletta patients clearly had these problems more often than the other patients.
The same picture appears for psychosocial problems. One third of the Aletta women worries about the future (as regards job, children) or about changes in the present-day society. About one fifth have problems with their self-image, their living and working circumstances, or their relationship with partner or parents. All these items were mentioned less often by the other women.
The women patients of the reference groups experienced, in the year before the interview, on the average fewer stressful life events than the Aletta women. The problems most often presented by women were negative experiences, e.g. serious illnesses or admission to a hospital of themselves or of relatives. Aletta women reported moving house, starting a course or a job, and entering into a relationship with someone (all positive life events), more often than the reference groups. These groups report an equal health status.

4.5.2 Medical consumption

More than half of all the women had visited their doctor in the two months before the interview (table 4.3). There were no differences in this type of medical consumption between the patient groups. However, the Aletta women had used mental health care during the past five years more often than the other women. This applied mainly to unemployed women (not shown in a table). The Aletta women also consulted alternative practitioners more often - for example homeopaths and haptonomists. The other women patients show an equal medical consumption.

The chance that a woman will visit a general practitioner (table 4.5) increases with the number of chronic and/or acute health complaints and if the woman feels unhealthy. Attitudes towards medical help-seeking, sex of the doctor and socio-demographic characteristics, such as living status (single or not) do not affect this medical consumption. With respect to frequency of doctor consultation, the different age groups do not differ from each other.
The use of mental health care is influenced by other factors. It is used more often in particular by employed women and women with more psychosocial problems, and by younger patients in comparison with older (over 55 years). Moreover, Aletta patients are more likely to use mental health care facilities.
As regards alternative practitioners, both Aletta patients and women aged between 35 and 44 are more likely to visit them. Feeling unhealthy and suffering from chronic health problems also seems to increase the probability of seeking alternative treatment. Further, people holding the view that illnesses are not a matter of chance and are more their own 'fault' are more likely to use this type of care.

Table 4.5 Regression coefficients and odds of the chance that women patients will use health care.

	general practitioner		mental health care		alternative health care	
	B	Exp(B)	B	Exp(B)	B	Exp(B)
GP's sex m/w	.26	1.30	-.24	.78	-.15	.86
low/high education	-.18	.83	.11	1.12	.26	1.30
employed no/yes	-.10	.90	-.57*	.56	.23	1.26
single no/yes	-.10	.90	.37	1.45	.23	1.26
childless no/yes	.08	1.08	-.05	.95	.05	1.05
private/public insured	-.02	.98	.35	1.42	-.06	.94
income						
low	.42	1.52	-.07	.94	-.45	.64
middle	.11	1.11	.26	1.30	-.18	.84
high						
healthy/unhealthy	.43*	1.54	.43	1.53	.50*	1.65
symptoms of ill health	.06*	1.06	.02	1.02	.02	1.02
chronic health problems	.17*	1.18	-.01	.99	.37*	1.45
mental health problems	.02	1.02	-.01	.99	.01	1.01
psychosocial problems	-.02	.98	.27*	1.30	.01	1.01
stressful life events	.07	1.07	.03	1.03	.02	1.02
GP orientation for common health problems	.00	1.00	-.05	.95	-.00	1.00
health locus of control:						
internal orientation	-.07	.94	.03	1.03	.14*	1.15
GP orientation	.07	1.07	-.07	.93	-.10	.91
chance orientation	.04	1.04	-.07	.93	-.26*	.77
patient's age						
15-24	.29	1.33	2.11*	8.29	-.16	.85
25-34	.46	1.59	2.45*	11.53	.17	1.18
35-44	.21	1.21	2.63*	13.92	.80*	2.22
45-54	.52	1.69	2.20*	9.01	.45	1.57
55-64	.12	1.13	1.96	7.13	-.10	.91
> 65						
Aletta patient no/yes	-.28	.76	1.07*	2.92	.53*	1.78

* $P \leq 0.05$

4.5.3 Who chooses for women's health care and why?

Choosing for women's health care

In order to give a rather rough sketch of 'the Aletta patient' a logical regression analysis was performed (see table 4.6).

Table 4.6 Regression coefficients and odds of the chance that women patients will choose for women's health care

	B	Exp(B)
low/high education	1.64*	5.17
employed no/yes	.01	1.01
single no/yes	.91*	2.48
private/public insured	-.65*	.52
childless no/yes	1.57*	4.80
income		
low	-.24	.79
middle	-.74*	.48
high		
healthy/unhealthy	-.47	.63
symptoms of ill health	.09*	1.09
chronic health problems	.05	1.05
mental health problems	-.01	.99
psychosocial problems	.21*	1.24
stressful life events	.17*	1.18
GP orientation for common health problems	.09*	1.10
health locus of control:		
internal orientation	.07	1.07
GP orientation	-.77*	.46
chance orientation	-.21	.81
patient's age		
15-24	.91	2.48
25-34	1.83*	6.25
35-44	1.77*	5.87
45-54	.97	2.65
55-64	.39	1.47
> 65		

* $P \leq 0.05$

It appears a clear profile emerges in terms of socio-demographic aspects as well as attitudes and health status towards the doctor for the women choosing women's health care. Women between 25 and 45 years old, with a high education, living single, without children, with a high income (compared to the average income) and with private health insurance choose more often for Aletta as opposed to other women. They experience more psychosocial

problems, more stressful life events and more symptoms of ill health. Further, they are more inclined to consult their general practitioner for common health problems, but their expectations of the doctor regarding solving their problems are lower.

Motives

To the question of what reasons were most important for the decision to choose Aletta as a general practice, most women answered that they preferred a woman general practitioner (table 4.7). Responsiveness to the patient's own opinions and willingness to consider non-medical solutions were mentioned also. Consideration of the relationship between the complaint and the patient's living and working situation was also important. Recommendation by others (often partners) and closeness to home were other reasons, though less important, for choosing Aletta. About a quarter of the women chose Aletta because of the feminist attitude of the doctors. The mean number of motives mentioned was four.

Table 4.7 Motives for choosing for women's health care and for a woman general practitioner (%)

Women's health care	
preference for a female GP	85.5
responsive to patient's own opinions	41.1
considering non-medical solutions	40.7
closeness to home	37.1
considering relationship complaint/situation	36.7
recommandation by others	33.1
feminist attitude	27.0
Woman GP:	
more at ease with physical examination	80.8
experience with women's health problems	67.1
easier talking to a woman doctor	64.6
less ashamed to talk about problems	56.7
better understanding of problems	34.2
more time for the patient	17.5
more personal interest	10.0
N	253

The reason most cited by women for preference for a woman doctor was feeling more at ease when an intimate physical examination was performed

(table 4.7). Two thirds mentioned that 'a woman doctor has her own experience with specific women's health problems' and that 'it is easier to talk to a woman'. More than half of them also reported being less ashamed or less shy when talking about problems with a doctor of their own sex.
On the question for which problems women were likely to visit a woman doctor (not shown in the table), almost all women answered to prefer a female doctor for women's health problems (93.6%) - such as menstruation, menopause and vaginal discharge. About half of them expressly chose Aletta for contraception and pregnancy.

4.6 Discussion

Differences between female practice populations were investigated by means of health interviews. A restriction of the study is that the response rate was rather low (49%). Non-response analysis showed, however, that the response and non-response group did not differ, except for the higher number of contacts of women in the response group. So, in this respect the results of the study give a slight biased picture.
The most important reason of non-response was the high number of Aletta patients that had moved, and therefore could not be contacted. From the point of view of continuity of care it may be worrisome, because it is assumed that a general practitioner knows most of her or his patients rather good, which would increase the quality of care.

The female practice population of the general practice Aletta, a practice providing women's health care, was found to be clearly different from the other practice populations of both women and men general practitioners under study. The other populations did not differ from each other. Keeping in mind that 84% of the patients listed in the Aletta practice are women, one could make the generalisation that 'the Aletta patient' is a young (aged 25-45), urban, single, highly educated, working, childless woman. Aletta patients are more androgynous than the other women, meaning that they have both female and male characteristics; they are more ambitious, individualistic, competitive and independent than other women.
Thus, the Aletta doctors fill the needs for a specific population, instead of the average practice populations of the other doctors (both women and men). One could argue, therefore, that the Aletta practice does not meet the basic thoughts and ideas of general practice, i.e. 'to give personal, integral and continuous care to individual people, families and other cohabitation units which together make up a practice'[29]. It is argued that, in view of a good practising, the general practitioner should see a diversity of people and health

problems. To what extent the deviant composition of a practice population like the Aletta population may have consequences for the health care delivered should be investigated.

Most of the women patients (Aletta and other patients) perceive their own health as good, but the Aletta women report, in comparison with the other women, more frequent fatigue and headache, as well as other central-nervous system symptoms like nervousness, apathy and sleeping problems - these 'minor illnesses' are often considered as psychosomatic symptoms[30]. The Aletta women also suffer from poorer mental health and they encounter more psychosocial problems and more stress in their lives - as was expected.
It has been shown that, apart from biological and psychological factors, sociological factors are determinants of the psychosomatic symptoms[31]. The cause of the symptoms, which from a feministic point of view are expressions of repression and impotence[32], may be a role conflict. The nineteenth-century young women of the comfortably wealthy classes may have been registering discontent with their overly limited social roles, which manifested itself in suffering from hysteria and being bedbound with paralysis. The twentieth-century women of the progressive urban milieus may be resisting overly expansive roles - the virtually limitless expectations of what they should be able to accomplish. The younger, well-educated middle-class women of today, of which group the Aletta female practice population may be seen as a -deviant- subgroup, may react with psychosomatic symptoms to the problems they experience in their life and work situations, and to the ambiguity of their role as 'career women'. Therefore, one could argue that the psychosomatic health problems, such as fatigue, headache and nervous symptoms reflect the culture of this decade.

What implications do the differences between the female practice populations have for the use of health care?
In spite of the fact that the Aletta patients are a societal favourable group of women, their medical consumption is rather high. Firstly, Aletta women did not visit their general practitioner less often than other women, as was expected. One reason could be that the Aletta women do not have a better somatic health. They do not feel more healthy than other women and, moreover, they report more psychosomatic and psychosocial problems. Another explanation may be that it seems that - for all patients - other characteristics more influence the visit to the general practitioner, such as having chronic health problems and feeling unhealthy. The lower expectation of the general practitioners Aletta patients have with respect to solving common health problems seems not to be related to visiting the general practitioner.

Research on the types of health problems patients actually present to their doctors in the consultation room could give more insight into the reasons for visits, and differences between the practice populations.

Congruent with their poorer mental health status as discussed above, the Aletta patients show a much higher use of mental health care than other women. Their experiencing of psychosocial problems and their young ages seem to be important factors in the use of mental health care. Being unemployed and feeling unhealthy are additional reasons for women to seek mental care. The presence of more psychosomatic problems in these women in itself does not lead to an increased use of mental health care.

It seems that Aletta women also use alternative treatments, e.g. by homeopaths adn haptonomists, more often than other women. The reasons why women tend to seek this type of care seem to be related to feeling unhealthy and having chronic problems, but the relation with high educational level, a high income and age between 30 and 59, that was reported earlier, was not found in this study[25]. A lower belief in coincidence and higher belief in the idea that one can influence his own health is related to a higher use of alternative care. Psychosocial problems do not increase the use of alternative health care, which is contrary to earlier studies[33].
Although the Aletta patients do not fit the characteristics described above with respect to using alternative care, they do visit alternative practitioners much more often. Possibly, they are frustrated in regular care or they go because it 'might work'. Also, features such as assertivity and independence and definite attitudes towards health and illness might result in a greater tendency of Aletta women to turn to alternative practitioners for support as compared to other women. Another explanation may be that visits to alternative caregivers have to be paid by the patients themselves. Insurance companies often do not pay for these treatments, or only partially. In view of the higher income of Aletta patients compared to other patients, this might lead to a higher use of alternative care.
Besides, the higher use of Aletta women might be partly related to the generally increasing use of alternative care, because of the difference in time of data collection (five years) in the National Study and the Aletta study (see methods).
Whether the Aletta patients use this type of care as alternative or additional medicine can not be known from the data. It was found earlier that most patients do not seek alternative help as a substitute to regular help, but as a supplement to it. While being treated by an alternative practitioner, most of them continue to visit their own doctor[25].

This study makes clear that women choosing for women's health care constitute a specific group of women. The question that arises is what implications might it has for future health policy.
Regarding educational level and living and working circumstances, it might be expected that in the future even more women will look like 'the Aletta patient'. In view of the motives mentioned by the Aletta women for choosing a woman doctor, even more women will prefer a woman doctor in the future. For the preference of a woman doctor the most important motives are being more at ease with a physical examination, being able to talk more easily, and being less ashamed to broach a problem in the presence of a woman doctor, as was shown both in the present study and in earlier studies (see Introduction). A unique reason for the Aletta patients' choice of a woman seems to be the doctor's high experience with women's health problems. The association of the general practice with the Women's Health Centre, which provides information about these specific problems, is probably the reason for this. Because these motives of women patients reflect some of the conditions that are important for delivering a good quality of health care, it has to be emphasized that there is a need for more women general practitioners in the future[34]. A recent study has indicated a high potential demand among women for women doctors - it was found that only half of women patients who prefer a woman general practitioner has in fact only ever attended a man practitioner[17].
In the Netherlands, 19.3% of all practising general practitioners in 1994 were women[35]. It is expected that this percentage will rise in the future, because 54% of the medical students in 1994 studying to be a general practitioner are women. However, the number of women general practitioners working in a practice is expected to show a slower increase, because more women than men want to work part-time[36]. Thus the need for women doctors will probably remain, unless health-policy makers will stimulate women to be educated as a general practitioner. Along with it they have to create better conditions of employment, such as the possibility to work part-time and to combine work and children.

The preference of women's health care seems to be well thought-out and mainly based on the principles of women's health care - which are found in the feminist attitudes of the Aletta general practitioners. It implicates that health-policy makers should take into consideration that in the future possibly more women, like the Aletta women, will prefer health care in which the ideas of women's health care are being applied. It means that health policy should be directed to an integration of some of the distinguishing aspects of women's health care into regular health care.

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5 FACTORS INFLUENCING THE TYPE OF HEALTH PROBLEMS PRESENTED BY WOMEN IN GENERAL PRACTICE: DIFFERENCES BETWEEN WOMEN'S HEALTH CARE AND REGULAR HEALTH CARE

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5.1 Abstract

Objectives: Differences between health problems presented by women (aged 20-45) to female "women's health care" doctors and both female and male regular health care doctors were investigated. This paper explores the relationship of patients' roles (worker, partner or parent) and the type of health care, controlling for education, to the presentation of psychological, social and purely somatic problems in general practice.

Method: Data was derived from a "women's health care" practice and 21 group practices providing regular care. The doctors registered detailed information about all patient contacts during a three-month period. Logistic regression analysis was used in order to calculate the likelihood of women attending their doctor to present with psychological, social or somatic health problems.

Results: We found that the effect of education was much stronger than the effect of roles. Women attending women's health care presented more psychological and social problems and less somatic problems than women visiting regular health care doctors. Patients of female and male doctors providing regular care did not differ in this respect between each other.

Conclusions: This study showed that patient characteristics, like roles and education, are related to the type of health problems presented to general practitioners. The type of health care was also important in explaining differences in the problems presented to them. Future research in primary care should include doctor characteristics to better understand how these characteristics might relate to patient outcomes.

5.2 Introduction

Considerable research has been done on the presentation of health problems in general practice. An increasingly important topic in this area is the relationship between the multiple roles of women and their physical and mental health. The literature on how these health problems are presented to doctors reveals inconsistent findings. Possibly, the inconsistency has to do with the way in which the relationship has been investigated. Almost exclusively the demand-side of health care, i.e. the patients, has been included in studies on this subject. The influence of the suppliers of health care, i.e. the doctors, on the presentation of health problems has scarcely been investigated. Nevertheless, there are indications that general practitioner's characteristics, such as gender, are related to the presentation of health problems. Previous studies showed that patients presented different health problems depending on whether they saw a male or female doctor[1 2]. It might be expected that even stronger effects might be found when the type of health care is taken into account. Nearly all general practitioners in the Netherlands as well as in other Western countries provide regular health care. Another type of health care provided is 'women's health care'. Women's health care is defined as 'consciously providing care from the perspective that patients' problems may be related to their socialization and their situation in society, and encouraging patients to map out strategies aimed at the realization of self-determination and self-responsibility with regard to both body and lifestyle' [3]. The presentation of health problems in women's health care may differ from that in regular health care because of the specific principles on which this type of health care is based, especially with respect to psychological and social problems. Moreover, it might be a case of a 'double selection mechanism': women may prefer to present their problems to a female doctor, and even more so to a female doctor providing women's health care.
Accordingly, the aim of this study was to investigate differences in the type of health problems presented to doctors by female patients. The patients visited women's health care doctors or regular health care doctors. The relation between the type of problems and women's multiple roles was investigated. Also, the relation of these problems with the type of care and with the doctor's gender was studied.

The literature on the impact on health of separate and multiple roles is reviewed. The principles of women's health care are also described. Based on this literature hypotheses are formulated about the relationship between roles, health care and health problems presented in general practice.

5.3 Literature and hypotheses

The worker role

Employment is generally a rewarding experience for women[4]. Employed women report better overall health[5] and fewer symptoms of psychological distress[6] than non-employed women[7]. So far, there has been little research into differences between women with part-time jobs and those working full-time, and findings to date are inconsistent. On the one hand, it was found that women working more hours enjoy a better health. This applies in particular to middle-aged women[8]. Paid employment is associated with reduced depression as long as working hours (job and housework together) do not exceed an upper threshold[9]. Young mothers in particular suffer from depression unless there are adequate financial resources to help with the burden of multiple roles. A more equal division of labour between the sexes in the home also contributes to a better mental health[10]. On the other hand, Kenekel[11] found no significant differences between the effects of part-time and full-time employment on the health of women in general. This finding contradicts the expectation that part-time employment is related to less role-overload and role-conflict than full-time employment.
The consistency of this 'beneficial effect' has led other authors to look for the 'healthy worker effect'. Healthy people may be more willing and able to work – a social selection effect. However, two longitudinal studies reported a positive effect of employment on health. This effect was independent of baseline health status[5,12].

The partner role

The relationship between the role of partner and physical and mental well-being is favourable to women, especially when they are employed[12-14]. One of the most consistent findings is that married women are happier and more satisfied than those who are not married, regardless of whether the latter are single, divorced, or widowed[15]. The partner role is a source of identity, social support, and self-esteem[5]. It was also found that the role of wife was not significantly associated with role conflict and role overload[16]. When the quality of the marriage is taken into account, the impact on well-being is even more pronounced[15], because marriage can be associated with suffering and stress, as well as with gratification[17]. However, a recent study did not support a health protective effect of marriage[18].

The mother role

The mother role, generally defined by the presence of (young) children at home, seems to have a positive relationship with the health of women[19]. Middle-aged women as well as younger women with a child enjoy better

health than other women[8]. However, it has been argued that the quality of the mother role is also important with respect to the effect on well-being[13 15]. Positive spill-over effects from job to parenting have been reported[20 21]. Though, other studies have reported that labour force participation may increase a women's vulnerability to the effects of parental stress[17]. The mental health advantage of the buffering or 'spill-over' effect applies equally to single and to employed mothers with a partner[21]. There are contradictory findings about the associations of the number of children and the health of employed women. Some studies found no differences, except among single working mothers[16 22]. Another study suggested a curvilinear relationship between parental responsibilities and health[23]. However, the hypothesis that persons with several young children or no children would have a poorer health status than persons with just one child, was only be partially supported[18].

Multiple roles

Two contrasting theories have been put forward to explain the relationship between multiple roles and health problems. The 'role-conflict hypothesis' assumes that multiple roles are related to more health problems. The more recent 'role-expansion hypothesis' assumes that multiple roles lead to fewer problems.

The traditional role-conflict hypothesis argues that additional roles create role strain, role conflicts, and role overload, subsequently causing illness as well as physical and psychosocial problems[3 4 8 24 25]. The role-expansion hypothesis focuses on the gratification derived from accumulating diverse roles[13]. Many studies have shown the generally positive relationship of a combination of paid employment and domestic responsibilities (caring for children and housekeeping) on women's mental and physical health. If the supportive circumstances are appropriate, multiple roles are associated with a lower level of psychological distress[14 20 26-30]. It is argued that in the past many women, and housewives in particular, were 'underburdened'. The absence of stimuli from the environment could lead a person to become introspective and, therefore, to have more problems[31]. Three major psychological factors have been proposed to explain this benefit of role combination on health (apart from the financial advantage): variety is healthier than monotony; multiple roles promote social contacts, satisfaction, self-esteem, a salient identity and therefore emotional health; and the consequences of stress arising in one area can be reduced by activities in another area (buffering effect)[9 24 27 30 31].

Some authors argue that the assumptions about the relationship between multiple roles and health tend to focus on the quantity of the roles rather than on the nature and quality of a woman's experiences within a role. They argue

that differences in health are related to the social context, the living situation, the way of thinking, judgement, and the reaction to aspects of the person's circumstances[10 32 33]. They emphasize that the nature and quality, and not merely the occupancy per se, are critical to understanding the processes affecting women's well-being. They also stress that the balance between the costs and the benefits of role involvement varies, depending on the specific characteristics of the role and the women considered[12 16 17 21 34 35].

Hypotheses with respect to roles

It is clear that employment is most consistently connected with good health for women. Thus, our first hypothesis is:

1. Employed women will consult the general practitioner less often with psychological, social and somatic problems than unemployed women.

The partner role is mostly favourable to women. Being a parent also tends to have a positive influence; the number and ages of the children seem to be of less importance. Being without a partner and having no children may have a negative influence on health and, as a consequence, increase the chance of psychological and social problems. Our second hypothesis is therefore:

2. Women living without a partner and women without children who consult the general practitioner will present more psychological, social and somatic problems than do women with partners and women who have children.

Multiple roles are generally associated with good health. Therefore, our third hypothesis is:

3. Women performing multiple roles will present less psychological, social and somatic health problems as compared to other women who visit their doctor.

Women's health care

Women's health originated from the second feminist wave at the end of the sixties, when women groups rebelled against 'regular' medicine. These women argued that the social position of women was not taken into account, and they fought against the 'women-unfriendly' treatment provided by doctors. The women's health movement has developed further in self-help groups and in independent women's health centres[36]. In the Netherlands, women's health care is provided exclusively by the general practice known as 'Aletta'. This practice was established in 1984 and it is named after Aletta Jacobs, the first Dutch female physician as well as the first Dutch feminist physician. It is the

only general practice known to provide women's health care, in the Netherlands as well as in other Western countries. In the Aletta practice three female general practitioners provide women's health care. Women's health care is based on feminist philosophy and aimed at improving the quality of care[37]. The principles women's health care are: (1) consideration of the patients' gender identity and gender roles; (2) consideration of the patients' personal and social situation; (3) respect for the patient; (4) encouragement of the patient's self-determination and ability to be responsible for herself; (5) avoidance of medicalization (labelling physical problems and problems of daily life as biomedical problems)[3]. The first two principles are considered the most important and distinctive characteristics of women's health care. The other three principles are already part of the ideology being propagated by the Dutch College of General Practitioners. In addition, specific attention is said to be paid to information-giving, which is an important means for realizing the principles. Though, other doctors also pay attention to information-giving.
It has to be emphasized that the general practitioners of the Aletta practice have had the same vocational training as other doctors wanting to become general practitioners. The Aletta doctors take care of a fixed population of patients, and they provide care for all health problems, just like the other doctors. But, they lay certain specific emphases on their practising in accordance with the principles of women's health care.

Hypothesis with respect to type of health care
On the basis of the first two principles of women's health care it may be expected that the Aletta general practitioners pay more attention to psychological and social problems, and that patients are encouraged to present these problems. However, on the basis of principles such as the prevention of medicalization and the encouragement of self-responsibility, one might assume that the women who attend the Aletta practice will present fewer problems than do women who attend regular practices. These considerations lead to our fourth hypothesis:

4. Women visiting women's health care doctors will present more psychological and social problems and fewer somatic problems than do women visiting regular health care doctors.

5.4 Method

Study design
The study design is cross-sectional. Data was derived from a study conducted among three female general practitioners in the women's health care practice

Aletta, in 1993. Also, data was used from the Dutch National Survey of Morbidity and Interventions in General Practice (1987-1988), a large-scale study among 161 general practitioners working in 103 general practices taking care of a fixed population of 340,000 patients[38]. For the present study, only data from the 21 group practices with both female (total n=23) and male (total n=27) general practitioners were considered, in order to equalize patients' opportunity to choose between a female or male doctor[1]. In this way, distance to the practice location can be ruled out as a possible explanation for differences between female and male general practitioners, as well as other relevant factors such as the composition of the practice population, the particular characteristics of the neighbourhood, and the availability of other health services in the surroundings.

Data collection

The data collection of the 'Aletta study' and the 'National Survey' was equal in all respects. The general practitioners recorded detailed information about all patient contacts during a 3-month period. The data recorded included, among others, patient characteristics (sex, age) and problems presented, classified according to the International Classification of Primary Care (ICPC)[39]. The classification was done in both studies by the same qualified research-assistants. The doctors also assessed, on a five-point scale the possible psychosocial character of the problem. Problems with a score of one are considered to be purely 'somatic' health problems. This method of registration has been reported earlier[40]. To ensure maximal uniformity in the data collection process, all participating doctors were trained in the use of the classification systems. A written instruction with definitions was provided to keep at hand during the consultation. Before the registration period started, all elements of the registration form were tested in each individual practice to check the data for completeness and irregularities and to discuss problems that might have arisen. The doctors, also the Aletta doctors, received feedback on their practice profile compared to the 'average' practice profile in the National Survey of Morbidity and Interventions in General Practice[38]. This service was highly appreciated by the doctors and provided an extra opportunity for data control.

Health problems were operationalized as the prevalence rate of health problems, with the prevalence being determined by counting the total number of health problems per patient; identical health problems were counted only once per patient. Patient characteristics, such as age, employment (unemployed, part-time or full-time employed), living situation (alone, partner, children), and educational level (low or high) were derived from the practices' patient registration system.

Analysis

Only health problems mentioned during the routine consultation were included in the analyses; home visits, emergencies, and special consultations were excluded. The analyses were restricted to women aged between 20 and 45 years, because most women of the Aletta practice population are in this age range and because the issues of this study are relevant to this age group.

For each patient who visited the doctor within a 3-month period was investigated whether she had presented at least once a psychological problem (ICPC chapter P), a social problem (ICPC chapter Z) or a purely somatic health problem (health problems from the other chapters of ICPC that were coded '1' on the scale 'somatic-psychosocial). The resulting groups consisted of 1006 patients of the Aletta practice, 3287 patients who consulted a female general practitioner, and 3793 patients who consulted a male general practitioner.

According to the 'fixed-role hypothesis'[29 41], people with a fixed role have more structure in their lives and as a result they are healthier. Therefore, women who followed daily educational courses were added to the category of employed women. Women who kept house or who did voluntary work were considered as having fewer fixed obligations and therefore having less structure in their lives. They were added to unemployed women.

The type of health care provided as well as the general practitioner's gender were included in the 'type of general practitioner'.

Lastly, the analyses were controlled for patients' age and education, and for the degree of urbanization of the practice setting (fewer or more than 100,000 inhabitants). Education was accounted for, because of the consistent relationship of the level of education to health, that is found in many studies. A higher education is generally associated with better somatic and mental health[19 41-46]. The degree of urbanization was included because the Aletta practice is established in a rather large city, and large cities are known to be related to the presentation of more psychosocial problems, in the Netherlands as well as in other countries[47].

The correlations between the independent variables were not sufficiently high to warrant concerns of collinearity. The percentages presented were tested for statistical significance by the chi-square test. For age an F-test with pairwise comparisons was used. Logistic regression analyses were performed in order to explain differences in health problems presented.

5.5 Results

Patient characteristics

Table 5.1 presents the distribution of the independent variables for the women who consulted the Aletta doctors, non-Aletta female general practitioners, and male general practitioners. The women who attended the Aletta practice were different from the women of regular practices. Women who consulted the male or female general practitioners also differed from one another, but to a lesser extent. Women who had a job, who had no children, who lived without a partner, and who were highly educated chose a female doctor more often, and especially an Aletta doctor.

Table 5.1 Socio-demographic characteristics of women patients aged 20-45 by type of general practitioner [*]

	Patients of Aletta GPs	Patients of Female GPs	Patients of Male GPs
mean age	29.4 [1]	30.1 [2,3]	30.6
% not employed	13.5 [1]	40.1 [2,3]	44.3
% part-time employed (< 32 hours per week)	23.1 [1]	18.6 [2]	19.0
% full-time employed (≥ 32 hours per week)	63.4 [1]	41.3 [2,3]	36.7
% no partner	67.6 [1]	26.7 [2,3]	17.1
% no children at home	89.4 [1]	45.5 [2,3]	35.3
% highly educated[**]	64.8 [1]	20.2 [2,3]	12.8
N	1006	3287	3793

[1] $P \leq 0.01$ Aletta GP's patients compared to women GPs' patients
[2] $P \leq 0.01$ Aletta GP's patients compared to men GPs' patients
[3] $P \leq 0.01$ women GP's patients compared to men GPs' patients

Health problems presented

Comparison of the three groups of women who consulted their doctor, revealed that the Aletta patients over all presented more psychological and social problems to the general practitioner, and less purely somatic health

[*] p-values for age come from an F-test with pairwise comparisons, other p-values come from chi-square tests.

[**] level at which full-time education was finished:
- low: primary and secundary education
- high:higher vocational training and university

problems than the other patients (Table 5.2). The level of employment, having a partner or children and educational level did not discriminate within the group of Aletta women patients. An exception was the relation between education and psychological problems. Less educated women presented the Aletta doctors with more of these problems than more highly educated women ($P \leq 0.05$).

Table 5.2 Percentages of women patients aged 20-45 with health complaints by employment, partner, child(ren), education, and by type of general practitioner *

	psychological	social	somatic	N
Aletta GPs	17.4	13.2	59.4	1006
women GPs	8.1 [1]	4.9 [1]	74.2 [1]	3287
men GPs	8.9 [2]	4.3 [2]	76.9 [2]	3793
not employed				
- Aletta GPs	19.5	18.6	59.3	113
- women GPs	8.3 [1]	5.6 [1]	75.7 [1]	968
- men GPs	9.4 [2]	4.8 [2]	76.2 [2]	1160
part-time employed				
- Aletta GPs	19.2	9.3	58.0	193
- women GPs	10.0 [1]	6.3 [1]	69.9 [1]	448
- men GPs	10.1 [2]	5.2 [2]	76.1 [2,3]	497
full-time employed				
- Aletta GPs	15.9	12.7	61.1	529
- women GPs	7.2 [1]	4.1 [1]	76.5 [1]	995
- men GPs	7.4 [2]	3.7 [2]	79.2 [2,3]	961
no partner				
- Aletta GPs	17.3	11.9	59.9	579
- women GPs	11.2 [1]	5.2 [1]	71.0 [1]	717
- men GPs	15.3 [3]	7.0 [2,3]	69.8 [2]	484
partner				
- Aletta GPs	17.7	14.8	59.9	277
- women GPs	6.9 [1]	5.1 [1]	76.1 [1]	1972
- men GPs	7.5 [2]	3.9 [2]	78.3 [2]	2384
no children at home				
- Aletta GPs	17.5	13.2	61.3	765
- women GPs	9.0 [1]	5.2 [1]	74.7 [1]	1223
- men GPs	9.4 [2]	4.2 [2]	76.6 [2]	1001

* p-values come from chi-square tests.

Table 5.2 (continued)

children at home				
- Aletta GPs	16.5	9.9	48.4	91
- women GPs	7.3 [1]	5.1 [1]	74.8 [1]	1466
- men GPs	8.6 [2]	4.5 [2]	77.0 [2]	1831
low education				
- Aletta GPs	21.4	14.7	61.2	299
- women GPs	8.3 [1]	5.5 [1]	73.7 [1]	2093
- men GPs	8.9 [2]	4.4 [2]	77.5 [2,3]	2625
high education				
- Aletta GPs	15.2	11.8	59.2	551
- women GPs	6.6 [1]	3.4 [1]	76.1 [1]	531
- men GPs	8.8 [2,3]	4.3 [2]	74.9 [2]	422

[1] $P \leq 0.01$ Aletta GP's patients compared to women GPs' patients
[2] $P \leq 0.01$ Aletta GP's patients compared to men GPs' patients
[3] $P \leq 0.01$ women GP's patients compared to men GPs' patients

There were few differences between the women patients who consulted the non-Aletta male and female general practitioners (Table 5.2). Women without a partner presented more psychological and social problems to male doctors than to female doctors. Both part-time and full-time employed women visited their male doctor more often with somatic health problems. Low educated women also presented more somatic health problems to male doctors. High educated women presented male doctors with more psychological problems.

Multivariate analysis

Logistic regression analysis showed that, taking into account the roles of worker, partner and parent, the level of employment did not affect the prevalence of somatic, psychological, or social problems among women attending the general practitioner, with one exception (Table 5.3). The probability that part-time employed women present psychological problems was higher than for full-time employed women (OR=1.35, 95% CI=1.06,1.73, data not in the table).

Women who had a partner and women who had children at home were less likely to present with psychological problems than their counterparts. However, women with a partner were more likely to have somatic health problems. Living situation did not influence the presentation of social problems.

Table 5.3 Odds and confidence intervals (95% CI) of women patients aged 20-45 presenting psychological, social and somatic health problems

	psychological	social	somatic
	Odds (95% CI)	Odds (95% CI)	Odds (95% CI)
employed: no	1.0	1.0	1.0
- part-time	1.19 (0.92,1.52)	0.92 (0.67,1.27)	0.86 (0.73,1.02)
- full-time	0.88 (0.69,1.11)	0.86 (0.65,1.15)	1.00 (0.86,1.17)
partner:			
- no	1.0	1.0	1.0
- yes	0.64 (0.51,0.80)	0.87 (0.66,1.16)	1.37 (1.17,1.60)
children:			
- no	1.0	1.0	1.0
- yes	0.76 (0.60,0.97)	0.79 (0.59,1.07)	0.96 (0.82,1.28)
type of GP:			
- Aletta GPs	1.0	1.0	1.0
- women GPs	0.57 (0.42,0.78)	0.38 (0.02,0.57)	1.51 (1.21,1.88)
- men GPs	0.65 (0.47,0.90)	0.31 (0.20,0.47)	1.70 (1.35,2.14)
education:			
- low	1.0	1.0	1.0
- high	0.63 (0.49,0.81)	0.65 (0.48,0.88)	1.18 (1.01,1.39)
age (per year)	1.04 (1.02,1.05)	1.04 (1.02,1.05)	0.97 (0.96,0.98)
>100,000 inhabitants:			
- no	1.0		
- yes	1.44 (1.10,1.90)	1.16 (0.79,1.68)	0.73 (0.61,0.88)

Interaction terms of the different roles did not contribute significantly to the explanation of the type of problems studied, with one exception (data not in the table). Employed women were more likely to present social problems to Aletta doctors than to other doctors (OR=1.45, 95% CI=1.02,2.04).
When accounting for roles and education, the probability that women who attend the Aletta practice present psychological problems was higher than for women consulting other doctors (OR=0.57, 95%CI=0.42,0,78 respectively OR=0.65, 95% CI=0.47,0.90). Aletta patients were also more likely to present with social problems. In contrast, non-Aletta patients were more likely to present with somatic health problems.
Patients of non-Aletta doctors did not differ in the probability of presenting psychological, social and somatic problems (data not in the table).
The probability that women with high education visit the doctor for psychological as well as social problems was lower compared to well educated women (OR=0.63, 95% CI=0.49,0.81 respectively OR=0.65, 95% CI=0.48, 0.88). In contrast, well educated women presented more somatic problems.

5.7 Discussion

The putative relationship between the presentation of health problems and multiple roles was investigated on the basis of three hypotheses. In contrast to other studies, the first hypothesis that there would be negative correlation between level of employment and health problems was not affirmed. One explanation may be that the present study involved women aged between 20 and 45 years, whereas in some other studies younger[10] or older women were included[5 12]. Younger women may more often suffer from depressions, especially if they have to work and to care for children at home. Also, the quality of work[34 35] was not included in the present study.
It appears that employed women are more likely to present psychological problems to Aletta doctors than to other doctors, or Aletta doctors are more alert to psychological problems with employed than non-employed women.

The second hypothesis that women living without a partner and women without children more often present psychological, social and somatic problems than do women with partners and women who have children is supported for psychological problems only. Both roles are related to fewer psychological problems, which is in agreement with other studies[12-17]. This relationship may reflect a buffering effect, meaning that the consequences of stress arising from one role can be reduced by another role[9 24 27 30 31].
The presentation of more somatic problems by women who have a partner was not hypothesized and has not been reported before. This finding may be related to their lower reporting of other health problems. It could also be due to the fact that partners may encourage women to see a doctor when they complain about a symptom.
Contrary to the hypothesis, women without a partner or children did not present more social problems than their counterparts. One explanation may be that the quality of the relationships of those with partners and with children was not included in the study. Quality includes the help of partners or other people, that is probably different for the roles of worker, partner and parent. Quality and also other characteristics, such as the number of children and having a high income may be of major importance for the presentation of health problems.

The third hypothesis that multiple roles have a beneficial effect on the presentation of health problems, was true for psychological problems only. Thus, it can be concluded that the role-expansion hypothesis is relevant with regard to the presentation of psychological problems. However, the number and age of children were not taken into account, which may be why this study failed to find a negative effect of parenthood on mental health as other

studies have[16 22 49]. It is also unknown to what extent employed mothers arrange for child care and to what extent there is social support. If employed mothers have enough help, their health may be less affected by having children than non-employed mothers' health[10 50 51]. In future studies the relationship between the three roles (worker, partner and parent) and health should be investigated by taking into account both the burden and quality of the various roles.

The relationship between health and the multiple roles is weaker compared to the relationships of health and level of education. Education had a marked effect on the type of problem presented. Less educated women visiting their general practitioner present more psychosocial problems than their better educated counterparts, replicating findings in the literature[41 42 44 52-54]. Well educated people may have a greater knowledge of medical care and use medical care more wisely than less well educated people[55]. Medical knowledge influences health and health behaviour[11]. Leigh[56] showed that education increases a person's chances of practising healthy habits, resulting in better health. Similarly, in our study, less educated Aletta patients did have more psychological and social problems than more educated women. However, we also found that the more educated Aletta women visited their doctor for psychological and social problems more often than all other groups except the less educated Aletta patients.

Women using regular care did not differ in the presentation of psychological, social and somatic problems, irrespective of whether they consulted a male or a female general practitioner. The literature on the prevalence of psychological and social problems presented to female and male general practitioners is very scarce. One study found no differences in morbidity pattern between female and male general practitioners other than for gender associated conditions[60]. In our earlier study[1] was found that female doctors saw more social problems, but no differences were found in the presentation of psychological problems.
One explanation may be that only women between 20 and 45 years were selected in the present study. Older women may talk easier about social problems with female doctors than with male doctors. For younger women perhaps the doctor's gender makes no difference. But, why this would not be applicable to psychological problems too remains an intriguing question. Future studies with a broader age range examining the type of psychological and social problems might help to answer this question.

The equivalence of female and male doctors providing regular care in this respect is more interesting in view of the differences with women's health

care doctors. Women who attended the Aletta practice presented a different pattern of problems than women who attended regular general practices. They presented with psychological and social problems more often, but with somatic problems less often. This is true even after taking into account their different living and working situation and their high level of education.

Thus, the differences in the type of health problems presented between women's health care and regular care seems to be related to the type of care rather than to the doctor's gender. One explanation for this could be that the women attending the Aletta practice are more receptive to signals from their body and that they are more inclined to 'psychologize' their problems. Additionally, the Aletta patients might be clearer in indicating what their psychological and social problems are, instead of presenting them as somatic health problems. In combination with this different way of presentation of health problems, doctors who work in the Aletta practice probably label their patients' problems as being psychological or social sooner than their counterparts in regular general practices. Both explanations are consistent with the principles of women's health care. This is important because many doctors underestimate and do not recognize their patients' psychosocial problems[61-64].

Women's health care practices may attract women with relatively more psychological distress who expect to receive care consistent with their own health beliefs and attitudes, and in accordance with the principles of women's health care. These women expect attention to be paid to their own opinions and consideration to be given to non-medical solutions. They also expect the doctor to take into account the relationship between the problem and patient's living and working situation[2]. It also is possible that these women have had a bad experience with the care given by doctors who work in regular general practices. The extent to which their expectations of women's health care will be fulfilled, and whether the general practitioners of women's health care treat their patients according to the principles of women's health care, will be subject of future studies.

This study showed that patient characteristics, like roles and education, are related to the type of health problems presented to general practitioners.The type of health care was also important in explaining differences in the problems presented to them. Future research in primary care should include doctor characteristics to better understand how these characteristics might relate to patient outcomes.

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6 DIFFERENCES IN TREATMENT: A COMPARISON BETWEEN GENERAL PRACTITIONERS PROVIDING WOMEN'S HEALTH CARE AND REGULAR HEALTH CARE *

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6.1 Abstract

The differences between interventions made by female general practitioners providing women's health care and female and male general practitioners providing regular health care were investigated. Women's health care is based on the following principles: (1) consideration of the patient's gender-identity and gender-roles; (2) consideration of the patient's personal and social situation; (3) to treat the patient respectfully; (4) to encourage the patient to cope with health problems and to stimulate self-responsibility; (5) avoidance of medicalization. This paper explores the relationship between the type of health care and general practitioner's gender on the one hand, and the interventions provided on the other, with respect to diagnoses made during first contacts with female patients (aged 20-45). Data were derived from a 'women's health care' practice and 21 group practices providing regular care. The doctors recorded detailed information about all patient contacts during a three-month period. Multi-level logistic regression analysis was used in order to calculate the likelihood of general practitioners performing interventions (diagnostics, physical examinations, prescriptions, referrals), making follow-up appointments and having long consultations (>10 min.).

It was found that, in comparison with other general practitioners, the Aletta doctors perform physical examinations less frequently, prescribe less medicines, advice more often 'over the counter' (OTC) medicines, are more inclined to wait and see, and refer more patients to mental health care, irrespective of the type of diagnoses and other relevant factors mentioned above. The Aletta doctors also order more diagnostic tests, just like the other female doctors.

The practising of the women's health care principle 'demedicalization' has only partly been demonstrated in the interventions studied, in the prescription behaviour of the Aletta general practitioners. The practising of the principle 'encouragement of the patient's self-determination and ability to be responsible for herself' has not been shown.

6.2 Introduction

Interventions in general practice have often been the subject of research in recent decades. In past studies on differences in interventions, most attention was paid to differences between female and male patients, and sometimes differences between female and male general practitioners have been considered[1-6]. In this article, we want to introduce another factor that might influence the interventions, namely the type of health care provided by general practitioners.

In the Netherlands, women's health care is provided exclusively by the general practice known as 'Aletta', which is named after Aletta Jacobs, the first Dutch female physician as well as the first Dutch feminist physician. It is the only general practice known to provide women's health care, in the Netherlands as well as in other Western countries. The Aletta general practitioners provide health care that is based on the following principles[7]: (1) consideration of the patient's gender identity and gender roles; (2) consideration of the patient's personal and social situation; (3) to treat the patient respectfully; (4) encouragement of the patient's self-determination and ability to be responsible for herself; (5) avoidance of medicalization (avoiding labelling physical problems and the problems of daily life as biomedical problems). The first two principles are considered the most important and distinctive characteristics of women's health care. The other three principles are already part of the ideology being propagated by the Dutch College of General Practitioners. In addition, specific attention is paid to information-giving, which is an important means for realizing the principles. The principles of women's health care serve as guidelines for care-giving that are aimed at enhancing the quality of care for women. It must be emphasized that these general practitioners have qualified in the normal way and provide care for all the health problems of their patients, and not only for 'female' health problems. However, they place different emphases on certain aspects of care, in accordance with the principles of women's health care[6].

Whether these principles influence the interventions carried out by Aletta general practitioners has not been established until now. Because their professional medical education was in regular health care, it might be assumed that the treatment they provide is roughly equal to that of general practitioners providing regular health care. However, the Aletta doctors are trying to practice the above-mentioned principles, which might lead to a specific fundamental attitude with regard to care. Although choice of intervention usually depends on the patient's health problem, the specific attitude of the Aletta doctors may be visible in their interventions.

So the aim of the article is to investigate the extent to which the vision of women's health care, as elaborated in the principles, is integrated into the interventions carried out by the general practitioners. Therefore, comparisons are made between female doctors providing women's health care and female and male doctors providing regular health care. The distinction between female and male doctors is made on the base of findings of earlier studies, in which important differences were found to exist between them. Female general practitioners spend more time with their patients than their male colleagues, they order more laboratory tests, write down fewer prescriptions and they have a stronger tendency to provide continuity of care[1 2].

6.3 Research questions

One might assume that the specific care provided by the Aletta general practitioners becomes apparent in the interventions they make as they attempt to follow the principles of women's health care. Firstly, avoiding medicalization means that a normal physiological symptom is not being considered pathological, such as certain complaints about menstruation. It also means that patients are not unnecessarily being kept in the medical circuit, or for an unnecessarily long time. Related to this principle one could expect that Aletta patients less often have a follow-up appointment, and that Aletta doctors are more inclined to wait and see the course of the health problem.
Avoiding of medicalization might also lead to fewer prescriptions, at least to less prescribing and to more frequently recommending the use of 'over the counter' (OTC) medicines. Prevention of medicalization might also be apparent in the ordering of fewer diagnostic tests, and in fewer referrals to to other primary care-givers, like physiotherapists, and secondary health care.
In view of the principle 'to encourage a person's self-determination and ability to be responsible for herself' one could expect that in the Aletta practice the decision for a follow-up appointment is more often left to the patient.

The other principles of women's health care mentioned above (consideration of the patient's gender identity and gender roles; consideration of the patient's personal and social situation; respect for the patient) will be expressed for the most part in doctor-patient communication, which was not the subject of the current study. The study is part of an extensive study of gender differences in health and health care, the general purpose of which is to describe and to compare care-giving and attitudes of Aletta general practitioners with those of other female and male general practitioners.

In the current study the following research questions are answered:

1. What are the differences in interventions made by general practitioners during consultations in providing women's health care and regular health care?
2. What are the differences in length of consultation and follow-up appointments between general practitioners providing women's health care and those providing regular health care?
3. Are the differences in treatment related to the type of general practitioner (Aletta, female, male)?

It has already been mentioned that different diagnoses require different interventions. Earlier studies have shown that on the level of ICPC chapters (a classification according to the International Classification of Primary Care)[8], the number of interventions are rather different[9]. Therefore, the type of diagnoses (classified in ICPC chapters) will be accounted for. However, there are other aspects which may influence the doctor's treatment. Choice of treatment may be related to whether the doctor is sure about a diagnosis. Uncertainty or doubt about a diagnosis might lead, for example, to postponing one's decision or to ordering more diagnostic tests. Interventions may be related to details about the patient as well, such as level of education and type of insurance (private or public). Because most of the Aletta patients are highly educated the educational level is accounted for in the analyses. With respect to the type of insurance, earlier studies showed for instance, that general practitioners ordered more diagnostic tests and prescribed less medicines with private than public insured patients[9]. Furthermore, the number of health problems presented may influence the interventions made by the doctor[2]. Lastly, the degree of urbanization has been accounted for, because there have been shown important differences in interventions between urban and rural regions, like in ordering external diagnostics[11]. And, the Aletta practice is established in a big city, with a laboratory close to the practice, whereas many of the other general practices are found in the country.

6.4 Methods

The study design is cross-sectional. Firstly, data was derived from a study conducted among the three female general practitioners of the Aletta women's health care practice and their 3740 patients in 1993. The second source of information was the Dutch national survey of general practice, a large-scale study of morbidity and interventions in general practice (1987-1988) [12]. The study was conducted among 161 general practitioners working in 103 practices. For the present study only data from group practices with

both women and men general practitioners were considered (21 practices with 23 female and 27 male doctors), in order to balance patients' opportunity to choose a female or a male general practitioner[1].

The general practitioners recorded detailed information about all patient contacts during a three-month period. The data recorded included characteristics of the consultation (such as first or repeat consultation in an episode of illness, length of consultation), problems presented and doctor's diagnoses (classified in ICPC chapters), interventions (diagnostics, prescription, referral), and further appointments. The extent to which general practitioners were certain about their working diagnosis was recorded on a five-point scale for each problem presented (1=very uncertain to 5=very certain). Information about validity and reliability of the data as been reported elsewhere[13]. Patients' characteristics such as age, sex, type of insurance and level of education, were derived from a registration of the entire practice population. A high educational level includes professional education or university.

Analysis
The analyses were restricted to diagnoses made during consulting-hour contacts with the general practitioner with respect to health problems that were presented for the first time (the first report of an episode), in order to compare the interventions and consultation characteristics on the level of episodes. It was assumed that doctors act on the basis of the diagnosis, and therefore the diagnoses were used as starting points for interventions carried out and for consultation characteristics. Only first contacts were included, because some episodes had already started and/or were unfinished (the general practitioners had recorded their information for only three months). In the present study only female patients from 20 to 45 years of age were included in the analysis, because women of this age group constitute the greater part of the Aletta practice population (86.3%). Although the principles of women's health care are also applicable to male patients, men were not included because their number was not large enough to include them in the analysis.

Multi-level logistic regression analysis was used in order to calculate the likelihood of general practitioners performing interventions, making follow-up appointments and having long consultations (>10 min.), when a patient presents a certain diagnosis (classified in a ICPC chapter). Multi-level analysis was used in order to deal with two problems. Firstly, because of the practice of nesting consultations among general practitioners, a clustering of consultations could be the result. The consultations held by one general

practitioner would be, on the average, more similar than the consultations of different general practitioners. Therefore, the consultations cannot be considered as completely separate independent observations.
The second problem is that all the dependent variables are on the level of diagnoses, while the independent variable of main interest is on the level of the general practitioners. So the lower level outcome measures are believed to be explained by a higher level explanatory variable - the type of general practitioner (Aletta, female and male GPs). Therefore, a two-level model was used to analyse the data[14 15], with the MLn software[16]. With the help of this program a logistic multilevel regression analysis was performed, which was necessary because the dependent variables are dichotomous. In this way the odds of interventions performed by the doctors were calculated (e.g. the chance that the general practitioner prescribes medicines, devided by the chance that it is not done). The differences were tested for statistical significance by en F-test for contrasts[16].
A summary of the dependent, control and independent variables is shown in Scheme 6.1.

Scheme 6.1. Independent, dependent and control variables: definitions

Independent variable:
- type of GP: Aletta/female/male

Dependent variables:
diagnostic tests
physical examination
wait and see
'over the counter' (OTC) medication
medical treatment
regimen
prescription
- yes
- psychopharmaca
- antibiotics
consultation >10 minutes
follow-up appointment: on initiative of the patient
follow-up appointment: on initiative of the GP and/or the patient

Control variables:
type of diagnosis: classified as ICPC chapters
number of health problems presented by the patient
patient's educational level: level at which full-time education was finished
- low: primary and secondary education
- high: vocational / professional training and university
patient's type of insurance: public or private
degree of urbanization: urban or rural
GP's certainty about a diagnosis

The relations between the control variables and the type of general practitioner are given in Table 6.2. The percentages and mean values presented (Tables 6.1, 6.2, and 6.3) were tested for significance using a difference of proportions test and a t-test respectively, both for independent random samples[17].

6.5 Results

Control variables

The diagnoses made for female patients by the general practitioners of women's health care and regular health care are shown in Table 6.1. Psychological problems as well as skin diseases were diagnosed more frequently by Aletta doctors than by the female and male doctors of regular health care, whereas the Aletta doctors saw fewer musculoskeletal and respiratory illnesses. Both the Aletta doctors and the other female doctors made more diagnoses concerning uniquely female health and social problems than male doctors.

Table 6.1 Diagnoses (ICPC chapters) (%) of female patients (20-45 years) in first contacts, by type of GP

	Aletta GPs	female GPs	male GPs
ICPC chapters			
general, unspecified	6.8 [1]	9.3 [3]	7.9
blood	2.5 [1,2]	1.4	1.3
digestive	5.1	5.5	6.2
eye	1.8 [2]	1.8 [3]	3.0
ear	4.0	3.8	4.1
circulatory	1.5 [1]	2.6	2.5
musculoskeletal	11.9 [1,2]	14.5	14.7
neurological	1.5	1.5	2.2
psychological	8.6 [1,2]	5.3	6.4
respiratory	7.8 [1,2]	11.6 [3]	14.8
skin	18.7 [1,2]	13.4	12.7
endocrine, metabolic	1.3	1.3	1.3
urology	0.8 [1,2]	2.1	2.2
pregnancy,family planning	9.6	9.1	8.3
female genital system	14.4 [2]	14.3 [3]	10.7
social	3.6 [1,2]	2.5 [3]	1.8
N	1101	3121	3588

[1] $P<0.05$ Aletta GPs' patients versus patients of other female GPs
[2] $P<0.05$ Aletta GPs' patients versus patients of male GPs
[3] $P<0.05$ patients of other female GPs versus patients of male GPs

From table 6.2 it becomes clear that many more of the Aletta female patients are highly educated than patients of the other doctors, whereas patients of female doctors are more likely to be highly educated than patients of their male colleagues. The Aletta patients present more health problems to their doctors than other patients - two complaints on the average. Furthermore, the Aletta and other female doctors more often admitted to being uncertain or doubtful about a diagnosis than male doctors, and Aletta doctors more often than the other female doctors. Aletta patients are more often private insured than other patients and, lastly, more of the male doctors' patients live in rural regions than female doctors' patients (the Aletta practice is established in a big city).

Table 6.2 Characteristics (% or means) of female patients (20-45 years) in first contacts, by type of GP

	Aletta GPs	female GPs	male GPs
% highly educated patients	61.2 [1 2]	21.0 [3]	13.4
mean number of RFEs	2.0 [1 2]	1.5 [3]	1.4
% uncertainty/doubt about diagnoses	25.7 [1 2]	16.9 [3]	12.5
% public insured	62.8 [1 2]	74.0	75.4
% urban	100.0 [1 2]	31.1 [3]	27.4
N	1101	3121	3588

[1] $P<0.001$ Aletta GPs' patients versus patients of other female GPs
[2] $P<0.001$ Aletta GPs' patients versus patients of male GPs
[3] $P<0.001$ patients of other female GPs versus patients of male GPs

Treatment

The raw percentages (without accounting for control variables and multi-level problems) show many differences among the three groups of general practitioners (Aletta, female and male) (Table 6.3). Aletta doctors gave fewer than half of their patients physical examinations, while the other doctors examined about three quarters of their patients (male doctors most often). Diagnostic tests were more often carried out or ordered by female than male doctors, which is partly ascribed to cervix smears. Aletta doctors were more inclined to wait and see, and to advise regimens and medications without giving a prescription, than either other female doctors or male doctors. Medical treatment, such as caring for wounds and administering injections, was less often performed by the Aletta doctors. Furthermore, the doctors of the Aletta general practice prescribed medicines such as antibiotics less

frequently than the other doctors, whereas female doctors in their turn prescribed fewer medicines than their male colleagues.

Table 6.3 Interventions and consultation characteristics (%) of female patients (20-45 years) in first contacts, by type of GP

	Aletta GPs	female GPs	male GPs
diagnostic tests	19.3 [2]	21.6 [3]	16.2
physical examination	44.0 [1 2]	73.3 [3]	76.0
wait and see	10.2 [1 2]	6.9	7.1
OTC medicines	7.5 [1 2]	3.5	4.0
medical treatment	2.8 [1 2]	4.6	5.5
regimen	4.2 [1 2]	2.9	2.3
prescription:			
- yes	31.6 [1 2]	40.0 [3]	45.0
- psychopharmaca	0.6	0.9	1.3
- antibiotics	2.2 [1 2]	4.9 [3]	6.7
referral:			
- secondary care	3.5	3.3	3.7
- mental health care	1.5 [1 2]	0.2	0.2
- physiotherapist	3.5 [1 2]	1.8	2.2
consultation >10 min.	51.4 [1 2]	37.8 [3]	29.4
appointment initiative pat	36.9 [1 2]	46.3 [3]	41.9
appointment initiative GP/pat	58.1 [1]	63.5 [3]	58.5
N	1101	3121	3588

[1] P<0.05 Aletta GPs' patients versus patients of other female GPs
[2] P<0.05 Aletta GPs' patients versus patients of male GPs
[3] P<0.05 patients of other female GPs versus patients of male GPs

Referrals to secondary care did not differ among the general practitioners. However, the Aletta doctors more frequently referred their patients to mental health care and physiotherapists than doctors providing regular care. In the Aletta practice the doctors left less often follow-up appointments to the patients themselves than in the other practices, with the other female doctors taking the lead in this regard. But, the Aletta and male doctors did not differ in follow-up appointments if it is not taken into account whether the initiative was taken by the patient or the doctor, whereas female doctors' patients also have the most appointments in this respect.

Lastly, about half of the consultations with Aletta doctors were longer than 10 minutes, which occurred less frequently in the other practices. Male doctors' consultations were more likely to be shorter than 10 minutes as compared with female doctors' consultations.

In order to get more insight in the differences in interventions, for each of the ICPC chapters the interventions made most frequently are shown in Appendix 6.A. Differences in ordering diagnostic tests are especially present with general, unspecified problems (Aletta more than male doctors), respiratory problems (Aletta doctors more than other female and male doctors) and uniquely female problems (male doctors less than both groups of female doctors). The relatively low percentage of tests with respect to pregnancy and family planning in the Aletta practice is probably due to the task of the practice assistants to perform tests.
In general, physical examinations are less done by the Aletta doctors than by the other doctors, irrespective of the type of problems (on the level of ICPC chapters).
The Aletta doctors are more inclined to wait and see if it concerns ear problems, respiratory problems and problems on the field of urology. On the one hand, they prescribe in many cases less medicines than other doctors for many types of problems, on the other hand they advice more often OTC-medicines, for example, for respiratory and specific female health problems. On the whole, Aletta doctors advise less medication.
Most differences in interventions between Aletta and other doctors are present in the chapters female genital problems (also between female and male doctors), respiratory problems and problems with respect to pregnancy and family planning. Interventions with psychological and social problems are the less common, but again especially in the Aletta practice.
Long consultations (>10 min.) seem not to be related to the type of health problems, in the Aletta practice they are most frequent (not shown in the table).

Additionally to the analysis on the level of ICPC chapters, interventions with five, very frequently made diagnoses are shown (Appendix 6.B). Also on this level it becomes clear that the Aletta doctors make fewer interventions as compared to other general practitioners. Patients with bronchitis are less often examined, get fewer prescriptions like antibiotics, but more advices for 'over the counter' medicines, and the doctors more often want to wait for the course of the infection. Concerning myalgia it is about the same story, whereas the Aletta patients are not significantly more referred to the physiotherapist.

Urogenital candidiasis is more often confirmed by a test by Aletta and other female doctors than by men. These patients are examined less often, especially Aletta patients, just like patients having a sinusitis, who nearly always get medicines (mostly antibiotics) of all doctors. Lastly, patients who are overworked get less prescriptions in the Aletta practice than in the other practices.

Multilevel analysis

The odds of the interventions made by the three groups of general practitioners, when accounting for the control variables - type of diagnosis (ICPC chapters), educational level, type of insurance, urbanization degree, type and number of health problems presented, and certainty about diagnosis - are shown in Table 6.4 (the coefficients of the control variables are not shown in the table; each row gives the results of an independent analysis). The odds of ordering a diagnostic test is higher for female doctors than for male doctors. For example, the chance that Aletta doctors order a diagnostic test divided by the chance that they do not order a test is 0.43, and for the other female doctors the odds is 0.37 (the higher the odds, the higher the chance that an intervention is done). Both groups differ significantly from male doctors in this respect. It means that the odds ratio of Aletta doctors versus male doctors is 0.43/0.30=1.43 or - in other words - the chance that Aletta doctors order a test is one and a half as high as compared to male doctors.
A female patient is much more likely to be given a physical examination when visiting a female or male doctor providing regular care than when visiting the Aletta practice. In regular care, the chance of being examined is more than twice as high as the chance not undergoing such an examination (odds ratio female doctors versus Aletta doctors=2.45/1.00=2.45; odds ratio male doctors versus Aletta doctors=2.70/1.00=2.70).
Furthermore, an Aletta doctor will more often wait for the course of a problem, sooner recommend OTC-medication or a regimen to a patient than the other doctors, although the chance is rather low. On the other hand, generally speaking not-Aletta patients have one and a half more chance to get a prescription than Aletta patients (both odds ratios 0.89/0.61=1.46), but this is not demonstrated in the prescription of psychopharmaca and antibiotics.
There was no indication of differences in referrals to secondary care, but the Aletta patients have a higher chance being referred to mental health care as compared with both other groups of general practitioners (odds ratios 5 and 2.5 respectively). Patients of the Aletta doctors are also more likely to be referred to the physiotherapist, although in general the chance is rather low for all patients.
All female patients have about an equal, high chance of a follow-up appointment, either on their own initiative or on the doctor's (the differences are not

significant). The chance of receiving a long consultation is about equal and rather low, if taking into account the control variables.
Between female and male general practitioners providing regular health care no differences of any kind were found, except from diagnostic tests ordered.

Table 6.4 Odds of interventions and consultation characteristics of female patients (20-45 years) in first contacts, by type of GP, controlled for educational level, insurance, urbanization, type and number of health problems, and certainty about diagnoses

	Aletta GPs	female GPs	male GPs
diagnostic tests	.43 [2]	.37 [3]	.30
physical examination	1.00 [1 2]	2.45	2.70
wait and see	.28 [1 2]	.11	.10
OTC medicines	.09 [1 2]	.02	.02
medical treatment	.14	.16	.20
regimen	.04 [1 2]	.01	.01
prescription:			
- yes	.61 [1 2]	.89	.89
- psychopharmaca	.04	.06	.06
- antibiotics	.01	.01	.01
referral:			
- secondary care	.01	.01	.01
- mental health care	.10 [1 2]	.02	.04
- physiotherapist	.01	.01	.01
consultation >10 min.	.03	.09	.06
appointment initiative pat	1.78	1.38	1.17
appointment initiative GP/pat	4.00	2.70	2.45
N	1101	3121	3588

[1] P<0.05 Aletta GPs' patients versus patients of other female GPs
[2] P<0.05 Aletta GPs' patients versus patients of male GPs
[3] P<0.05 patients of other female GPs versus patients of male GPs

6.6 Discussion

This article studies the differences between the treatment given to female patients (20-45 years old) by general practitioners providing women's health care and by those providing regular health care, as well as differences between female and male general practitioners. The general conclusion is that the women's health care doctors in the Aletta practice differ to a certain extent from the other doctors, but that there are strong similarities between the female and male doctors in regular care. The first conclusion could be expected, considering the principles being followed in the Aletta general practice. The second conclusion does only partly agree with findings in earlier studies[1-6]. These studies on gender differences in practice style found male doctors ordering fewer laboratory tests, in accordance with the present study. But on the other hand, male doctors were found writing more prescriptions, and doing more technical-medical interventions in consultations involving female patients. A recent study on the approach of female urinary incontinence showed that the drug prescriptions rate is too high with male general practitioners, while the referral rate is too high with female doctors[18]. These result do not agree with our results, indicating no differences between both genders in these respects. However, in a study on differences in the treatment of uniquely female health problems, there were no differences in the number of prescriptions and referrals between female and male doctors (except for more prescriptions written for menstrual problems by male doctors). Furthermore, in the studies mentioned, female doctors were found to hold more long consultations (>10 min.) and to make more follow-up appointments. If confounding factors were accounted for, these differences between women and men disappeared in our study.

There are some factors that might explain these distinctive results of the present study. Firstly, only female patients were selected between 20 and 45 years old. Furthermore, in this study the only consultations selected were those in which problems were being presented for the first time. Moreover, diagnoses were accounted for (on the level of ICPC chapters) as well as the patient's educational level, the type of insurance, the degree of urbanization, the number of complaints presented by the patients, and the doctor's certainty about the diagnosis. In earlier studies these relevant factors were not included.
The fact that only group practices were included in the study cannot explain the results, because in an earlier study no differences in treatment were found between general practitioners working in a solo practice or in a group practice[19]. Lastly, the use of multi-level analysis accounts for similarity of

treatment for one general practitioner, and at the same time for important patient characteristics, which was not done before in other studies.
With respect to the results, it must be mentioned that some treatments (e.g. referrals to physiotherapists and mental health care, and the prescription of psychopharmaca) were not performed so very often. Therefore the chance that they will be performed might be overrated slightly.

Lastly, the difference in the time at which data were gathered should be taken into account when interpreting the results; the regular health care doctors recorded their patient contacts in 1987 and 1988, the Aletta doctors in 1993. Because with respect to some health problems, standards for treatment have been developed, it might be possible that some interventions have changed, such as the prescription of medicines and the ordering of diagnostic tests. Also, referrals to physiotherapists and the use of OTC-medicines have risen in that time period, which might influenced the results found to some extent. The percentage of patients, however, who received medicines on prescription remained stable between 1987 and 1992 (the time period between the two studies)[20].

Despite the limitations mentioned above, it can be concluded that there are striking differences between general practitioners providing women's health care and general practitioners providing regular health care. The Aletta doctors order more laboratory tests, perform physical examinations less frequently, prescribe less medicines, advice more often OTC-medicines, are more inclined to wait and see, and refer more patients to mental health care, irrespective of the type of diagnoses and other relevant factors mentioned above. Differences between female and male general practitioners were not found, except for ordering diagnostic tests.

On the one hand, avoidance of medicalization by the Aletta doctors seems to be reflected in some interventions of the Aletta doctors, like their prescription behaviour. They write out less prescriptions in general, but not less antibiotics and psychopharmaca. They are more inclined to provide medical advice for OTC-medicines, and they give their patients more often advice about regimens. It might be that there is a substition of prescribed medicines by OTC medicines, but overall the Aletta doctors prescribe or advise less often than the other doctors.

It seems to be a somewhat puzzling result that Aletta doctors generally give their patients fewer physical examinations than other doctors, both female and male. In view of the principle of women's health care to avoid medicalization, the Aletta doctors probably avoid unnecessary physical

examinations because they try to consider the patient's feelings and emotions, especially when it concerns intimate examinations. Furthermore, women's health care strives to give biopsychological or integrated care. implying that somatic and mental problems are considered as one entity. It means that specific attention is paid to the relation of health and situation as well as and social circumstances. Possibly, the Aletta doctors are more inclined and better at explaining to their patients that a health problem does not always have a somatic background, and that therefore a physical examination is not always required. One could argue, that these reasons are demonstrated in the fewer examinations of patients presenting with psychological problems, like surmenage, and specific female problems, like urogenital candidiasis. However, the reason why they perform less examinations when making some other diagnoses, like respiratory problems in general, and - more specifically - bronchitis, remains unclear, all the more because a physical examination is often seen as a demand. But, a value judgement about leaving off an examination can not be given on the base of the available data. A more detailed study into the process of making a diagnosis based on the patients' complaints (reasons for encounter) may give a clearer insight in the differences in treatment.

On the other hand, prevention of medicalization is not reflected in other treatments. The Aletta doctors order more diagnostic tests, just like the other female doctors. This last result is a rather consistent finding in a lot of studies. Because it has been proven that the more tests are done, the more deviant test results are found[21], it would be worthwhile to pay attention to this fact. For, it may lead to more instead of less medicalization, in terms of staying in the medical circuit if not necessary, which is not according to the 'demedicalization' principle of women's health care.
The higher number of tests may be related to the fact that female doctors more often say (or admit) to be not sure about a diagnosis. Consequently, female doctors should order more laboratory tests, which is in accordance with our results.

The referral behaviour of the Aletta doctors shows mixed findings. They more often refer their female patients to mental health care, but not to physiotherapists and other medical specialists of secondary health care (if accounting for other influencing factors). Earlier studies found that Aletta patients have more psychological problems, and it was argued that these patients may be more able to explain their problems in psychological terms than non-Aletta patients. This is a probable explanation for the greater likelihood of Aletta patients of being referred to mental health care by their doctors. Furthermore, the difference in the time at which data were gathered

should be taken into account; the regular health care doctors recorded their patient contacts in 1987 and 1988, the Aletta doctors in 1993. The number of patients being referred to mental health care has been increasing since the first period indicated[21]. So the higher referral rate with respect to mental health care may be partly related to the difference in the time at which data was gathered. But, again, is does not seem to be in accordance with the principle 'demedicalization'.

Lastly, the chance of receiving a lengthy consultation (more than 10 minutes) appears to be equal if, among other factors, the number of health problems presented by a patient are accounted for, although more than half of the Aletta consultations are longer than 10 minutes. However, keeping in mind that Aletta patients on the average present more health problems in one consultation than other patients (2 versus 1.5), it is understandable that the chance of a long consultation strongly decreases when the number of health problems is taken into account. In an earlier study[2] the same result was found. It is an interesting finding, especially for health policy makers, because apparently the length of a consultation is to a large extent dependent on the number of problems.
There is no (significant) indication that Aletta doctors make less appointments, neither on their own initiative nor on the patients'. The principle 'to encourage the patient to cope with health problems and to stimulate self-responsibility' has not been proved to be practised in this respect.

To conclude, the practising of the women's health care principle 'demedicalization' has not been demonstrated in the interventions studied, except for the prescription behaviour of the Aletta general practitioners, neither the principle 'encouragement of the patient's self-determination and ability to be responsible for herself'. The rather equal treatment by general practitioners providing regular health care and women's health care is an example of the attention that is also paid to these aspects by general practitioners providing regular health care.
Possibly, more in-depth studies into the processes of making specific diagnoses and taking decisions for interventions might be helpful for understanding the way of practising and are recommended for the future.

Appendix 6.A Interventions (%) with diagnoses classified in ICPC-chapters with female patients (20-45 years) in first contacts, by type of GP

	Aletta GPs	female GPs	male GPs
General, unspecified			
- diagnostic tests	30.7 [2]	25.1	19.1
- physical examination	17.3 [1,2]	64.3	57.2
- wait and see	10.7	8.6	9.2
- prescription	28.0	28.2	22.3
- OTC medicines	2.7	2.4	0.7
N	75	291	283
blood			
- diagnostic tests	37.0	53.5	43.8
- physical examination	37.0 [2]	58.1	72.9
- wait and see	18.5	7.0	6.3
- prescription	3.7 [1,2]	37.2	39.6
- OTC medicines	3.7	4.7	4.2
N	27	43	48
digestive			
- diagnostic tests	12.5	22.5 [3]	13.9
- physical examination	46.4 [1,2]	79.2	82.5
- wait and see	14.3	12.1	7.2
- prescription	25.0 [1,2]	39.3 [3]	58.7
- OTC medicines	12.5	1.7	5.4
N	56	173	223
eye			
- diagnostic tests	5.0	3.6 [3]	0.0
- physical examination	65.0 [2]	83.9	88.0
- wait and see	10.0	1.8	7.4
- prescription	45.0	51.8	66.7
- OTC medicines	20.0 [1,2]	0.0	0.0
N	20	56	108

[1] $P<0.05$ Aletta GPs' patients versus patients of other female GPs
[2] $P<0.05$ Aletta GPs' patients versus patients of male GPs
[3] $P<0.05$ patients of other female GPs versus patients of male GPs

Appendix 6.A (continued)

	Aletta GPs	female GPs	male GPs
ear			
- diagnostic tests	4.5	3.4	1.4
- physical examination	88.6	88.2	93.2
- wait and see	20.5 [1,2]	3.4	1.4
- prescription	45.5	44.5	38.5
- OTC medicines	20.5 [1,2]	5.0	7.4
N	44	119	148
circulatory			
- diagnostic tests	17.6	21.0	31.3
- physical examination	76.5 [2]	90.1	95.6
- wait and see	11.8	9.9	10.0
- prescription	11.8	30.9	33.3
- OTC medicines	11.8	2.5	3.3
N	17	81	90
musculoskeletal			
- diagnostic tests	10.7	8.6	8.9
- physical examination	72.5 [1,2]	92.9	93.3
- wait and see	16.8	10.8	12.5
- prescription	12.2 [1,2]	24.1	27.8
- OTC medicines	4.6	3.1 [3]	6.5
N	131	8.6	8.9
neurological			
- diagnostic tests	11.8	12.5	11.5
- physical examination	52.9 [2]	77.1	76.9
- wait and see	35.3	20.8	19.2
- prescription	5.9 [2]	22.9	30.8
- OTC medicines	11.8	0.0	2.6
N	17	48	78
psychological			
- diagnostic tests	11.6	16.4	15.7
- physical examination	12.6 [1,2]	40.0	45.0
- wait and see	7 4	3.6	7.4
- prescription	15.8 [1,2]	29.7	36.7
- OTC medicines	2.1	3.0	1.7
N	95	165	229

Appendix 6.A (continued)

	Aletta GPs	female GPs	male GPs
respiratory			
- diagnostic tests	11.6 [1 2]	4.4	4.1
- physical examination	62.8 [1 2]	86.5	88.5
- wait and see	14.0 [1 2]	5.5	5.1
- prescription	58.1 [1 2]	73.0	75.0
- OTC medicines	17.4 [2]	13.2	10.4
N	86	363	531
skin			
- diagnostic tests	4.9	4.3	2.9
- physical examination	75.7 [1 2]	87.3	88.8
- wait and see	7.8	5.0	6.2
- prescription	50.5	52.4	57.5
- OTC medicines	8.7 [1 2]	2.9	2.4
N	206	418	454
endocrine, metabolic			
- diagnostic tests	28.6	27.5	28.9
- physical examination	21.4 [1 2]	70.0	57.8
- wait and see	0.0	2.5	2.2
- prescription	0.0 [2]	20.0	26.7
- OTC medicines	7.1	0.0	0.0
N	14	40	45
urology			
- diagnostic tests	77.8	82.8	87.2
- physical examination	33.3	35.9	37.2
- wait and see	22.2 [1 2]	1.6	2.6
- prescription	33.3 [2]	64.1	69.2
- OTC medicines	0.0	0.0	2.6
N	9	64	78
pregnancy,family planning			
- diagnostic tests	19.8 [1 2]	41.9	34.3
- physical examination	13.2 [1 2]	54.9	53.5
- wait and see	0.0	3.5	2.4
- prescription	50.9 [1 2]	33.5	31.6
- OTC medicines	0.0	0.7	2.7
N	106	284	297

Appendix 6.A (continued)

	Aletta GPs	female GPs	male GPs
female genital system			
- diagnostic tests	55.7 [2]	49.0 [3]	39.1
- physical examination	15.2 [1 2]	66.7 [3]	72.2
- wait and see	8.2	7.6	6.5
- prescription	22.8 [1 2]	38.5	41.1
- OTC medicines	8.9 [1 2]	2.0	0.8
N	158	447	384
social			
- diagnostic tests	0.0 [1]	9.1	4.8
- physical examination	0.0 [1]	9.1	6.3
- wait and see	0.0	0.0	1.6
- prescription	5.0	7.8	11.1
- OTC medicines	0.0	0.0	0.0
N	40	77	63

Appendix. 6.B Interventions (%) with four diagnoses with female patients (20-45 years) in first contacts, by type of GP

	Aletta GPs	female GPs	male GPs
bronchitis			
- diagnostic tests	9.7 [2]	2.8	0.5
- physical examination	71.0 [1 2]	91.6	92.3
- wait and see	22.6 [1 2]	4.9	7.2
- prescription	54.8 [1 2]	72.7	71.3
- antibiotics	3.2 [2]	16.1	16.4
- OTC medicines	35.5 [2]	20.3	14.9
N	31	143	195
myalgia			
- diagnostic tests	4.3	6.5	4.2
- physical examination	69.6 [1 2]	92.8	94.1
- wait and see	26.1 [1]	9.4	15.1
- prescription	13.0 [1 2]	33.8	35.3
- OTC medicines	0.0 [2]	5.8	15.1
- referral physiotherapy	26.1	12.2	11.8
N	23	139	119
urogenital candidiasis			
- diagnostic tests	76.0 [2]	56.5 [3]	26.0
- physical examination	8.0 [1 2]	69.3 [3]	93.5
- prescription	84.0	87.0	92.2
- OTC medicines	8.0 [2]	2.9	0.0
N	25	69	77
surmenage			
- diagnostic tests	35.0	19.4	21.7
- physical examination	15.0	29.0	37.0
- prescription	5.0 [1]	29.0	17.4
- psychopharmaca	0.0	12.9	13.0
N	20	31	46

[1] $P<0.05$ Aletta GPs' patients versus patients of other female GPs
[2] $P<0.05$ Aletta GPs' patients versus patients of male GPs
[3] $P<0.05$ patients of other female GPs versus patients of male GPs

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7 GENDER AND COMMUNICATION STYLE IN MEDICAL ENCOUNTERS: DIFFERENCES BETWEEN GENERAL PRACTITIONERS PROVIDING WOMEN'S HEALTH CARE AND REGULAR HEALTH CARE *

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7.1 Abstract

Differences in communication style were investigated between general practitioners providing women's health care (4 women) and general practitioners providing regular health care (8 women and 8 men). Hypotheses were formulated on the basis of the principles of women's health care and literature about gender differences. Data was used from 405 videotaped consultations of women patients (15 years and older). Roter's Interaction Analysis System (RIAS) was used to measure the verbal affective and instrumental behaviour of the doctors and their patients. These data was supplemented by various nonverbal measures. The data was analyzed by means of multi-level analysis. Results show that the doctors in the women's practice (Aletta) look at their patients and talk with them more than other doctors. The general practitioners have about the same affective behaviour, but the Aletta doctors show more verbal attentiveness and warmth than men doctors. They give more medical information and advice than other doctors, but their women colleagues providing regular care more often talk with their patients about psychosocial issues. Patients of Aletta doctors and of other women doctors show many similarities, but women doctors' patients talk the most, especially about psychosocial issues. Men doctors' patients talk least and feel the least at ease. The principles of women's health care are partly reflected in the communication of Aletta doctors and their patients, but other women doctors' communication style is rather equal.

7.2 Introduction

In the Netherlands as well as in some other Western countries, special women's health care centres have been developed, providing health care based on feminist principles. While this development has been accompanied by an emerging progression in research, up to now little attention has been given to the impact of the type of health care (women's or regular health

care) on communication style, even though doctor-patient communication is generally receiving increased attention. Nevertheless, women's health care may be expected to influence doctor-patient communication because of the specific principles of women's health care. Furthermore, recent studies reveal important doctor-gender differences in doctor-patient communication (see Literature). The aim of the current study is, therefore, to investigate whether there are differences between women's health care and regular health care (both women and men doctors) in terms of the communication style of general practitioners with women patients, and to explore possible explanations for these differences. The study is part of a larger study on differences between general practitioners providing women's health care and regular care, such as differences in practice populations[1], and in health problems presented[2].
Firstly, women's health care is explored in more depth, and the existing literature on the topic of gender differences is then reviewed. Finally several hypotheses are formulated about communication style, based on the principles of women's health care and based on the differences between women and men doctors.

Women's health care
In the Netherlands, (women) general practitioners are providing women's health care in a general practice named Aletta (after Aletta Jacobs, the first Dutch woman feminist physician). Women's health care is defined as 'to work consciously in care-giving to women from the viewpoint that women's problems can be related to their socialization and their position as women in this society, and to help women to develop strategies in order to get more authority over and responsibility for their own bodies and lives' [3]. This type of care is based on principles which had evolved from the feminist movement of the early seventies, in imitation of other Western countries. The women's health movement challenged the established health care system because of: 'women-unfriendly' attitudes of - in particular men - doctors towards women; the 'blind spot' in knowledge about the somatic diseases of women; demedicalization of women's lives; not taking into account the personal and social situation of women. The women's health movement developed further into self-help groups and in independent women's health centres that provide care based on the philosophy of feminist health care. In the Netherlands, a Centre for Women's Health Care was established in 1980. This Centre, named "Aletta", has developed from a local initiative into a national expert's centre of women's health care. The Aletta Centre is considered to be the cradle and driving force of women's health care, and to be of vital importance for the quality of health care in general. The Aletta practice, that is allied to

this Centre, is the only general practice known to provide women's health care, in the Netherlands as well as in other Western countries.
The principles of women's health care can be summarized as[4]: consideration of patient's gender-identity and gender-roles; consideration of the patient's personal and social situation; respect for the patient; encouragement of the patient's own responsibility and self-determination; demedicalization (prevention of labelling daily life problems as biomedical problems). The two first principles are considered to be the most important and distinctive characteristics of women's health care; the other three principles are already part of the body of thoughts that is being propagated by the Dutch College of General Practitioners. Besides, specific attention is being payed to information-giving, which is an important means for realizing the principles. However, they are given specific emphasis in women's health care, which also requires a specific knowledge of and attitude to women's health problems[5]. Aletta doctors are trying to put these principles into practice, when providing care to their patients for all health problems (not only for specific women's health problems). It may therefore be assumed that doctor-patient communication and the way in which doctors in women's health care approach their patients, will be based on these principles. It might be manifest in the degree to which they give their patients the opportunity to tell their whole 'story', including non-medical aspects. This may result in their listening to their patients more and allowing them more speaking time. As a result, consultations will probably be longer. Because of the emphasis on patients' own responsibility and self-determination, it may be assumed that general practitioners in women's health care are more patient-oriented, involving their patients in the diagnostic process and in decision-making about therapeutic choices.

In medical communication two types of behaviour are thought to be important: instrumental behaviour and affective behaviour, corresponding with the two main purposes of the medical consultation[6]. Firstly, information exchange, which is necessary to solve the medical problem and, secondly, creating a therapeutic relationship, necessary to manage the psychosocial aspects of patients' health problems and gain their confidence. Both types of behaviour are important in medical encounters, for patients have two types of need: 'the need to know and understand' and 'the need to feel known and understood' [7]. Both types of need are believed to be met in women's health care. Following the principle of 'encouraging the patient's own responsibility and self-determination' might be expected to lead to Aletta doctors' giving clear and full information, which is related to a higher emphasis on instrumental behaviour in women's health care as compared to regular care.

Practising the other principles could be expected to lead to relatively more affective behaviour. The principle 'consideration of patient's gender-roles and gender-identity' implies - among other things - that the patient's feelings and nature are taken into account. The principle 'consideration of the patient's personal and social situation' might be expected to lead to their giving special attention to living and working circumstances and to showing the relationship between health problems and the patient's circumstances. As a result, the patient may feel she is accepted by the doctor as a person, or - in Engels' words - 'to be known and understood'. So, it could be expected that in women's health care there are higher levels of talk on affective and instrumental behaviour as compared to regular health care.
As regards instrumental behaviour, the Aletta doctors are concerned to give more attention to psychosocial aspects of patients' health problems in proportion to medical aspects, following the principle 'considering the patient's personal and social situation'. However, most patients are reluctant to talk about nonmedical matters, because they think that the doctor may not be interested in such matters or because they feel embarrassed or are anxious about presenting psychosocial problems and worried about its possible meaning[8 9]., To make patients feel sufficiently at ease to present such problems, it is argued that empathy is a necessary condition. It is found that non-verbal behaviour, such as patient-directed gaze, is essential for conveying empathy, and that much of the emotional communication is transferred by visual cues[10]. So, in agreement with the principle of paying attention to psychosocial aspects, it could be hypothesized that doctors providing women's health care look at their patients relatively more than other doctors.
In their interaction with the doctors, Aletta patients may to some extent show the same communication style as do their doctors. For, firstly, reciprocity in interaction has been shown earlier[11-13], meaning that patients are effected by their doctor's communication. Additionally, the patients' choice for the Aletta practice was partly based on motives related to the principles of women's health care. As regards instrumental behaviour, they probably expect their doctor to pay attention to the psychosocial background of their problems and might therefore be expected to ask more questions and give more information, especially about psychosocial aspects. Furthermore, for reasons of reciprocity in interaction, the Aletta patients' affective behaviour also may be like the doctors' behaviour, resulting in more emphasis on affective behaviour as well as on instrumental behaviour.

Literature about gender differences in communication style
Explanations given for differences between same-gender and opposite-gender communication mainly concern gender socialization and status congruency.

Martin et al[14] distinguish two types of socialization: gender and medical socialization. As women (in American society, but probably also in other Western countries), female physicians have been 'gender' socialized to accept a less directed, interactive style of communication (especially when interacting with men). Moreover, the training of communication skills probably has a more 'female' character, by which female physicians acquire these skills more easily than men. However, a physician is 'medically' socialized to be assertive and to dominate the doctor-patient interaction, and to use directive questions and empathic speech to control both the flow and the topics of conversation. They conclude that gender socialization has a larger impact on women doctors' communication style than on males'. Because gender socialization strongly influences conversational patterns, and because there are no 'strict' rules for doctor-patient communication, gender differences in doctors' communication style develop.
Maltz and Borker[15] argue that gender socialization also becomes apparent in the specific language used by women and men, leading to the existence of sexual subcultures. It might be especially manifest in the relation oriented approach of women and the task orientated approach of men.
Other explanations consist of psychological and power differences between opposite gender-dyads. These differences might affect the status relationship between physician and patient, resulting in greater status congruence and equality between same-gender dyads[16].

Most studies found differences between the communication of women and men doctors with their patients[17,18]. Empirical studies show that integration of the two conflicting paradigms (gender and medical socialization) by women physicians leads to more empathy[19,20], more accepting of patients' feelings[21], and more attention to psychosocial issues[22]. Women doctors were more likely to engage in therapeutic listening and counselling[23], and were more egalitarian in their relationships with patients[24]. Male physicians were more imposing and presumptuous[14], and they reassured their patients more often[25]. Women doctors were more non-directive, talked more and were more engaged in question-asking and information-giving than men doctors[12,13,18,22], and spent more time with their patients[18], especially with women patients[25].

Patient expectations and the physician gender differences could be mutually reinforcing during the medical encounter. It was found that patients of women physicians talked much more than male physicians' patients did and, similarly to women physicians, engaged in more positive talk, more partnership-building, question-asking, and information-giving related to both medical and psychosocial topics[18]. Some authors argue that patients may identify male

physicians with the norm of 'affective neutrality', and that they may expect and desire that women physicians will be more expressive or humane[20 23].

To summarize, the overall impact of physician gender on the communication between women doctors and women patients in comparison with men doctors and women patients is hypothesized to be more listening, showing greater affective instrumental behaviour, paying more attention to psychosocial aspects and allowing the patient a greater contribution.

Hypotheses
On the basis of the principles of women's health care, it is hypothesized that consultations (of women patients) of general practitioners providing women's health care, in comparison with consultations of general practitioners (both women and men) providing regular health care, will be characterized by:

1. less speaking time on the part of the general practitioner and more speaking time on the part of the patient, and more patient-directed gaze;
2. a greater patient orientation during the diagnostic and therapeutic phase;
3. more affective as well as instrumental behaviour of both general practitioner and patient
4. within instrumental behaviour, more attention to psychosocial than medical aspects, by both general practitioner and patient.

On the basis of the literature on differences between women and men doctors, it is hypothesized that differences between consultations (of women patients) in women's health care and in regular health care will be greater for men general practitioners than for women.
When explaining differences in communication style between general practitioners, it is important to control for possible confounding variables. Firstly, Roter[26] found strong statistical evidence, based on a meta-analytic review, that older patients receive more information than younger patients. Furthermore, the presenting of psychological or social problems may be related to more communication on the whole as well as more talk about psychosocial aspects. It has been proved that bringing up such problems leads to longer consultations[6], in the same way as bringing up a number of health problems does[9]. Lastly, it has previously been shown that communication between doctor and patient during a first visit differs from communication in a repeat visit, in which a known problem is discussed[16]. Thus patients' age, the type and number of health problems presented to the doctor, and the type of consultation (first or repeat visit) ought to be controlled for when measuring the impact of the type of health care on communication style.

7.3 Method

Study Design

Consultations of women patients with their general practitioners were videotaped in their entirety, with the exception of physical examinations, during which only the verbal doctor-patient communication was recorded. Videotaping was used because video recordings allow the examination of both verbal and nonverbal behaviour can be examined. Moreover, the observation of videotaped consultations has been proven to be a reliable method for analysing doctor-patient communication[6 27].

Sample

The data is derived from consultations of women patients aged 15 years and older visiting their general practitioner. The sample is restricted to women patients because 85% of the practice population of 'Aletta' are women. Three groups of general practitioners are included in this study. While the Aletta practice is the only women's health care practice known where general practitioners provide this specific type of health care, for obvious reasons the first group consists of only the four general practitioners of the group practice Aletta. The second group consists of eight women general practitioners and the third group of eight men general practitioners, both groups providing regular health care. The general practitioners providing regular health care were included in a Dutch national survey of general practice, a large-scale study of morbidity and interventions among 161 general practitioners in 103 general practices[28]. Of this random sample of practices, only groups practices (21) with both women (23) and men (27) general practitioners were considered, in order to balance patients' opportunity to choose a woman or a man doctor[25]. Of these group practices, 16 general practitioners were willing and able to participate in this observation study. The mean number of consultations which were observed is approximately 20, resulting in a total of 405 consultations.

Observation scheme

Roter's Interaction Analysis System (RIAS)[29] was used to measure the affective or socio-emotional (care-oriented) behaviour as well as the instrumental or task-related (cure-oriented) behaviour of general practitioners. From a comparison of several interaction analysis systems RIAS seems to be very suitable for the present study, because it measures doctor-patient communication during medical consultations, and is specifically modified for the clinical setting (based on Bales' system)[30]. Furthermore, coding is done directly from videotape, inter-rater reliability is high and the system is applicable both to verbal and non-verbal behaviour[6]. RIAS codes each

statement or complete thought made during the visit by either physician or patient into one of 34 mutually exclusive and exhaustive categories. Factor analysis showed roughly the same three dimensions of affective behaviour as have been found in earlier studies[6 25 31]. These dimensions are: verbal attentiveness (agreement, paraphrase, empathy, legitimize, partnership); showing concern (worry, reassurance); social behaviour (personal remarks, jokes, approval); and disagreement. Instrumental behaviour includes giving information; asking questions and counselling, each about medical as well as psychosocial aspects; asking clarifications (bids, ask for understanding); giving directions (directions, transitions). Psychosocial aspects that are directly related to the medical problem are scored as 'medical', in contrast with other psychosocial aspects that come up during the consultation.
Indices were used to examine the relation between instrumental and affective behaviour (hypothesis 3) as well as the relation between the attention given to medical and psychosocial aspects (hypothesis 4). Furthermore, RIAS contains affect ratings, which are measured by a six-point scale, including: anger/irritation; anxiousness/nervousness; dominance/assertiveness; interest/concern; warmth/kindness. Following Byrne and Long[11], we used a five-point scale to measure the degree of influence the patient gets in a consultation. Like them, with respect to patient-oriented behaviour we made a distinction between the diagnostic and the therapeutic phase. Speaking time of general practitioners and patients and patient-directed gaze (the amount of time the doctor looks at the patient) were measured with a stopwatch.

Reliability of the observations
The consultations were coded by three observers who had been trained for the RIAS observation scheme. The first three consultations that were filmed were not scored, in order to avoid 'socially-desirable behaviour'. This has proven to be a sufficient number, because doctors rapidly become accustomed to the videotaping[27]. Each observer coded approximately the same number of consultations of each of the 20 doctors. The consultations were assigned to and coded by the observers at random.
Twenty consultations were coded by each of the three observers in order to calculate the reliability of the observation scores. Reliability mostly proved to be high, with interobserver correlations (Pearson' Product Moment Correlation) between .72 and .91 for the general practitioners' socio-emotional clusters, between .67 and .90 for the patients' ones. For the task-related clusters the correlations were between .77 and .94 for the general practitioners and between .63 and .98 for the patients. The interobserver correlations were between .50 and .89 for the affect ratings and between .57 and .64 for the patient-orientation measures, and, lastly, the interobserver correlations of speaking time and that of patient-directed gaze were .97 or higher.

Data Analysis
Because of the nesting of 405 consultations within 20 general practitioners, there are two major statistical problems to address. The first is the clustering of consultations among general practitioners. It might be argued that one general practitioner's consultations would, on average, be more alike than those of different general practitioners, implying that the 405 videotaped consultations cannot a priori be considered as completely separate independent observations. The amount of clustering can be calculated by means of the intra-class correlation coefficient (ρ), which reflects the proportion of total variance of an observation that is associated with the class (in our case the general practitioner) to which it belongs[32]. Consider the 20 general practitioners as random effects in a one-way ANOVA. Then the between variance (σ^2_{GP}) indicates the variation between general practitioners, while the pooled within variance (σ^2) relates to the variation of consultations within general practitioners. ρ is defined as $\sigma^2_{GP} / (\sigma^2 + \sigma^2_{GP})$. When σ^2_{GP} is close to zero, ρ is also close to zero. In that case there is no cluster effect and the consultations can be regarded as 405 independent observations. On the other hand, when σ^2 is close to zero, ρ is close to unity. In that case there is no variation within general practitioners, the cluster effect is complete and we have only 20 independent observations.

The second problem is that all the dependent variables are at the level of consultations, while the independent variable of main interest is at the level of the participating general practitioners. So we have essentially two-level hypotheses in which variation in the lower level outcome measures (for instance in the length of consultation) is believed to be explained by a higher level explanatory variable - the type of general practitioner (Aletta, women and men GPs).
The idea of observation dependencies and multi-level hypotheses is formalized in the hierarchical linear model approach[33]. This approach takes into account whatever clustering the data presents and adjusts the standard errors of the estimated coefficients accordingly. Standard errors at the GP-level are neither based solely on the number of consultations, like in an analysis where the general practitioners' characteristics are linked to the consultations, nor are they based solely on the number of general practitioners, like in an analysis where the consultation measures have been aggregated to the level of general practitioners.
Hierarchical Linear Models are regression models. The regression models were calculated in three steps. First the one-way ANOVA model with random effects was modelled, to obtain the results in Table 7.1. In the next step the control variables were added. In the third and final step the variable *type of GP* was added, represented by two dummy variables: *Aletta* and *women*,

leaving the male GPs as the reference group. In this last step the hypotheses were actually tested. A series of models was computed with each GP characteristic (see Table 7.4) as a dependent variable. This was repeated in another series with some patient characteristics as the dependent variable (see Table 7.5). Hierarchical linear models specified in this way are labelled 'one-way ANCOVA with random effects' models (Bryk & Raudenbusch, 1992, p.18). The ML3 software[34] was used to analyze the data. A summary of the dependent, independent and control variables is shown in Scheme 7.1.

Scheme 7.1 Independent, dependent and control variables: definitions

Independent variable:
- type of GP: Aletta/woman/man

Dependent variables
- GP's and patient's speaking time: relative to length of consultation
- patient-directed gaze: time the GP looks at the patient: relative to length of consultation (excluding physical examination)
- GP's patient-orientation: 5-point scale (1=very low, 6=very high)
    - during the diagnostic phase
    - during the therapeutic phase
- GP's and patient's affect ratings: 6-point scale (1=very low, 6=very high)
    - anger/irritation
    - anxiousness/nervousness
    - dominance/assertiveness
    - interest/concern
    - warmth/kindness
- GP's and patient's affective behaviour:
    - total number of utterances
    - verbal attentiveness
    - showing concern
    - social behaviour
    - disagreement
- GP's and patient's instrumental behaviour (psychosocial and medical):
    - total number of utterances
    - giving information
    - asking questions
    - counselling (only GPs)
    - asking clarification
    - giving directions

Control variables
- patient's age: number of years
- patient's health problem(s): psychological or social (ICPC chapter P and Z), or not
- number of health problems presented
- type of consultation: first or repeat

Statistical power and significance

The statistical power of the analysis is, of course, related to the standard errors of the estimated coefficients (see Tables 7.3, 7.4 and 7.5). These standard errors are functions, among others, of the number of general practitioners, the number of consultations (approximately 20) for every GP, as well as the amount of clustering in the data. According to the lines pointed out by Snijders and Bosker[35], we have calculated the expected standard errors of one of the outcome measures to get an idea of the power of the analysis. The standard deviation of the length of time of consultation is 323 seconds. The expected standard errors of the mean consultation length for different types of GPs are: 48 seconds for male and female GPs and 71 seconds for Aletta GPs. With standard errors of this magnitude, a reasonable power of 75% can be obtained by setting a conventional alpha level in order to detect medium (not small) differences between Aletta, female and male GPs. It meets the aim of this study, that is analysing more substantial differences between women's health care and regular health care. The power is sufficient to detect differences of this magnitude.

7.4 Results

Table 7.1 presents intra-class correlation coefficients for various general practitioner behaviours.

The highest coefficients are those of the percentage of patient-directed gaze (.35) and general practitioner's speaking time (.33). Although these coefficients are regarded as being rather high[36], none of the coefficients are close to unity. The value of .33 implies that one-third of the variance is between general practitioners, while the remaining two-thirds is due to the pooled within variance. So, we conclude that one general practitioner's consultations do indeed exhibit a greater degree of similarity than consultations of different general practitioners.

Table 7.1 Intra-class correlation coefficients of speaking time, patient-directed gaze and GP's behaviour

	Intra-class R
% GP's speaking time	0.33***
% patient's speaking time	0.10***
% patient-directed gaze	0.35***
GP's patient orientation:	
diagnostic phase	0.16***
therapeutic phase	0.09***
GP's affect ratings:	
anger/irritation	0.07**
anxiousness/nervousness	0.11***
dominance/assertiveness	0.16***
interest/concern	0.25***
warmth/kindness	0.27***
GP's affective behaviour:	
total	0.24***
verbal attentiveness	0.15***
showing concern	0.12***
social behaviour	0.07***
disagreement	0.04*
GP's instrumental behaviour:	
total	0.14***
giving information	0.15***
- medical	0.13***
- psychosocial	0.02
asking questions	0.23***
- medical	0.17***
- psychosocial	0.12***
counselling	0.16***
- medical	0.13***
- psychosocial	0.02
asking clarification	0.21***
giving directions	0.21***
ratio instr/aff	0.20***
ratio med/psysoc	0.07**

* $P \leq 0.05$
** $P \leq 0.01$
*** $P \leq 0.001$

The length of consultations did not differ significantly between the three groups of general practitioners (Table 7.2). However, the total number of instrumental 'utterances' was higher for Aletta doctors than for men doctors, whereas there was no difference in the total of affective behaviour.

Table 7.2 Mean length of consultation, and GPs' and patients' mean scores* on speaking time and eye contact, by type of GP, and controlled for patients' age, type and number of problems presented and type of consultation

	consultations Aletta GPs (N=89)	consultations women GPs (N=164)	consultations men GPs (N=152)
Mean consultation length	11.98	11.60	10.95
% GPs' speaking time	39.21[a,b]	31.23	31.44
% pats' speaking time	33.12[a,b]	36.25[c]	28.28
% eye contact	68.60[a,b]	51.40	46.47

[a] $P \leq 0.05$ Aletta GPs versus women GPs
[b] $P \leq 0.05$ Aletta GPs versus men GPs
[c] $P \leq 0.05$ women GPs versus men GPs

The type of health problems, the women patients presented with in the videotaped consultations, shows only a few differences. Aletta doctors saw more problems related to pregnancy and family planning than men doctors, and less circulatory problems than women doctors of regular care (Table 7.3).

* Means are calculated in Hierarchical Linear Models. Number of Aletta GPs is 4, number of women GPs is 8 and number of men GPs is 8

Table 7.3 Percentage of general practitioner (GP) consultations in which one or more health problems (ICPC chapters) were presented. The Aletta GPs provide women's health care, whereas the female and male GPs provide regular health care

	Aletta GPs	Female GPs	Male GPs
ICPC chapters			
General, unspecified	10.1	15.2	13.2
Blood	3.4	4.3	2.0
Circulatory	3.4[a]	15.2	8.6
Digestive	10.1	5.5[c]	13.8
Ear	7.9	4.3	4.6
Endocrine, metabolic	3.4	7.3	3.9
Eye	3.4	1.2	4.6
Female genital system	18.0	18.9	13.2
Musculoskeletal	24.7	23.2	23.0
Neurological	5.6	4.3	5.3
Pregnancy, family planning	13.5[b]	6.7	5.9
Psychological	5.6	11.6	11.8
Respiratory	13.5	11.0	9.2
Skin	13.5	17.7	10.5
Social	6.7	4.9	6.6
Urology	2.2	0.6	2.0
N	89	164	152

[a] $P < 0.05$ Aletta GPs' patients versus patients of female GPs
[b] $P < 0.05$ Aletta GPs' patients versus patients of male GPs
[c] $P < 0.05$ patients of female GPs versus patients of male GPs

General practitioners' behaviour
Aletta doctors talk more than either other women or men doctors during the visit. During consultations in the Aletta practice, 72% of the time is spent talking, in women and men doctors' consultations less (67% and 60% respectively). With regard to the total speaking time, Aletta doctors use 54% of the time, which is about the same percentage as men doctors (53%), whereas other women doctors talk less than their patients (46%).
Aletta doctors look at their patients much more (patient-directed gaze) than the other doctors, who do not differ from each other in this respect.

The general practitioners providing regular care show about the same behaviour in consultations, but the Aletta doctors differ from them in some respects (Table 7.4). There are no differences in patient orientation, meaning that the general practitioners involve their patients to the same extent in both

the diagnostic process and the therapeutic decisions made in consultations. With respect to the affect ratings, the Aletta general practitioners appear to be irritated or angry less often than their colleagues providing regular health care. However, all the doctors are only rarely angry or nervous. The Aletta doctors show more warmth during visits than men doctors. The affective behaviour of Aletta doctors, measured by means of the RIAS observation scheme, differs from men doctors' behaviour in showing more verbal attentiveness. Regarding the other dimensions (showing concern, social behaviour, disagreement) no differences were found. With respect to instrumental behaviour it appears that the doctors in the Aletta practice give more medical information to their patients than doctors in regular care, and more often counsel them about medical issues. The Aletta doctors less often ask their patients questions about psychosocial matters (that are not directly related to the problem) than do other women doctors. Asking clarification and giving directions does not discriminate between the three groups of general practitioners.

Indices of general practitioners' behaviour

Ratios of instrumental versus affective behaviour do not differ between the general practitioners. Indices of medical and psychosocial behaviour (concerning instrumental behaviour) show that, relative to medical issues, women doctors providing regular care more often talk about psychosocial issues than their male colleagues (Table 7.4).

Women patients' behaviour

The Aletta patients have more speaking time than patients of men doctors, but less than women doctors' patients, who talk the most. The affective ratings show women patients are less irritated and nervous when they visit a woman doctor than a man doctor (Table 7.5). Aletta patients are more assertive as compared with other women patients. At the same time, the patients of women doctors are more friendly than men doctors' patients. The Aletta patients are more verbally attentive than other women patients, whereas patients of other women doctors show more social behaviour than patients of either their male colleagues or the Aletta doctors.
Patients' instrumental behaviour is especially different with respect to information-giving. Patients of women doctors inform their doctor more about psychosocial issues by comparison with other patients, and also more about medical matters than men doctors' patients. Aletta patients ask their doctor for clarification less often than other women patients.

Table 7.4 Mean scores* of GPs' behaviour in consultations, by type of GP, and controlled for patients' age, type and number of problems presented and type of consultation

	consultations Aletta GPs (N=89)	consultations women GPs (N=164)	consultations men GPs (N=152)
Patient orientation:			
diagnostic phase	3.21	2.94	3.02
therapeutic phase	3.22	3.00	3.08
Affect ratings:			
anger/irritation	0.98[a,b]	1.10	1.13
anxiousness/nervousness	0.98	1.05	1.11
dominance/assertiveness	4.79	4.59	4.74
interest/concern	4.82	4.65	4.57
warmth/kindness	4.93[b]	4.69	4.58
Affective behaviour:			
total	47.02	43.05	38.07
verbal attentiveness	39.85[b]	32.74	29.08
showing concern	2.84	3.84	3.64
social behaviour	4.34	6.52	5.39
disagreement	0.17	0.35	0.25
Instrumental behaviour:			
total	67.57[b]	60.23	50.71
giving information:			
- medical	32.29[a,b]	24.93	23.23
- psychosocial	1.70	1.24	0.78
asking questions:			
- medical	13.79	15.79	13.30
- psychosocial	1.72[a]	4.16	2.68
counselling:			
- medical	16.37[a,b]	12.08	9.44
- psychosocial	1.40	1.90	1.23
asking clarification	6.17	6.64	6.35
giving directions	18.86	15.71	20.53
ratio instr/aff	1.68	1.50	1.52
ratio med/psysoc	21.43	15.20[c]	20.89

[a] P ≤ 0.05 Aletta GPs versus women GPs
[b] P ≤ 0.05 Aletta GPs versus men GPs
[c] P ≤ 0.05 women GPs versus men GPs

* Means are calculated in Hierarchical Linear Models. Number of Aletta GPs is 4, number of women GPs is 8 and number of men GPs is 8

Table 7.5 Mean scores* of patients' behaviour in consultations, by type of GP, and controlled for patients' age, type and number of problems presented and type of consultation

	consultations Aletta GPs (N=89)	consultations women GPs (N=164)	consultations men GPs (N=152)
Affect ratings:			
anger/irritation	1.07[b]	1.06[c]	1.22
anxiousness/nervousness	1.17[b]	1.34[c]	1.77
dominance/assertiveness	4.65[a,b]	4.31	4.38
interest/concern	4.83	4.77	4.81
warmth/kindness	4.55	4.60[c]	4.42
Affective behaviour:			
total	46.45	40.98	37.51
verbal attentiveness	34.49[a,b]	24.56	22.70
showing concern	6.37	8.06	8.17
social behaviour	5.75[a]	8.64[c]	6.79
disagreement	0.20	0.42	0.42
Instrumental behaviour:			
total	71.77	85.76[c]	62.97
giving information:			
- medical	47.84	50.18[c]	42.86
- psychosocial	18.43[a]	30.46[c]	15.35
asking questions:			
- medical	4.13	3.89	3.57
- psychosocial	0.10	0.01	0.03
asking clarification	2.36[b]	3.08	3.67
giving directions	2.45	1.98	2.68
ratio instr/aff	1.57[a]	2.06[c]	1.67
ratio med/psysoc	7.29[b]	7.08[c]	10.81

[a] $P \leq 0.05$ Aletta GPs versus women GPs
[b] $P \leq 0.05$ Aletta GPs versus men GPs
[c] $P \leq 0.05$ women GPs versus men GPs

* Means are calculated in Hierarchical Linear Models. Number of Aletta GPs is 4, number of women GPs is 8 and number of men GPs is 8

Indices of women patients' behaviour
Relative to instrumental behaviour, patients of Aletta doctors and of men doctors show more affective behaviour than patients of other women doctors (Table 7.5). Within instrumental behaviour, patients of women doctors (both groups) pay more attention to psychosocial than to medical aspects as compared with men doctors' patients.

7.5 Discussion

In the present study we made comparisons, based on hypotheses, between doctors' and women patients' communication style during medical encounters in the general practice. Women general practitioners providing women's health care are compared with women and men general practitioners providing regular health care. Some restrictions have to be made before the results are discussed. Firstly, while the number of consultations (n=405) is sufficient, the number of general practitioners studied is fairly small. To some extent this problem has been taken into account by using multi-level analyses. However, this technique does not help fully to diminish the problem of generalization, especially with regards to the Aletta doctors. Unfortunately, this problem can not be solved by including more of such women's health practices, because there is just one such practice, as was stated before (see Introduction). But, we did everything possible to be able to compare the Aletta doctors with the other doctors, such as selecting general practitioners of group practices, and using multi-level analysis. Furthermore, the advantage of having only one women's health practice is that the study of the Aletta practice is a population study instead of a random sample. Notwithstanding the limitations, the study of the women's health care practice Aletta is an extraordinary and important opportunity to gather and to expand the knowledge about such a innovative and forerunner practice as Aletta, both from a social and a scientific point of view. The results are usable to indicate differences between Aletta doctors providing women's health care and (women and men) doctors providing regular health care.

The current study confirms the results of other studies that verbal communication is shortest in medical consultations with opposite gender dyads, i.c. male doctors with female patients. It is in agreement with earlier studies in which was found that patients feel more at ease and less embarrassed in communication with women doctors[18]. However, the dyad man doctor and man patient was not included in the current study, neither was woman doctor and man patient.

Aletta doctors and their patients talk with each other the most, which is largely attributable to the doctors. The last finding is contrary to our hypothesis (1), which assumed that Aletta doctors would talk less than other doctors, because they would give their patients the opportunity to tell their 'whole story'. Instead, it emerges that Aletta doctors talk more than other doctors. This is probably related to another finding, namely the greater amount of information given by the Aletta doctors by comparison with other doctors. However, the speaking time of all the doctors is lower than was found in another study, which reported that doctors' contribution to the medical dialogue is 60% (average amount) [37]. It was not only hypothesized that Aletta patients would talk more than their doctors, but also more than other patients. This is found to be true for the comparison with patients of men doctors. But, in contacts of other women doctors patients talk the most. The finding seems to be related to more talk about psychosocial matters and by more social talk. Thus, the patients of female non-Aletta doctors have even more opportunity to tell their problems, especially non-medical ones.

The last part of hypothesis 1 can be accepted: Aletta doctors look at their patients much more than either other women or men doctors. The shorter time that men doctors look at their patients, together with their shorter speaking time, does not seem to be related to the opposite gender dyad. For, relative to the length of conversation, men and women doctors in regular health care look at their patients the same amount. However, relative to the conversation time, Aletta doctors look at their patients the most. So, this seems to be related to the type of health care. This is an important finding, because the proportion of time the doctor looks at the patient shows interest in the patient and her problems, and because it may encourage patients to talk about worries that would otherwise remain concealed[10 39]. Another study concluded that, because patients always start with a medical problem, and are often reluctant to discuss non-medical matters, the psychodiagnostic process takes time and a relaxed, inviting attitude on the part of the doctor, which is characterized by a high amount of patient-directed gaze is helpful[10]. The higher amount of patient-directed gaze of Aletta doctors is all the more important since their patients reported relatively many psychological and social problems. Thus, the positive influence of looking at the patient might be related to the relatively high registration of such problems by the Aletta doctors[3]. More attention should be given to this important aspect of non-verbal communication when doctors are being trained in communication skills.

The second hypothesis has to be rejected. Other doctors involve their women patients as much as Aletta doctors during the diagnostic and therapeutic phase. So, practising the principle of women's health care 'encouraging their

patients' own responsibility and self-determination' is not expressed in the doctors' orientation towards their patients as measured in the current study.

The hypothesis about affective behaviour (hypothesis 3) has been confirmed with respect to verbal attentiveness, but only with respect to the comparison between Aletta patients and men doctors' patients. The three groups of general practitioners seem to be the same in other respects, which is contrary to our expectation. The Aletta doctors show more empathy (verbal as well as by eye-contact), paraphrasing, encouragement, support and sympathy than men doctors. They are also more kind and less irritated than men doctors. Women doctors providing regular care show about the same affective behaviour.
It seems that the Aletta patients are like their doctors in this respect. They too are less irritated or anxious than men doctors' patients. However, patients of other women doctors also differ from men doctors' patients. On the whole, patients of women doctors are more like each other than like men doctors' patients. Women visiting men doctors tend to be more irritated, more nervous and less kind. The findings emphasize the better understanding, the easier and more informal communication between doctors and patients of same gender than between those of opposite gender, a fact often cited in the literature. It makes it easy to understand why - when there is a preference - many women prefer women doctors[40].

Furthermore, it was hypothesized that Aletta doctors and their women patients would show more instrumental behaviour as well as affective behaviour (second part of hypothesis 3). The results do confirm this. Aletta doctors give more attention to both affective and instrumental aspects as compared with other doctors. The reason is that Aletta doctors give more medical information, about illnesses and their possible treatments, and that they counsel their patients more about medical issues. Information-giving has proven to be of great importance for patients[10], and it goes back on the principles of women's health care, like encouraging patients' own responsibility and self-determination. In line with the high amount of information-giving is the copious supply of information materials in the practice as well as in the allied Women's Health Centre. The information is partly derived from protocols that have been developed in the Health Centre with respect to some recurrent female health problems, such as vaginal discharge, problems about menstruation and urine-incontinence of women.
With respect to other women doctors' patients, the women patients' balance between affective and instrumental behaviour is not as hypothesized. Aletta patients show relatively more affective than instrumental behaviour, which seems mainly to be related to their lower amount of information-giving,

especially on psychosocial issues. In this respect, Aletta patients are more like men doctors' patients who, however, also give less information about medical issues.

The ratio of the attention given by doctors and women patients to medical and psychosocial aspects of instrumental behaviour is only partly as was expected (hypothesis 4). The Aletta doctors do give more attention to medical issues in proportion to psychosocial issues than the other doctors, which is contrary to the hypothesis. Female non-Aletta doctors talk more about psychosocial and lifestyle issues that are not directly related to health problems, but are important in the whole context of those problems. An explanation could be that they know one another for a longer time and better, and therefore are in general more intimate, especially with patients having psychosocial problems. by which the Aletta doctors may be more sensitive to patient needs regarding psychosocial attention. An additional explanation may be that the Aletta doctors, being specialists in women's health problems to some extent (see above regarding protocols), give therefore more 'specialist-like' information and counselling, especially on biomedical issues.
Likewise, women doctors' patients inform their doctor relatively more about psychosocial matters than Aletta doctors' and men doctors' patients. This finding is likely a reflection of the reciprocity effect. For, when a doctor asks psychosocial questions, the patient will easier disclose psychosocial information. This finding is reasonable because one may suppose that the doctors have a more powerful effect on setting the stage in regard to conversational style than patients do[11].
Women doctors providing regular care seem to be more sensitive to psychosocial than medical issues as compared with their male colleagues, which supports earlier findings[10].

Contrary to the results of our current study, results from a previous study of ours[25] indicated that women doctors give less information about health problems and treatment than their male colleagues (both providing regular health care). Three explanations can be given for this. Firstly, the methods differed. In the previous study data from a self-registration of general practitioners was used, whereas in the present study data was derived from observation of videotaped consultations. Secondly, the categories of information-giving are somewhat different, and thirdly, in the current study the amount of information-giving was measured, whereas the earlier study only recorded whether information was given or not.

Reviewing the findings, there is apparently a discrepancy between theory and practice. Most of the hypotheses have to be rejected, particularly about

general practitioners' communication style. The rather high similarity of Aletta and other female general practitioners seems to indicate that all of them aim at a good communication with their patients, as expressed either in the principles of women's health care, or in the body of thoughts that is being propagated by the Dutch College of General Practitioners.

Finally, how can the relation between gender and communication style best be characterized? Although the differences are often small, the specific characteristics can lead to a cautious formulation of communication styles.
The communication style of the women Aletta doctors, providing women's health care, may best be described as both caring - creating a good relationship (affective behaviour) - and curing - giving a great deal of information and advice (instrumental behaviour). The principles of women's health care seem partly to be reflected in their (verbal and nonverbal) communication with their women patients. Most of the characteristics of Aletta doctors fit women doctors providing regular health care too. Men doctors are in almost every respect less pronounced than women doctors. The differences between general practitioners are reflected in their patients' communication style.

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8 WOMEN'S HEALTH CARE: PRINCIPLES AND PRACTICE

8.1 Abstract

This study investigated how the principles of women's health care are applied by female general practitioners (GPs) who provide women's health care (Aletta GPs) and by male and female GPs who provide regular health care (regular GPs). An observation analysis system was developed to assess videotaped consultations between doctors and female patients. The five principles of women's health care were operationalized in the "Women's Health Care Analysis System" (WAS). Four scales of this system were used in multilevel analyses to investigate the influence of the type of health care on differences between GPs. The results show that the three groups of GPs differed from each other in some aspects, and that the Aletta GPs were more like the female regular GPs than male regular GPs. Although the differences are small, the distinguishing aspects could be included in general or continuing educational programs. Regular health care might benefit by the appliance of some aspects of women's health care.

8.2 Introduction

Interest in the theory and practice of women's health care has increased over the past decade, both in mental and somatic health care[1]. Women's health care is based on the philosophy of feminist health care. It originated from the second feminist wave at the end of the sixties[2], when women's groups rebelled against the established health care system because they were discontented with the 'women-unfriendly' attitudes of — in particular male — doctors towards women, and because of the 'blind spot' in knowledge about the somatic diseases of women. They challenged the medicalization of women's lives and the appropriateness of medical practice to women's health problems, arguing that the social position of women was not taken into account. They also fought for freedom of reproduction and for legal and safe abortion. The women's health movement developed further in self-help groups and in independent women's health centres that provide care based on the philosophy of feminist health care, with emphasis on self-help and self-determination. These centres often organized group consultations and conversations to provide support for women and to exchange relevant information and knowledge about women's health problems.

In the Netherlands, a Centre for Women's Health Care was established in 1980 in Utrecht. It was called "Aletta", after Aletta Jacobs (1854-1929), who was one of the driving forces of Dutch feminism. She was both the first Dutch female student, physician, and Doctor of Medicine. She fought for a higher quality of women's health care and for the availability of contraceptives. She also sought to improve women's health and working conditions, for instance, by advocating that prostitutes should be examined regularly for sexually transmitted diseases.

The Aletta Centre has developed from a local initiative into a national Centre for Women's Health Care that develops and promotes knowledge of women's health care. The three main areas are information, care-giving, and education, and the interaction between theory and practice is considered one of the most important pillars of the Centre for Women's Health Care. The Centre now has a general practice run by female general practitioners (GPs). These GPs have qualified in the normal way and provide care for all the health problems of their patients and not only for 'female' health problems. However, they place different emphasis on certain aspects of care, in accordance with the principles of women's health care. It should however be emphasized that regular health care and women's health care have the same goal — improvement of the quality of care[3 4].

Women's health care is defined as 'consciously providing care from the perspective that patients' problems may be related to their socialization and their situation in society, and encouraging patients to map out strategies aimed at the realization of self-determination and self-responsibility with regard to both body and lifestyle' [5]. In this definition, women's socialization and their social position are considered as important determinants of psychological and social problems. Gender-specific complaints, power relations, and patterns of care in the lives of women and men are, according to this vision, indications of the interactions between women's individual histories and their social-cultural position[6]. The solution to these problems is aimed at increased autonomy and decreased power inequality, and in this respect it is emancipatory.

The most important and distinctive characteristics of women's health care are the principles relating to the patients' gender identity and gender roles, and their personal and social situation. Other principles, which are also common to regular health care, are to encourage the patient to cope with health problems and to stimulate self-responsibility, to treat the patients respectfully, and to prevent medicalization (e.g., erroneously regarding daily life and body problems as biomedical problems) [7]. These principles are already part of the body of thoughts that is being propagated by the Dutch College of General Practitioners. Besides, specific attention is being payed to information-giving, which is an important means for realizing the principles. However, they are

given specific emphasis in women's health care, which also requires a specific knowledge of and attitude to women's health problems.
As little is known about how these principles of women's health care are put into practice during doctor-patient consultations, the aim of this study was to investigate how these principles are applied in consultations by female GPs who provide women's health care (referred to as Aletta GPs) and male and female GPs who provide regular health care (referred to as male and female regular GPs). The following research questions were formulated, (1) how are the principles of women's health care applied in the doctor-patient consultations of GPs who provide women's health care as compared to regular health care?, and (2) are differences related to the type of GP (Aletta GPs, female and male regular GPs).

8.3 Methods

Study Design
Complete doctor-patient consultations were videotaped, with the exception of the physical examination, during which doctor-patient communication was recorded only. These consultations were videotaped to allow scoring of verbal and nonverbal behaviour, such as looking and listening at the patient and showing interest. Assessment of such videotaped consultations has been proven to be a reliable method for analysing doctor-patient communication[8 9]. Nonverbal behaviour, such as patient-directed gaze, is recognized as an important technique for decoding patients' mental problems and for showing interest in the patients' story[10].
The distinction between female and male GPs was made because we thought that female GPs may apply the principles of women's health more often than male GPs do. Earlier studies have shown that GPs who provide women's health care are more like female regular GPs than male regular GPs, and the same is true for their female patients[11-13].

Although the principles of women's health care are theoretically applicable in every consultation, it should be remembered that they might not necessarily be put into practice in each consultation because, for instance, of the time available for the visit, or whether the patient presents a problem for the first time or not[14]. For this reason, the length of the consultation and the type of visit (first or repeat) were recorded. The type of problem might also affect whether the principles of women's health care are put into practice. As it is impossible to list all the health problems presented, they have been grouped according to the ICPC classification[15], to give a general impression of the types of problems. Furthermore, sometimes quotations from the videotaped

consultations are given as examples of the application of the principles of women's health care.

Sample

The data are derived from the consultations between female patients aged 15 years and older and their GPs. The sample was restricted to female patients because 85% of the practice population of 'Aletta' are women[11]. Three groups of GPs were studied: the four women GPs of the Utrecht Aletta practice, which provides women's health care, eight female GPs who provide regular health care, and eight male GPs who provide regular health care. The 16 GPs providing regular health care were selected from a large-scale, national survey of Dutch general practices[16]. These GPs were selected because they are members of group practices, as are the Aletta GPs, and they were part of the group of GPs used as a reference group for the Aletta GPs in the Aletta study[11 12]. Consultations of seven GPs had already been videotaped for the national study. The consultations of the other GPs were videotaped during the current study. The mean number of consultations per GP was approximately 20, resulting in a total of 405 consultations.

Response

Female patients who visited their GPs were asked for permission to videotape their consultations and, if they agreed, to sign an informed consent declaration. In the Aletta practice 70% of the patients agreed, in the other practices 85%. The reason why patients did not agree were for all practices much the same — most patients thought their problems too personal to be videotaped. The GPs' registers showed that about half of the patients presented with psychological and (psycho)social problems, such as stress, anxiety, and relational problems with family members and relatives. About one third had specific female complaints, such as vaginal discharge, or came for a PAP smear. The remaining patients presented with other health problems (cough, earache, etc.).

Women's Health Care Analysis System

The principles of women's health care were operationalized in a newly developed instrument — the Women's Health Care Analysis System (WAS, see Appendix 8.A). On the basis of information in the literature, each principle (main category) was divided into items (subcategories) which together form a scale that should reflect the content of the principle. Because we could not list every possible item, we added the category 'other, namely...'. We also determined whether the consultation was an 'explicit' women's health care consultation or not, based on whether the five principles were put into practice. This is referred to as the overall measure in the analyses.

The WAS observation scheme was adapted several times by the observers. It was then submitted to the Aletta group and again a few aspects were adapted. Both the main categories and the subcategories were scored on a 5-point scale indicating the extent to individual items were applied: 1=not applied; 2=hardly applied; 3=moderately applied; 4=mostly applied; 5=explicitly applied. When some item was applied in a wrong way, e.g. when a GP clearly did not accept the patient's norms and values, the item was also scored 1.

Reliability of Women's Health Care Analysis System

The distribution of the items was examined in order to remove the skewed items. It appeared that all the items of the scale 'gender identity' had low scores but the scale still was still usable. The items C11, D5, E3 and E4, as well as every item 'other' (see Appendix 8.A), were too skewed and were removed from the scales. Furthermore, the two items, C9 and C10, which together with the item C11 rate the respect shown by the GP during the physical examination, were removed because factor analysis showed these items to deviate from the other items. A factor analysis was carried out to investigate whether the items which, on a theoretical basis, were thought to represent the four principles of women's health care, really did so. The scale items indeed produced four distinguishable factors consistent with the principles 'gender identity', 'situation', 'respect', and 'self-responsibility'.
The reliability of the adapted scales was also examined. Cronbach's alpha was 0.76 for the scale 'gender identity', 0.84 for the scale 'situation', 0.87 for the scale 'respect', and 0.73 for the scale 'self-responsibility'. These scales were (rather) good and could be used in further analyses. However, the scale 'demedicalization' was not satisfactory: Cronbach's alpha was only 0.47. Factor analysis showed that there was not one dimension (or two interpretable factors) which could represent this principle. However, although this scale was not used, the main category 'demedicalization' was used in further analyses to give an indication of whether this principle was applied.

Interobserver reliability

The consultations were scored by three observers who had been trained to use the WAS. The first three consultations filmed were not scored, in order to avoid 'socially desirable behaviour' on the part of the GP. It was not necessary to ignore more consultations because GPs rapidly become accustomed to being videotaped[9]. Each observer scored about the same number of consultations for each of the 20 GPs. The consultations were assigned to and scored by the observers at random. Twenty consultations were scored by each of the three observers in order to calculate the reliability of the observation scores. The interobserver correlations (Pearson's Product

Moment Correlation) were 0.60 for 'respect', 0.72 for 'demedicalization, 0.73 for 'situation' and 'self-responsibility', 0.91 for 'gender identity', and 0.68 for the overall measure. Thus the reliability of the WAS was sufficient.

Data analysis
The recording of 405 consultations of 20 GPs gives rise to two major statistical problems. The first is the clustering of consultations among GPs. The consultations of one GP would be, on the average, more alike than the consultations of different GPs. Therefore, the consultations cannot a priori be considered as completely separate independent observations. In order to examine the possible clustering of consultations, the intraclass correlation coefficients of the scales were calculated[17], which reflect the proportion of total variance of an observation that is associated with a GP (Table 8.1). The consultations of one GP were indeed more similar than the consultations of different GPs[18]. The second problem is that all the dependent variables are on the level of consultations, while the independent variable of main interest is on the level of the participating GPs. So, the lower level outcome measures are believed to be explained by a higher level explanatory variable — the type of GP (Aletta GPs and female and male regular GPs).
In order to solve these problems, multilevel analyses were used to analyze the data[19 20]. Differences were tested for significance by means of the difference of proportions test[21].

Table 8.1 Intraclass correlation coefficients (r) for general practitioner (GP) behaviour concerning women's health care

GP behaviour	Intraclass r
Gender identity/roles	0.04*
Personal/social situation	0.10***
Respect for the patient	0.30***
Self-responsibility	0.19***
Demedicalization	0.22***

* $P < 0.05$
** $P < 0.01$
*** $P < 0.001$

8.4 Results

Health problems
Table 8.2 shows the health problems (classified as ICPC chapters) presented by the female patients. The figures represent the percentages of consultations

in which one or more health problems of a specific ICPC chapter were presented. Because on average the patients presented two problems per consultation, and these problems were often classified in different ICPC chapters, the percentages add up to more than 100%. There were hardly any differences between the Aletta GPs and the female and male regular GPs. Musculoskeletal and female genital problems were presented in most consultations. The Aletta GPs had more consultations for pregnancy and family planning than the other GPs did, and fewer consultations for cardiac and vascular diseases. The male regular GPs had the fewest consultations in which women presented with digestive or metabolic problems.

Table 8.2 Percentage of general practitioner (GP) consultations in which one or more health problems (ICPC chapters) were presented. The Aletta GPs provide women's health care, whereas the female and male GPs provide regular health care

	Aletta GPs	Female GPs	Male GPs
ICPC chapters			
General, unspecified	10.1	15.2	13.2
Blood	3.4	4.3	2.0
Circulatory	3.4[a]	15.2	8.6
Digestive	10.1	5.5[c]	13.8
Ear	7.9	4.3	4.6
Endocrine, metabolic	3.4	7.3	3.9
Eye	3.4	1.2	4.6
Female genital system	18.0	18.9	13.2
Musculoskeletal	24.7	23.2	23.0
Neurological	5.6	4.3	5.3
Pregnancy, family planning	13.5[b]	6.7	5.9
Psychological	5.6	11.6	11.8
Respiratory	13.5	11.0	9.2
Skin	13.5	17.7	10.5
Social	6.7	4.9	6.6
Urology	2.2	0.6	2.0
N	89	164	152

[a] $P < 0.05$ Aletta GPs' patients versus patients of female GPs
[b] $P < 0.05$ Aletta GPs' patients versus patients of male GPs
[c] $P < 0.05$ patients of female GPs versus patients of male GPs

The items constituting the five principles of women's health care were applied differently by the three groups of GPs (Table 8.3).

Table 8.3 Percentage of items of the principles of women's health care which were moderately or more often applied in the general practitioner - patient consultation. The Aletta GPs provide women's health care, whereas the female and male GPs provide regular health care

	Aletta GPs (N=89)	Female GPs (N=164)	Male GPs (N=152)
Gender identity/roles			
Continue about shame/taboo	10.1[b]	11.6[c]	4.6
Pay attention to gender-specific presentation	9.0	7.9	6.6
Consider feelings/experiences	13.5[b]	10.4[c]	4.6
Consider gender nature	12.4[b]	7.9	3.3
Personal/social situation			
Consider psychic status	66.3	69.5	59.2
Consider consequences illness	61.8	65.9[c]	55.3
Ask about living situation	70.8	69.5	61.8
Refer to living situation	61.8[b]	61.6[c]	47.4
Show relation problem-life	58.4[b]	50.9[c]	40.1
Respect for the patient			
Interest/involvement	100.0	96.3	98.0
Listen attentively	100.0	98.2	98.7
Consider complaints seriously	100.0	97.6	98.7
Understand perception complaints	100.0[a,b]	92.7	88.8
Look at the patient	100.0[a,b]	92.1	87.5
Encourage to tell the story	95.5[b]	89.6	82.9
Clear information	97.8[b]	93.3	93.4
Egalitarian attitude	100.0[b]	98.2	94.1
Ask about patient satisfaction	58.4[a,b]	39.6	23.7
Accept patient norms/values	43.8[b]	39.6[c]	20.4
Self-responsibility			
Shared decision-making	77.5[b]	67.1[c]	53.9
Ask for self-treatment	49.4[b]	39.0[c]	25.7
Ask for patient's opinion	57.3[a,b]	43.3	37.5
Give alternatives/information	78.7[a,b]	56.7	55.3
Stimulate to share problems	5.6	6.1	3.9
Demedicalization			
Minimize prescription	38.2	28.7	32.2
Provide information (dis)advantages medicines/referral	53.9[b]	42.7	34.9
Refer to self-help groups	3.4[b]	0.6	0.0
Critical of technical-medical developments	4.5	7.3	3.9
Pay attention to prevention	38.2[b]	40.9[c]	24.3
Discuss repeat consultations	82.0[a,b]	64.6[c]	53.9

[a] $P < 0.05$ Aletta GPs versus female GPs
[b] $P < 0.05$ Aletta GPs versus male GPs
[c] $P < 0.05$ female GPs versus male GPs

Consideration of the patient's gender identity and gender roles

The Aletta GPs and the female regular GPs seemed to apply the different items of this principle. All female GPs considered the patients' gender identity and gender roles more often than the male GPs did. It is important for GPs to recognize and handle the way in which women express health problems. For example, when women visit their GPs for several problems, they usually begin with the least serious problem and only then move on to what really bothers them.

This is shown in this excerpt from a consultation. GP: " But has it something to do with stress? " Woman: "Yes ..... yes ....." GP: "Are you stressed now?" Then the patient talked about problems associated with moving house. After a moment of silence, she suddenly started to cry. The real problems were then mentioned — her sister-in-law was seriously ill, and she also found it hard to cope with the early retirement of her husband. At the end of the consultation she said: "Apart from that, I don't have any worries ....."

The way in which GPs handle problems which women feel embarrassed to talk about is very important. Although GPs should persist in asking about embarrassing problems in order to discover the real problem, they must also consider the woman's feelings and perception of her problems. The next conversation, between a GP and a middle-aged woman who mentioned casually that she did not like to make love, expresses this: GP: "Don't you ..... eh ..... miss it ..... together?" Woman: "Maybe ..... but ..... I don't like it at all ..... no ..... I don't know why". GP: "No, no ..... how are you about that together ?" Woman: "Eh ..... there is no need for me, it is not pleasant ....." The GP then continued to ask the women about her sexual relationship with her husband, and it became clear that neither the woman nor her husband really regretted that they made love less often. The GP accepted this fact and said to the patient: "If you think it's alright, and he thinks it's alright, who am I to say ..... Then I will not interfere".

Consideration of the patient's personal and social situation

Comparisons showed that the two groups of female GPs did not significantly differ in the application of this principle, but they again differed from their male colleagues in some aspects. The female GPs referred more often to the living situation, also in relation to a health problem.

The female GPs more than the male GPs explained that a woman's health problems could be related to her living or working conditions. For example, a GP said to a woman who was often dizzy and had pain in the breast "Previously you had complaints and you didn't understand the reason. Now, you know that when you have problems with your body, they may be caused by tension at home". The female regular GPs also considered the possible consequences of (mental) health problems and of illnesses more often than

the male regular GPs did. For example, as in the case of a woman with two young children and who had relational problems. GP: "When you would decide to separate for a while, you could get home help, so that you can go out and have time for yourself".

Respect for the patient

All GPs appeared to respect their female patients. Most of the items of this scale were applied in every consultation. However, the Aletta GPs looked at their patients and asked them whether they were satisfied with the consultation more often than did their colleagues in regular general practice.

Compared to the male regular GPs, the Aletta GPs gave clearer information and, like the female regular GPs, more often showed acceptance of the patient's norms and values. An example is a GP who questioned, without showing any disapproval, a woman with vaginal discharge and itching. GP: "Could you have got something? Have you had various sexual contacts?"

All GPs had high scores for showing interest in and involvement with their patients' problems. The male regular GPs had slightly lower scores than the Aletta GPs and female regular GPs when it came to showing understanding of the patient's perception of complaints, looking at the patient, and encouraging the patient to tell her story. Understanding of the problem was shown by a GP who was visited by a woman whose husband took early retirement, which had diminished her 'freedom' to run the home in her own manner: Woman: "He interferes with everything....." GP: "So, you don't feel free now, I can imagine"

Respect also includes giving clear information, not medical jargon, and asking the patient whether she understood everything she had been told. When a GP told a 30-year-old woman that cervical smears were only done routinely in women older than 35 years: GP: "So, you do understand the reason for it?" Woman: "... That you are not in a risk group".

Encouragement of the patient's self-responsibility and self-determination

The Aletta GPs gave patients information about illnesses and about various treatment possibilities, and they asked the patient's opinion about medical aspects more often than did the female and male regular GPs. Shared decision-making is shown by the following excerpt of a conversation between a woman who had a prolapse and her GP, who had informed her about possible treatments: GP:"..... and then you can say what you want.... there is no need to say it today..... when you have taken a decision, you come over".

The Aletta GPs and the female regular GPs involved their patients in decision-making more than the male regular GPs did and also asked their patients what they had done to help themselves to get better and what they thought should be done more often than their male colleagues did. Only a few

times was a patient told to share her problem with other people, for instance, a woman whose husband did not understand her psychological problems: GP: "I think that you should discuss this problem with your husband, otherwise these problems will remain".

Demedicalization
Patient medicalization can be avoided by, for example, minimizing the number of prescriptions or medicines. The GPs did not differ from each other in this respect. The Aletta GPs and the female regular GPs appeared to pay more attention to the prevention of sustained and frequent use of health care as well as medicines than the male regular GPs did.
The Aletta GPs informed their patients about the (dis)advantages of medicines and referrals more than the male regular GPs did. The Aletta GPs discussed repeat consultations with their patients more often than did the other GPs, although the female regular GPs talked about repeat consultations with their patients more often than their male colleagues did. The Aletta GPs and the female GPs regular Gps payed more attention to prevention than the male Gps did.

Explicit women's health care consultations
Based on their impression of the whole consultation, the observers determined whether a consultation was an example of a consultation that should be given in women's health care. The Aletta GPs gave more of these consultations (18%) than the male regular GPs did (5.9%), but not significantly more than the female regular GPs did (11.6%).

Multilevel analysis
Multilevel analysis, which was used to account for the control variables 'number of health problems presented' and 'first or repeat consultation', showed that the Aletta GPs applied the principles 'respect' and 'self-responsibility' during consultations more often than the regular GPs did (Table 8.4). They were also found to apply 'demedicalization' more often than the male GPs did. The female regular GPs also applied 'self-responsibility' more often than the male regular GPs did. No differences between the three groups of GPs were found with respect to 'consideration of gender identity and gender roles' and 'consideration of the patients' personal and social situation'.

Table 8.4 Mean scores, calculated in hierarchical linear models with four Aletta general practitioners (GPs), who provide women's health care, eight male GPs who provide regular health care, and eight female GPs who provide regular health care, on the scales of the principles of women's health care, by type of health care, controlled for number of health problems presented, and type of consultation (first or repeat)

	Aletta GPs (N=89)	Female GPs (N=164)	Male GPs (N=152)
Gender identity/roles	1.11	1.12	1.03
Personal/social situation	2.63	2.66	2.39
Respect for patient	4.00[a,b]	3.58	3.29
Self-responsibility	2.88[a,b]	2.54[c]	2.32
Demedicalization	3.03[a,b]	2.61	2.35

[a] $P < 0.05$ Aletta GPs versus female GPs
[b] $P < 0.05$ Aletta GPs versus female GPs
[c] $P < 0.05$ female GPs versus male GPs

8.5 Discussion

The five principles of women's health care were operationalized in several items, to form the "Women's Health Care Analysis System" (WAS). The research questions concerned differences in the application of the five principles in general practice.
Some restrictions have to be made. It should be remembered that, in addition to the type of health care, other factors may influence the application of the principles. Although the principles can be put into practice in any consultation, it is obvious that their application depends - among others - on the type of health problems presented by a patient. However, as explained in the Methods, the type of health problem was not taken into consideration. Further research based on the same kind of health problem, such as a specific female health problem, or research by means of simulation patients, is needed to provide further support for the differences found in our study as well as to validate the observation scheme.
In addition, characteristics such as the patient's level of education and the degree of acquaintance of the GPs with their patients may influence whether the principles of women's health care are applied during doctor-patient consultations. These aspects should be examined in future research.
Lastly, it was the first attempt to operationalize the principles of women's health care. Because the scarce literature about women's health care, and

the possibly implicit handling of the principles, the results must be interpreted cautiously. However, this article gives a first insight how the principles are applied in general practice.

Some aspects of women's health care were applied by all GPs in their consultations with their patients, but there were also some differences between the GPs. The Aletta GPs and the male regular GPs were especially different, whereas the Aletta GPs and the female regular GPs were more similar. The male regular GPs applied the items of women's health care the least, which is perhaps not surprising as female GPs, irrespective of the type of health care they practice, probably find these principles easier to handle and apply than male GPs do.

Most of the time all GPs showed respect for their patients. Though, some aspects, such as asking about the patient's satisfaction with the consultation, looking at the patient, and understanding the perception of complaints, were more often applied by the Aletta GPs. In consultations of female GPs the principle 'accept the patients' norms and values, was more often visible than in male GPs' consultations.

The Aletta GPs and the female regular GPs applied the items of the principle 'consideration of the patients' personal and social situation' more often than the male regular GPs did. Apparently, female GPs, irrespective of the type of health care they practice, refer to life and work situation and relate them to health problems sooner than male GPs do.

The patient's contribution to decisions about treatment was higher for the patients of the female regular GPs than for the patients of the male regular GPs. This was even more so for the patients of the Aletta GPs. This greater provision of information is an important way of giving patients the possibility to share in decision-making, and increasing their responsibility for their on health.

The already mentioned rather low scores on the items of the principle 'consideration of the patient's gender identity and gender roles' showed, nevertheless, that the Aletta GPs and the female regular GPs applied these items more often than the male regular GPs did. Again, one could imagine that, in general, female GPs respond to female patients better than male GPs do.

With regard to 'demedicalization', the Aletta GPs and the female regular GPs adopted a more preventive approach than the male regular GPs did, and the Aletta GPs gave their patients more information about prescriptions or referrals than the regular GPs did. These factors, together with the discussion of follow-up appointments, are important aspects of stimulating patient self-determination.

With regard to the relation between the differences found and the type of GPs (when accounting for the clustering of consultations by means of multilevel analysis), the Aletta GPs were found to apply the principles 'respect for the patient', and 'demedicalization' more often than the other GPs did. All female GPs (Aletta and regular) applied the principle 'stimulating self-responsibility and self-determination' more often than their male colleagues did.
Thus, in consultations of GPs who provide women's health care the principles of this type of health care are more often visible than in other consultations. However, the two principles that are called the most distinguishing principles of women's health care, namely, taking into consideration the patient's gender identity and gender roles, and their personal and social situation, were applied similarly by the GPs of the two health care systems (women's health care and regular health care). In fact, the principle of gender identity and gender roles was hardly applied. It is probably difficult to recognize the items of this principle, because they may be so implicitly interwoven in the practice of GPs (both Aletta and other GPs). It is also possible that this principle is used more often in other fields of health care, such as mental health. Improvement of this scale, e.g. by refining the items, is necessary. Whether the scale for the principle 'consideration of the patient's personal and social situation' should also be amended needs to be investigated.

Partly, the principles of women's health care seem to be applied by general practitioners equally. However, there are also some differences, especially between Aletta doctors and men doctors. Women doctors look more like each other than like men doctors. The principles are more visible in women doctors' daily practising, and even more in the practising of the Aletta general practitioners.
Although the differences are small, regular health care might benefit by applying some of the distinguishing aspects of women's health care.

Appendix 8.A
WOMEN'S HEALTH CARE ANALYSIS SYSTEM

1= not applied; 2=hardly applied; 3=moderately applied; 4=mostly applied; 5=explicitly applied

	1	2	3	4	5
A. Gender identity/roles:					
1. continue about shame/taboo					
2. pay attention to gender-specific presentation					
3. consider feelings/experiences					
4. consider gender nature					
5. other, namely					
B. Personal/social situation					
1. consider psychic status					
2. consider consequences illness					
3. ask for living situation					
4. refer to living situation					
5. show relation problem-life					
6. other, namely					
C. Respect for the patient:					
1. interest/involvement					
2. listen attentively					
3. take seriously notice of a problem					
4. understand perception complaints					
5. look at the patient					
6. encourage to tell the story					
7. clear information					
8. egalitarian attitude					
9. information physical examination					
10. the right attitude during the physical examination					
11. no unnecessary undressing					
12. ask about patient's satisfaction					
13. accept patient norms and values					
14. other, namely					

Appendix 8.A (continued)

	1	2	3	4	5
D. Self-responsibility:					
1. shared decision-making					
2. ask for self-treatment					
3. ask for patient's opinion					
4. give alternatives/information					
5. stimulate to share problems					
6. other, namely					
E. Demedicalization:					
1. minimize prescription					
2. provide information (dis)advantages med/referral					
3. refer to self-help groups					
4. critical of technological-medical developments					
5. pay attention to prevention					
6. discuss repeat consultations					
7. other, namely					

Overall measure: an explicit women's health care consultation no/yes

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9 CONCLUSION

The research questions featured in this thesis *Gender, health and health care in general practice* have been addressed in seven chapters. Each chapter has focused on a part of the whole. Here, general conclusions are drawn and policy implications for health care, education and research considered. But attention must first be paid to such methodological aspects of the study as the validity and reliability of the measuring instruments and the extent to which the results can be generalized.

Methodological aspects

Data from different sources has been used. The data concerning health problems, diagnoses, and treatments was gathered by the self-registration of general practitioners in both the Aletta practice and the other general practices included in *The Dutch National Survey of Morbidity and Interventions in General Practice*[1]. This method of data collection has been validated and has proven to be reliable, at least with respect to the hard data[2 3]. The soft categories measured via the general practitioners' self-registration, such as counselling and information-giving, (Chapters 2 and 3) must be interpreted with caution, because measurement in the observation study (Chapters 7 and 8) appeared to be more reliable.

Besides, a time-period of five years between the data collection of the two studies may have some consequences for the results found. On the side of the patients, in general their behaviour and attitudes towards health and health care may have changed, by which differences in medical consumption and type of health problems presented have changed to some extent. On the side of the general practitioners, new protocols and standards for treatment of health problems have been introduced and in the vocational training new issues have been included by which their treatments may have changed, like their prescription and referral behaviour.

The second source of information was the observation of videotape consultations by means of two different observation schemes. The Roter's Interaction Analysis System (RIAS)[4] measures both instrumental behaviour (corresponding to cure) and affective behaviour (corresponding to care) in medical settings. The instrument has been used quite frequently and has been proven valid for analysing doctor-patient communication, both verbal and nonverbal[5]. The inter-observer reliability showed satisfactory values in line with the affective behaviour measurements resulting from coding each statement, or complete thought, of either the general practitioner or the patient.

A new observational instrument was developed for measuring the application of women's health care principles in everyday practice: *The Women's Health Care Analysis System*. Four of the five scales developed showed good reliability, although some of the scale items had to be eliminated because of their high skewness. Only one scale (demedicalization) was unsatisfactory and was not used. Instead, the overall measure of demedicalization was used to give a rough indication of whether this principle had been applied. The conclusions with respect to demedicalization as measured by this observational instrument must therefore be interpreted carefully.

With regard to the extent to which generalizations from the study results can be made, some limitations have to be taken into account. The first limitation concerns the selection of practices. Only group practices in which both female and male general practitioners work were included in the study, in order to equalize patients' opportunities of choosing between a female and a male general practitioner. A bias might therefore have arisen with respect to male doctors, because about half the Dutch male general practitioners have a solo practice whereas women work almost exclusively in group practices. However, this disadvantage is outweighed by several advantages of selecting group practices. As an explanation of the differences between the groups of general practitioners and the composition of the practice population, the distance to the practice location can be ruled out, as can the particular characteristics of the neighbourhood and the availability of other health services in the neighbourhood. Additionally, comparison with the Aletta practice can be made more correctly, because this is also a group practice.

The second limitation concerns the selection of patients. The first part of this thesis, about differences between female and male general practitioners providing regular health care, was aimed at the whole practice populations. Comparison of women's health care and regular health care was, however, restricted to female patients aged between 20 and 45 years old. This was necessary because by far the greater part of the women in the Aletta practice population were in this age group. Since the comparison was particularly concerned with the two different types of health care and the differences between female and male doctors, the age selection was not a problem. Nevertheless, it would be interesting to know what differences there might be between female and male doctors in their consultations with male patients.

The most significant limitation affecting the extent to which generalizations can be made concerns the number of general practitioners providing women's health care. Since Aletta is the only general practice, either in the Netherlands or elsewhere, where general practitioners apply women's health

care principles in the total care for their patients, the comparison between women's health care and regular health care has necessarily been restricted to Aletta versus 21 regular health care practices, including 23 female and 27 male general practitioners. While aware of the limitations of our study with respect to generalizing the results, everything was done to facilitate comparison of women's health care and regular health care in selecting group practices of regular care, by using multi-level analysis and using the same measurement instruments in both the Aletta and the National Survey.
In addition, the study of the women's health care practice is a real population study, whereas the practices providing regular care were derived from a random sample. Therefore, the results of the Aletta study may give an even more precise picture of 'the Aletta practice' than of 'the Dutch general practice'.

The deviant characteristics of the Aletta female patients, however, cause a rather big problem. For, although some of the characteristics, such as age, educational level, insurance, urbanization and type of health problems presented, were accounted for in the analyses, other, unknown characteristics might influence the results too. Every patient has her individual medical history, experiences with health care, personal ideas and beliefs, and social situation. Therefore, individual problems may ask for an individual solution, at microlevel instead of macrolevel. In view of the results of this study, one might assume that it especially concerns the Aletta patients, having, for instance, many psychosocial problems and a high consumption of mental and alternative health care. They seem to constitute a specific subgroup of 'the ' young, highly educated, urban, single, working and childless women, who are ambitious, assertive, independent and individualistic. Thus, although we have tried to account for some characteristics, the specificity of 'the' Aletta patient of 'the' women's health care practice remains a problem that has not been resolved. In future, another way of data collection may solve this problem, such as using simulation patients or randomized trials, or using a more qualitative approach at microlevel. Unfortunately, it has not been possible in this study.

The general practitioners of Aletta are considered to be the forerunners and the driving force in women's health care, a rather recent type of health care that is aimed at the improvement of health care for women. Though, also other female (and male) general practitioners providing regular health care are structurally involved with it, based on the body of thoughts that is being propagated by the Dutch College of General Practitioners. Their striving, especially by female doctors, for the improvement of the quality of care for

women's health may be expressed in the few differences found between Aletta and other female doctors.

From both a social and a scientific point of view, the comparison between female and male general practitioners and between women's health care and regular health care can be considered to be of major importance, notwithstanding the limitations mentioned. Nevertheless, some caution is needed with respect to the results, which are discussed now.

Differences between female and male general practitioners

The main conclusion of the study of gender differences in general practice is that gender issues are important. Chapter 2 demonstrates that female general practitioners see more female patients than their male colleagues in the same practices. Female patients tend to choose female doctors if and when they have the opportunity to do so. Important reasons for this are that women feel more at ease in a physical examination, they talk more easily to female doctors, and they feel less embarrassed when talking about private problems (Chapter 4).

General practitioners seem to attract not only patients of the same gender, but also specific types of health problems, regardless of the gender of the patient. These types of health problems correspond with masculine and feminine stereotypes, and they are related to the prevailing norms and values in our society. Naturally, specific female problems, such as gynaecology, pregnancy and family planning, are considered to be feminine health problems. But these also include human relationships and metabolic problems. Masculine problems cluster around the male genital and musculoskeletal system and respiratory problems. Other health problems, such as general and unspecified skin and circulatory problems, are presented roughly equally to female and male general practitioners. The important finding is that both female and male patients present feminine problems to a female doctor, and masculine problems to a male doctor.

Women's preference for female doctors for uniquely women's health problems, such as the menopause and menstruation problems, vaginal discharge, breast examination and cervical smears, are even stronger (Chapter 3). Besides, the present study (Chapters 2, 3 and 5), earlier studies have also shown that at least one in four women would prefer a female doctor. Women were more likely to consult a female doctor were she to be more readily available, for example through working longer hours. Younger women were more likely than older women to choose female general practitioners.

However, one half of the female patients who would prefer a female have a male general practitioner, since there is a shortage. Only one fifth of Dutch general practitioners are women. And, although at present women account for more than half the medical students, the percentage actually becoming established as general practitioners after qualification is expected to increase less, to 30% over the next ten years[6]. Conditions of employment largely account for the fact that women do not prefer to have their own practices. Thus, health policy measures should be taken to increase the number of female general practitioners.

The study of gender differences in general practice (Chapter 2) confirms the findings of other studies that female doctors conduct longer consultations and have a stronger tendency to provide continuity of care. Whether these findings are related to women's greater uncertainty about an exact diagnosis (or they more often admit to be uncertain) cannot be determined from the data. It might also be possible that women generally are more precise and eager to know exactly what is wrong.
The service profile of female doctors also differs from male doctors, with female doctors doing more counselling and ordering more diagnostic tests, but prescribing less medication. Differences between part-time and full-time doctors have been found in most questions studied, in addition to gender differences. This is an important finding, because part-time female doctors spend more time on information-giving and counselling, two important types of behaviour in preventive and psychosocial care. The results of the more detailed study in gender differences with respect to women's health problems (Chapter 3) show only small differences between female and male doctors in the treatment of women's health problems. The differences are mainly related to the verbal part of the consultation: counselling and providing information.

The studies described above showed important and interesting differences between female and male general practitioners. At the same time, the results raised questions about the differences between these female and male general practices providing regular health care, and general practitioners providing women's health care. It is expected that not only may more women prefer a female doctor, but also that the number of women who want to visit a doctor providing women's health care may grow, because the principles of women's health care are reflected in the motives of the Aletta women for choosing the Aletta practice (Chapter 4). The motives most frequently mentioned are responsiveness to a patient's opinions, consideration of non-medical solutions, and consideration of the relationship between complaint and situation. These motives reflect the ideas and principles of women's health care.

In order to be able to anticipate this development, the characteristics and health problems of the female practice population of Aletta are described and compared with the female practice populations of female and male general practitioners, who are also compared.

Practice populations: characteristics and health problems

The conclusion that can be drawn from the results of Chapter 4 is that there is a specific group of women for whom Aletta fills a specific need. The Aletta patient is characteristically a young, highly educated, single, employed woman, without children and with relatively many psychological and social problems. The Aletta women are also more androgynous than other women; they are more ambitious, competitive and independent. The ambiguity of their role as 'career women' might partly explain that Aletta women more often suffer from psychosocial problems, and psychosomatic problems such as fatigue, headache and nervousness. The ambiguity would have its origin in the expectations that contemporary society has of highly educated women to make a career. These women might have a role conflict with respect to having children and to keep working. But, is also might apply to non-Aletta women.

Furthermore, on the one hand patients may translate their psychological problems into psychosomatic symptoms, or - in other words - they are somatizing, which might explain that they visit the doctor less often for somatic health problems, but that reported more psychosomatic problems. On the other hand, they may psychologize their somatic problems, resulting in more psychological problems. Whether Aletta patients are intended to do this more or less often than other patients as well as the reasons for it remains an unanswered question in this study.

Another explanation might be that they have more worries in their individual lives and in general, which would agree with the worries the Aletta women mentioned to have, in the health interviews, like worries about their self-image, living and working circumstances, and relationship with partner or parents. It has been mentioned earlier, that probably specific characteristics of the Aletta women, aside from those that was accounted for, play an important role in the explanation of differences between Aletta patients and other patients. An additional explanation might be that the supply of care creates a demand for care. With respect to psychological care in the Aletta practice, if a demand is created, it might well be sustained and may even increase.

The specificity of the Aletta population may also be an explanation with respect to the influence of education on the presentation of psychological, social and purely somatic problems to the general practitioner. Education was

found to be much stronger than the influence of the roles of worker, partner or parent (Chapter 5). A low education is generally related to the presentation of more psychological and social problems. So, one would expect that Aletta patients, being highly educated, would present less instead of more psychological and social problems than the other patients. But, on the contrary, they visited their doctor more often with these problems, although the lowly educated Aletta patients even more than the highly educated patients. Thus, the type of health care, or the type of patients using a specific type of health care, seems to be important in explaining differences in the problems presented.
Patients of female and male doctors do not differ in their presentation of psychological problems and - in contrast with earlier findings (chapter 2) - of social problems. An explanation for the difference may be that in the present study relevant factors such as educational level and roles of worker, partner and parent were accounted for. For, patients of female and male general practitioners do differ with respect to these characteristics.

The Aletta patients contrast with patients using regular care in other respects too. As the health interviews show, Aletta patients use mental health care more often, which is in line with the higher number of mental health problems reported by them (Chapter 4). Not only the referral rate of the Aletta doctors to mental health care is higher, but the Aletta patients also reported to have visited psychiatrists and psychologists more often than other patients, probably on their own initiative. They also more often visit alternative practitioners, possibly additionally to visits to their general practitioner. Thus, the total medical consumption of Aletta patients is much higher than of other patients, which may again be explained by their earlier mentioned specific, unknown characteristics. Another explanation could be that visits to mental and alternative caregivers often have to be paid by the patients themselves, totally or partly. While the Aletta patients more often have a higher income as compared to other patients, it would be easier for them to use mental and alternative care.

How the principles of women's health care were reflected in the various aspects of general practice is discussed in the following paragraphs.

Treatment

Practising women's health care principles may influence general practitioners' medical treatment (Chapter 6). The reflection of the principles in general practitioners' interventions might be particularly visible in the principles of *demedicalization* and *encouraging the patient to cope with health problems and to stimulate self-responsibility*.

On the one hand, the application of the demedicalization principle is only partly reflected in the practising of women's health care doctors. The principle is reflected in the prescription behaviour of the Aletta doctors; they prescribe less medication than average, they show a greater inclination to provide medical advice for OTC-medicines, as well as giving their patients advice about regimens. Furthermore, the Aletta doctors perform physical examinations less often than the doctors of regular care, in general independently of the type of problem.
One could argue that demedicalization is facilitated by this reticence. The extent, however, to which it contributes to the quality of care remains an intriguing question. Since it is generally assumed that making a diagnosis requires an examination, not undertaking an examination may neither be sensible nor wise, because it may lengthen the period of illness or even worsen the illness. Then, demedicalization might change into medicalization. This argument may also be applicable to not prescribing medicines.

On the other hand, practice of the demedicalization principle has not been demonstrated. Ordering more diagnostic tests does not contribute to the prevention of medicalization, because the more requests there are for tests, the more deviant are the results found, as demonstrated in other studies. Possibly, ordering more tests leads to the treatment of problems that should be otherwise resolved, that is to say, to medicalization.
The observation study gives no clear answer about the application of this demedicalization principle, although there was a trend for both Aletta and other female doctors to adopt a more preventive approach and to give more information about prescriptions and referrals (Chapter 8). Both information giving and health education are important in view of prevention as well as demedicalization. The principle of *encouraging the patient to cope with health problems and to stimulate self-responsibility* is not reflected in such interventions as leaving decisions concerning follow-up appointments to patients.

The verbal and nonverbal behaviour was studied through the observation study (Chapters 7 and 8) with the question whether women's health care principles were reflected in the behaviour of the general practitioners. This is probably a more appropriate way of investigating how the principles are applied and how the three groups of doctors differ from one another.

Communication style
Aletta doctors discuss more than their colleagues providing regular care (Chapter 6). In the consultations of the other female doctors, the reverse is true: their patients have more discussion time. The Aletta doctors' greater amount of speaking time stems largely from the greater amount of information

and counselling provided, especially with respect to medical or medical-related issues. Aletta patients are generously supplied with information, which may contribute to the realization of such principles of women's health care as *encouraging patient's responsibility and self-determination*. Moreover, the importance of the relationship between the Aletta general practice and the Aletta Women's Health Centre is visible in the large volume of information giving. The Centre has a specific task in the field of information and counselling for both patients and caregivers.

Another difference in communication style between the types of health care is the somewhat more friendly communication and higher verbal attentiveness of the Aletta doctors. This affective behaviour (through which good therapeutic relationships are built) seems to relate in part to the greater amount of eye contact (patient-directed gaze) of the Aletta doctors during consultation. Eye contact makes the doctor's interest in a patient and her problems evident and stimulates the patient to talk about problems which might otherwise remain undetected[7], like psychosocial problems. Though, it might be the other way around, namely that patient's story about such problems influences the amount of doctor's eye contact to the patient. Probably, however, doctor's and patient's behaviour influence and strengthen one another[7], by which more eye contact may improve the recognition of such problems.
Certainly, this is an important issue in doctor-patient communication, especially in the Aletta practice, because Aletta patients reported more psychological and social problems than other women. Aletta doctors may recognize these problems more frequently because of this higher amount of eye contact. Since other studies have found that psychological problems often go unnoticed, general practitioners' knowledge should be better geared to psychological and social problems.

With respect to doctors' communication style, the general practitioners of Aletta are very like their female and male counterparts providing regular care. The communication style of the Aletta doctors may best be described as both caring and curing, corresponding to affective and instrumental behaviour. These characteristics also fit female doctors of regular health care, though to a somewhat lesser extent. Male doctors' communication style is in general less affective than that of female doctors.

With respect to patients' communication style, the groups of female doctors' patients resemble each other more closely than the male doctors' patients. A frequently described general phenomenon is that consultations between female doctors and female patients are more friendly and less stressful than those between opposite genders, with male doctors and female patients. The

preference many female patients have for female doctors derives from this, and suggests steps aiming at growth in the number of female doctors should be taken.

How women's health care is practised should most readily become clear in the application of its principles in everyday practice. This has been studied by means of translations of the principles into measurable entities. The principles are apparently applied in part by female and male doctors in equal measure, but there are also some differences, especially between Aletta doctors and male doctors. The two groups of female doctors are most alike. They more often relate a patient's life and work situation to the presented health problem, possibly because of their own experiences. Moreover, their patients (especially the Aletta patients) contribute more to decisions about possible treatments. The greater extent to which information is given plays an important role in this aspect as well as in others such as the encouragement of self-responsibility.
The principle of women's health care indicated as one of the two most discriminating —considering the patients' gender identity and gender roles— is not visible in this study. The other of these two principles -considering the patients' personal and social situation- is more visible, but does not discriminate between de three groups of general practitioners. Possibly, these principles are too embedded in general practice to be apparent. Alternatively, the way in which they have been measured has not been sufficient. A more penetrating study of this issue might reveal in more detail how these principles are applied in daily practice. In future, combining such a study with training in women's health care would be interesting. Measurements of the application of the principles should be taken before and after the training, to facilitate its evaluation.

This study has shown that there are some differences between general practitioners providing women's health care and regular health care. There are however many similarities, for which several explanations are available. First, the general practitioners of Aletta have after all had the same vocational training as other general practitioners. But, in their practice, the Aletta doctors emphasize specific aspects derived from women's health care. Second, general practitioners providing regular care, especially female general practitioners, have also been devoted to enhancing the quality of health care for women. It is based on the body of thoughts that is being propagated by the Dutch College of General Practitioners.
Nevertheless, on the base of the results, some recommendations are given with respect to the most distinguishing aspects of women's health care by which other caregivers might benefit. Of course, it does not imply that

women's health care could not benefit by regular health care. For, the results also point at possible improvements of caregiving in women's health care.

Recommendations

Health care policy could anticipate the phenomena discussed above by taking measures in:

(1) general practitioners' education,
(2) conditions of employment, and
(3) the diffusion of the principles of women's health care through regular health care on a wider scale.

This suggestion applies especially to the most important and distinguishing aspects of women's health care; information giving, prescription behaviour, and such communication skills as verbal attentiveness and eye contact. Recommendations concerning these aspects are discussed in more detail below.

Implications for education

The integration of women's health care aspects into regular health care could best be achieved by integrating them into both the vocational training of general practitioners and the basic curriculum of all future doctors, general practitioners and medical specialists. Caregivers should account for somatic, psychological and social dimensions, as well as for gender, behaviour, and cultural, religious, sexual, emotional and cognitive aspects[8]. The ability to use these aspects and to pay attention to individual diversity during consultations requires a certain level of knowledge as well as specific skills and a special attitude. It is already learned by the current education of doctors, but it might be emphasized more.

The Aletta Centre educational programme for doctors and other care givers is based on women's health care principles and follows the three lines of knowledge, skills and attitude that are also used in the vocational training of general practitioners. The Centre functions as an academic institution for the development of knowledge in the field of women's health care.

The staff members of Aletta give lectures at congresses, universities and other institutions and conduct workshops. Above that, they counsel and participate in project groups of expertise advancement, especially in primary health care. This manner of transferring knowledge could be extended to secondary health care.

Continuing to pay attention to the communicative skills of doctors in the detection of patients' problems, both in vocational and in postgraduate education, is also important since improvement in communication skills brings with it an improvement in the quality of care.

Information giving is an important aspect of care giving. For, patients ought to receive good, balanced, critical information about unnecessary medicalization, unnecessary translation of somatic problems into psychological problems, and the effects of various treatments. Appropriate information also contributes to patients' self-determination and self-responsibility, one of the main principles of women's health care. Women's health care pays considerable attention to it. However, in regular health care information giving is also an important aspect of care giving. In order to meet the wishes of all patients, this aspect should be specially emphasized in medical education.

Implications for research
This thesis has shown that gender is a factor influencing health and health care, on the part of both doctors and patients. Chapters 2 and 3 feature all four gender dyads (female-female, female-male, male-female, male-male), while elsewhere the study has been restricted to the two dyads: female patients and both female and male doctors. Nevertheless, investigating the remaining dyads would be very interesting, particularly if in future the principles of women's health care were to become more integrated into regular health care. If all four dyads were included, such a study might usefully serve two goals. First, a comparison over time would be possible, if only with respect to the two dyads of this study. In view of changing attitudes towards women's health care, such a comparison might reveal noteworthy differences. Second, relatively few studies of the differences in communication between male patients and female and male doctors have been conducted. Such a study would meet a need.

The principles that have been indicated as one of the most discriminating principles of women's health care — considering the patients' gender identity and gender roles— is hardly visible in this study. Possibly, this principle is too embedded in general practice to be apparent. Alternatively, the way in which they have been measured may have been insufficient. A more penetrating study of this issue might reveal in more detail how it is applied in daily practice, both in women's health care and regular health care.
Combining such a study with training in women's health care would be interesting. Measurements taken before and after the training would facilitate its evaluation.

The first part of this thesis shows that part-time female doctors have longer consultations, give more information and talk more with their patients. The Aletta doctors were found to give the most information and talk the most with their patients, whereas the female and male doctors in the other practices did not differ from one another. To what extent the part-time working of the Aletta

doctors influences these results could not be investigated, because other doctors (both male and female) participating in the observation study also worked part-time. But, in view of the differences found, attention could well be paid to the factor of part-time work in future studies, particularly because male general practitioners increasingly express the wish to work also less than five days a week in their practices. Whether psychosocial problems are more often diagnosed by part-time doctors because their patients get more time and therefore have a higher opportunity and inclination to present psychosocial problems should be investigated. It is also possible that a patient more often presents a psychosocial problem because a doctor has a higher sensitivity with respect to psychosocial problems. Further research might give more insight.

The last recommendation for further research concerns an international comparison of general practitioners. How the characteristics of various health care systems might affect health care, for example doctor-patient communication, taking into account the gender differences of both doctors and patients, could be important. Research findings should form guidelines to improve the quality of care by policy measures, vocational and postgraduate training, and education.

Implications for health care policy

It has been found that the preference of many female patients for a female doctor derives from the easier and more friendly communication between women. The preference suggests measures should be taken to increase the number of female doctors. Such measures should include the continued stimulation of women to be general practitioners, especially through providing opportunities for working part-time and combining work and children.

Concerning the costs of health care, more detailed investigation of the prescription behaviour of female general practitioners, especially in women's health care, might be useful, because they gave fewer prescriptions and advised more OTC-medicines and regimens. On a overall base they advised less to take medicines. But, to what extent their prescription behaviour might influence the quality of health care, both in positive and negative respect, should be investigated and watched carefully. It also applies to the lower number of physical examinations in the Aletta practice.
The costs of health care may decrease by fewer prescriptions, but, in contrast, they may increase by the ordering of more diagnostic tests, which was found to be done by female doctors. Both findings show the need for further research in this area.

The question of the ways in which the principles of women's health care might be disseminated over regular health care is still a matter of discussion. The preceding question, whether it is advisable, was confirmed with respect to certain aspects mentioned earlier.
One way is to embed the dissemination in education, protocols and standards of general practitioners. Another way is integration proceeding from co-operation, by which the Centre would function an independent institution, keeping a watchdog function with respect to abuses and lacunae in care giving[10], as well as contributing to the integration of the body of concepts, working methods and products into regular health care[11], including secondary health care, where integration has only occurred as yet in gynaecology and obstetrics.
Integration is however a rather slow process, because changing attitudes and behaviour takes time. Transforming traditional ideas about differences between men and women, and the casual thinking in the medical profession about the various relationships between gender, health and health care is difficult. This study has shown that for the greater part regular health care and women's health care look like each other. It seems that not only women's health care, but also regular health care has changed her ideas, behaviour and thinking about these issues to some extent.

At the Congress organized on the occasion of the fifteenth anniversary of the Aletta Centre, it became clear that Aletta is still a movement in motion, meeting the requirements for survival. According to the director of Aletta, the innovative function of Aletta is important. Integration proceeding from co-operation means, by definition, interaction with other people and institutions. New themes have been developed. Three examples are:
- a women's health care project for gynaecology and obstetrics in three hospitals, with the first of these aimed at secondary care;
- the project *50+ women, care in one's own hands*, including information meetings about being a woman, growing older and health;
- the appointment of an Aletta project leader to the Dutch College of General Practitioners. She assesses the contribution of women's health care principles to standards, curriculum contents et cetera.

This appointment forms part of the sub-project *The Integration of Women's Health Care Into Family Medicine* of the *Work Programme in Women's Health Care* [13]. The aim of the project is *the integration of the ideas, knowledge and skills of women's health care into policy, vision and content of family medicine*. In each of the three examples cited, the integration of (aspects of) women's health care would have led to a quality improvement[13].

Last February, the Minister of Welfare, Health and Sports emphasized that women's health care and regular health care depend on each other in the context of quality improvement[14]. But, she concluded, the love affair is not yet two-sided. Although integration into primary health care and gynaecology has started off well, regular health care, especially secondary care, should be more receptive to the know-how and expertise developed by women's health care. The Centre has developed from a local initiative to a national expertise centre for women's health care. In her view, women's health care includes tailor-made care for women, men, the elderly, the chronically ill, and other people. in that view, women's health care meets the demands of general practice: providing health care for all people.

The question to what extent the quality of care provided by women's health care and by regular health care is better or worse, and to what extent this quality is influenced by the distinguishing aspects found in this study, remains unanswered. On the base of the findings it is impossible to give a judgement about the quality of care. Also in this area more research seems necessary. Thus, the discussion about quality is left to the general practitioners themselves, or to the Dutch College of General Practitioners.

It appears that not only women's health care, but also regular health care has done much to enhance health care for women. Nevertheless, the integration of certain aspects of women's health care into regular health care might be desirable in the light of the further improvement of the quality of care for women and men, or, in other words, for everybody.

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SEKSE, GEZONDHEID EN GEZONDHEIDSZORG IN DE HUISARTSPRAKTIJK: een vergelijking tussen vrouwengezondheidszorg en reguliere gezondheidszorg

SAMENVATTING

Voortgekomen vanuit de tweede feministische golf eind jaren zestig vestigde zich in 1980, uit kritiek op de heersende gezondheidszorg, in Utrecht het Centrum voor Vrouwengezondheidszorg 'Aletta'. In het Centrum werd informatie gegeven over de gezondheid en gezondheidszorg, en er werden praatgroepen en zelfhulpgroepen gevormd. Het Centrum ontwikkelde een eigen medische deskundigheid. 'Aletta' is inmiddels uitgegroeid tot een landelijk Centrum voor Vrouwengezondheidszorg. Naast informatie en voorlichting over gezondheid en gezondheidszorg, is 'Aletta' betrokken bij scholing en deskundigheidsbevordering van hulpverleners. Ook is er aan het Centrum een huisartspraktijk verbonden. De praktijk werd opgericht in 1984, er werken momenteel drie huisartsen en twee praktijkassistenten. Uitgangspunt van het handelen is de vrouwengezondheidszorg, waarin het leggen van een relatie tussen de maatschappelijke positie en gezondheidsklachten een belangrijke plaats inneemt.
De vijf principes van de vrouwengezondheidszorg zijn:

* rekening houden met het vrouw-zijn van patiënten, met hun sekse-identiteit en sekse-rollen;
* betrekken van de persoonlijke en maatschappelijke situatie van patiënten bij de hulpverlening;
* stimuleren van zelfredzaamheid en eigen verantwoordelijkheid;
* met respect behandelen;
* vermijden van medicalisering.

Daarnaast wordt er specifieke aandacht gegeven aan informatie en voorlichting, welke aspecten tevens belangrijke instrumenten zijn om verwezenlijking van de principes te bereiken. De twee eerstgenoemde principes zijn de belangrijkste en meest onderscheidende principes. De andere drie principes maken ook deel uit van het algemene gedachtengoed van de Nederlandse huisartsgeneeskunde, zoals dat wordt uitgedragen door het Nederlands Huisartsen Genootschap (NHG) en wordt gedoceerd aan de Vakgroepen Huisartsgeneeskunde van de Universiteiten. Echter, in de vrouwengezondheidszorg wordt nagestreefd een specifieke invulling aan deze drie principes te geven.

De aanleiding tot dit onderzoek is de behoefte aan inzicht in de meerwaarde van de vrouwengezondheidszorg. De algemene vraag die wordt beantwoord is: 'Welke verschillen zijn er in de hulpverlening door vrouwelijke huisartsen die vrouwengezondheidszorg verlenen en vrouwelijke en mannelijke huisartsen die reguliere gezondheidszorg verlenen?'
De resultaten van het onderzoek kunnen bijdragen aan de integratie van de vrouwengezondheidszorg in de reguliere huisartsenzorg en aan de verbetering van de kwaliteit van de gezondheidszorg in haar geheel.

De relaties tussen sekse, gezondheid en gezondheidszorg huisartsen staan in dit proefschrift centraal.
Eerst wordt gekeken naar algemene verschillen tussen vrouwelijke en mannelijke huisartsen in hun contacten met vrouwelijke en mannelijke patiënten. Dit gebeurt op basis van gegevens die afkomstig zijn van de Nationale Studie naar Ziekten en Verrichtingen in de Huisartspraktijk (1987-1988). Daarna wordt de soort gezondheidszorg in het onderzoek betrokken, namelijk vrouwengezondheidszorg, verleend in de huisartspraktijk van het Centrum voor Vrouwengezondheidszorg Aletta, en reguliere gezondheidszorg.
De aan de algemene vraag gerelateerde deelvragen worden beantwoord in zeven hoofdstukken, waarin de theoretische achtergrond, de relevante literatuur en de onderzoeksmethoden worden beschreven en bediscussieerd.

Inleiding

Tijdens de eerste feministische golf in het begin van de twintigste eeuw werd er van vele kanten kritiek geuit op de heersende gezondheidszorg. Vrouwen benadrukten naast algemene, ook specifieke aspecten, zoals de sociale misstanden op het werk, de moeder- en kindzorg en het recht op opleiding en kiesrecht voor vrouwen. Een belangrijke voorvechtster van het feminisme was Aletta Jacobs.
Eind jaren zestig resulteerde de tweede feministische golf in de vrouwengezondheidsbeweging. Vrouwen bekritiseerden de vrouw-onvriendelijke houding van de (voornamelijk mannelijke) artsen, de onnodige medicalisering van vrouwenlevens, en de ongeschiktheid van de medische zorg voor specifieke vrouwenproblemen, waarbij ze aanvoerden dat geen rekening werd gehouden met de maatschappelijke positie van de vrouw. Zij vochten voor vrijheid van reproduktie en voor wettelijk geregelde en veilige abortus. De vrouwengezondheidszorg die hieruit voortkwam ontwikkelde zich in de Westerse landen verschillend. De betrokkenheid van de betreffende ministeries verschilt nogal per land, evenals het ontstaan van vrouwengezondheidscentra, hun taken en de samen-

werking met reguliere zorginstellingen. In de meeste landen is de zorg beperkt tot specifieke vrouwenproblemen. De basis van de hulpverlening wordt gevormd door de ideeën over vrouwengezondheidszorg, zoals een sekse-specifieke benadering en het rekening houden met de persoonlijke en maatschappelijke omstandigheden van de patiënt. Het geven van informatie wordt algemeen van groot belang geacht.
Drie centra,in Duitsland, Engeland en Nederland, zijn uitgebreider onderzocht. Deze vrouwengezondheidscentra werken vanuit een feministische visie op gezondheidszorg. Het zijn alle drie nationale centra voor de opleiding en ontwikkeling van de vrouwengezondheidszorg. Verschillen blijken er met name te zijn wat betreft de vrouwen (etnische minderheden of jonge werkende vrouwen) die van deze centra gebruikmaken, de samenwerking met en integratie in de reguliere zorg, en de soort zorgverlening en de betrokkenheid hierbij van vrijwilligers.
De vrouwengezondheidszorg is in Nederland verder ontwikkeld dan in de andere Westerse landen. De aan het Centrum voor Vrouwengezondheidszorg 'Aletta' verbonden huisartspraktijk is - in Nederland en andere Westerse landen - de enige praktijk waar vrouwengezondheidszorg wordt toegepast in de gehele zorgverlening aan patiënten.

Het overheidsbeleid ten aanzien van vrouwengezondheidszorg in Nederland startte in 1983 met de instelling van de 'Projectgroep Vrouwenhulpverlening', die de minister adviseerde over de integratie van de vrouwengezondheidszorg in de reguliere zorg. De instelling van een nieuwe Adviesgroep (in 1988) leidde tot het 'Advies Functies van de Vrouwenhulpverlening'. Om de integratie te stimuleren werd in 1992 het 'Werkprogramma Vrouwenhulpverlening' opgesteld, met zes speerpunten voor beleid, met als belangrijkste opdracht de verschillende partijen te betrekken bij de werkelijke uitvoering van het beleid. Het Ministerie van Volksgezondheid, Welzijn en Sport stelde in 1966 een nationale Centrale Commissie in die verantwoordelijk is voor de verdere uitvoering van het Werkprogramma.
Het overheidsbeleid ten aanzien van de vrouwengezondheidszorg en de integratie van de principes in de reguliere gezondheidszorg kan als positief worden omschreven. Het leidde onder andere tot de subsidie van het (toenmalige) Ministerie van Volksgezondheid, Welzijn en Cultuur tot het verstrekken van een subsidie voor dit onderzoek. De resultaten worden hieronder beschreven, te beginnen met verschillen tussen vrouwelijke en mannelijke huisartsen in de reguliere zorg. Deze gegevens hebben als uitgangspunt gediend voor het verdere onderzoek.

Verschillen tussen vrouwelijke en mannelijke huisartsen

Patiënten, problemen en behandeling
Hoofdstuk 2 behandelt sekseverschillen in patiëntcontacten, gepresenteerde problemen en behandeling van vrouwelijke en mannelijke huisartsen.
In het algemeen komen meer vrouwen dan mannen bij de huisarts. Van alle spreekuurbezoekers is 62% vrouw. Bij de mannelijke huisartsen ligt dit percentage op 55%, bij de vrouwelijke huisartsen op 71%. Deze oververtegenwoordiging van vrouwelijke patiënten bij vrouwelijke huisartsen is sterker in duo/groepspraktijken waar de vrouw full-time werkt dan in praktijken waar de vrouw part-time werkt. Naarmate dus de mogelijkheid om voor een vrouwelijke huisarts te kiezen groter is, doen vrouwen dit vaker.
Patiënten van vrouwelijke huisartsen zijn over het algemeen jonger dan die van hun mannelijke collega's. Dit geldt voor zowel vrouwelijke als mannelijke patiënten.

Patiënten van vrouwelijke huisartsen presenteren ook andere problemen aan hun huisarts. De sekse van de huisarts is belangrijk in de huisartspraktijk: huisartsen trekken niet alleen meer patiënten van gelijke sekse aan, maar ze zien ook specifieke gezondheidsproblemen, ongeacht de sekse van de patiënt. De soorten gezondheidsproblemen komen overeen met de bestaande stereotypen: 'feminine' gezondheidsproblemen (zoals gynaecologische klachten, zwangerschap/gezinsplanning problemen, en stofwisselingsstoornissen) worden vaker gezien door vrouwelijke huisartsen, terwijl 'masculine' gezondheidsproblemen (zoals problemen aan het bewegingsapparaat en mannelijke genitaliën) vaker worden gepresenteerd aan mannelijke huisartsen, zelfs als er rekening wordt gehouden met de ongelijke verdeling van patiënten.

Vergelijking van de behandeling door mannelijke en vrouwelijke huisartsen laat zien dat vrouwelijke artsen meer adviseren en informatie geven, en meer diagnostische testen (laten) doen, maar minder medicijnen voorschrijven.
Vrouwelijke huisartsen besteden gemiddeld genomen meer tijd aan hun patiënten dan mannelijke huisartsen. Verder zien we bij vrouwelijke huisartsen meer herhaalconsulten, meer vervolgafspraken en in samenhang hiermee minder contacten op het initiatief van de patiënt. Het lijkt erop dat vrouwelijke huisartsen meer aandacht besteden aan continuïteit van zorg. Het kan echter ook worden uitgelegd als het gevolg van een grotere onzekerheid van vrouwelijke dan mannelijke huisartsen over de gestelde diagnose (of hun grotere bereidheid om onzekerheid toe te geven), of de grotere behoefte van vrouwen aan een uitgebreid onderzoek.

Part-time werkende vrouwelijke huisartsen besteden meer tijd aan hun patiënten dan full-timers, met name aan adviseren en informatie geven, welke beide aspecten van belang zijn in de preventieve en psychosociale zorgverlening. Mogelijk als gevolg hiervan, beoordelen part-time vrouwelijke huisartsen de gezondheidsproblemen van hun patiënten vaker in een psychosociale context. Er is dus sprake van zowel een verschil tussen vrouwen en mannen als tussen part-time en full-time werkende huisartsen.
In hoeverre deze verschillen spelen bij specifieke vrouwenproblemen komt vervolgens aan de orde.

Specifieke vrouwenproblemen
Verschillen tussen vrouwelijke en mannelijke huisartsen wat betreft specifieke vrouwenproblemen worden weergegeven in hoofdstuk 3. Onderzocht zijn menstruatie- en menopauzeklachten, vaginale afscheiding, screening op baarmoederhalskanker en op borstkanker (beide op initiatief van de patiënt). Vrouwelijke huisartsen zien aanzienlijk meer patiënten met deze problemen dan hun mannelijke collega's. Naarmate de vrouwelijke huisarts meer dagdelen per week werkt, wenden vrouwen zich vaker tot haar, en jongere patiënten kiezen eerder voor een vrouw dan oudere patiënten.
De verschillen in de behandeling tussen vrouwelijke en mannelijke artsen zijn klein en betreffen voornamelijk het verbale gedeelte van het consult, zoals advisering en informatie geven. De beschikbaarheid, ervaring en mate van zekerheid over een diagnose verklaren deze verschillen voor een deel.
De langere consultduur van vrouwelijke huisartsen in vergelijking met mannelijke huisartsen komt voor het grootste deel voort uit het grotere aantal problemen dat patiënten aan vrouwelijke huisartsen presenteren, ofwel uit zichzelf ofwel daartoe aangemoedigd door de arts. Part-time werkende, minder ervaren, huisartsen die hun patiënten minder goed kennen hebben langere consulten.
Vrouwen die de huisarts raadplegen voor specifieke vrouwenproblemen geven dus de voorkeur aan een vrouwelijke huisarts. Het blijkt echter dat er, als ze in de spreekkamer zijn, met name verschillen zijn in de arts-patiënt communicatie, en veel minder in de behandeling.

Verschillen in praktijkpopulaties

Hoofdstuk 4 beschrijft de kenmerken van de praktijkpopulaties van de praktijk Aletta, en vrouwelijke en mannelijke huisartsen die reguliere gezondheidszorg verlenen. De motieven van patiënten om voor 'Aletta' te kiezen worden eveneens besproken.

De praktijkpopulatie (het aantal ingeschreven patiënten) van de huisartspraktijk 'Aletta' bestaat voor 84% uit vrouwen, bij de andere vrouwelijke huisartsen is dat 63% , en bij de mannelijke huisartsen (uit dezelfde groepspraktijken) 51%. Omdat de praktijkpopulatie van Aletta dus voor het overgrote deel uit vrouwen bestaat, is het vergelijkende onderzoek beperkt tot vrouwelijke patiënten.
Generaliserend, zou 'de Aletta patiënt' kunnen worden gekarakteriseerd als een jonge, hoog opgeleide, alleenstaande, werkende vrouw, zonder kinderen, met relatief veel psychische en sociale problemen. Daarnaast zijn er in de Aletta praktijk meer vrouwelijke patiënten dan in andere praktijken, die van zichzelf vinden dat ze vrouwelijke eigenschappen, bijvoorbeeld zorgzaam, begrijpend en lief, combineren met eigenschappen die in onze cultuur meer aan mannen worden toegeschreven, zoals onafhankelijk, ambitieus en assertief.
Van de vrouwelijke patiënten behoort 86% tot de leeftijdsgroep van 20-45 jaar. Ruim de helft van deze groep woont alleen, één op de zeven van hen heeft kinderen. Verder heeft twee derde van hen een betaalde, meestal full-time, baan en twee derde heeft een HBO-studie of een universitaire opleiding voltooid.
Uit de patiëntenquête komt naar voren dat de vrouwelijke patiënten van Aletta, in vergelijking met 'de Nederlandse vrouw', minder geneigd zijn hulp bij de huisarts te zoeken, onder andere voor alledaagse aandoeningen. De meesten zeggen dat hun gezondheidstoestand goed tot zeer goed is, evenals de vrouwelijke patiënten van de niet-Aletta huisartsen. Aletta patiënten hebben wel vaker dan andere vrouwen last van psychosomatische problemen, zoals moeheid, hoofdpijn en nervositeit. Dit leidt niet tot meer bezoeken aan de huisarts: ze bezochten, volgens eigen zeggen, ongeveer even vaak de huisarts als patiënten van de 'reguliere' huisartsenzorg. Ze rapporteren in het interview vaker sociale problemen en stress, en een slechtere geestelijke gezondheid. Dit resulteert in een hogere consumptie van de geestelijke gezondheidszorg door Aletta patiënten. Daarnaast maken ze ook vaker gebruik van alternatieve geneeswijzen, zoals homeopathie en haptonomie.
De vrouwelijke patiënten van de vrouwelijke en mannelijke huisartsen die reguliere zorg verlenen verschillen nauwelijks in de kenmerken die hierboven zijn beschreven.

De belangrijkste redenen om voor de praktijk 'Aletta' te kiezen zijn: voorkeur voor een vrouwelijke huisarts; oog hebben voor de eigen mening van de patiënt; het zoeken van niet-medische oplossingen; relatie leggen tussen gezondheidsprobleem en leefsituatie. De principes van de vrouwengezondheidszorg worden in deze motieven gereflecteerd.
Aan de voorkeur voor een vrouwelijke arts ligt met name ten grondslag dat vrouwelijke patiënten zich dan meer op hun gemak voelen bij een lichamelijk

onderzoek, minder schaamtegevoelens hebben, makkelijker praten, en dat ze het gevoel hebben beter begrepen te worden.

Verschillen in aan de huisarts gepresenteerde problemen

In hoofdstuk 5 wordt het verschil nagegaan in het soort gezondheidsproblemen dat wordt gepresenteerd aan de drie groepen huisartsen. De invloed van zowel de verschillende rollen die vrouwen (20-45 jaar) kunnen vervullen (werkende, partner, moeder) als de soort gezondheidszorg op het presenteren van psychologische, sociale en puur somatische problemen wordt onderzocht.
Aletta patiënten presenteerden meer psychische en sociale problemen, maar minder puur somatische klachten dan patiënten van andere vrouwelijke en van mannelijke huisartsen. De laag opgeleide Aletta patiënten komen met de genoemde problemen vaker bij hun huisarts dan de hoog opgeleiden.
Er zijn weinig verschillen in gepresenteerde problemen tussen patiënten van vrouwelijke en mannelijke huisartsen die reguliere zorg verlenen.

Het zoeken naar verklaringen voor deze verschillen laat zien dat bij vrouwen in het algemeen (dus zowel Aletta patiënten als andere patiënten) de mate waarin iemand werkt het presenteren van de genoemde problemen niet beïnvloedt. Voor vrouwen met een partner en vrouwen met thuiswonende kinderen is de kans op het bezoeken van de huisarts voor psychische problemen kleiner dan voor hun tegenhangers. Maar vrouwen met partner hebben meer kans op het presenteren van somatische gezondheidsproblemen. De leefsituatie (partner en/of thuiswonende kinderen) heeft geen invloed op het huisartsbezoek voor sociale problemen. De kans dat er psychische en sociale problemen aan de huisarts worden gepresenteerd is hoger voor laag opgeleide vrouwen dan voor hoog opgeleide vrouwen.
Ongeacht andere factoren (opleiding, werk, wel of geen partner en/of kinderen) is de kans dat Aletta patiënten psychische problemen presenteren groter dan bij andere patiënten. Hetzelfde geldt voor sociale problemen, maar de kans dat puur somatische problemen worden gepresenteerd minder groot is. Hieruit blijkt dat er binnen de Aletta praktijk een bijzondere probleemgroep is, namelijk een (kleine) groep patiënten die niet alleen een lage opleiding heeft maar ook, in vergelijking met andere laag opgeleide vrouwen, veel psychische en sociale problemen heeft.
De relatie tussen opleiding en gezondheid is duidelijker; laag opgeleiden gaan vaker naar de dokter in verband met psychosociale problemen dan hoog opgeleiden.

Patiënten van vrouwelijke, niet-Aletta huisartsen verschillen niet van patiënten van mannelijke collega's in de kans op het presenteren van psychische, sociale en somatische problemen. De verschillen in de soorten problemen die aan de huisarts worden gepresenteerd blijken zowel te zijn gerelateerd aan patiëntkenmerken (rollen, opleiding) als aan de soort gezondheidszorg (vrouwengezondheidszorg of reguliere zorg), meer dan aan de sekse van de huisarts.

Verschillen in behandelingen

Hoofdstuk 6 heeft de behandeling van de patiënt tot onderwerp. Aan de hand van diagnosen die zijn gesteld in huisarts-spreekuurcontacten met betrekking tot klachten die voor de eerste keer werden gepresenteerd door vrouwelijke patiënten van 20-45 jaar, is nagegaan op welke wijze Aletta artsen en andere vrouwelijke en mannelijke artsen van elkaar verschillen.
Het blijkt dat de Aletta artsen minder lichamelijke onderzoeken doen, vaker even willen afwachten hoe de klacht verloopt, vaker medische adviezen geven zonder een recept uit te schrijven, en vaker leefregels geven. Ze schrijven minder vaak medicijnen voor in vergelijking tot de andere vrouwelijke en de mannelijke artsen. Voorts verwijzen de Aletta artsen vaker patiënten naar de geestelijke gezondheidszorg en de fysiotherapeut.
Ten slotte duurt ongeveer de helft van hun consulten langer dan 10 minuten, bij andere vrouwelijke huisartsen geldt dit voor een derde van de consulten, bij mannelijke huisartsen voor een vijfde. De andere vrouwelijke huisartsen verschillen op hun beurt eveneens van hun mannelijke collega's, zoals eerder is gebleken. Het verschil tussen de Aletta artsen en mannelijke artsen is echter groter.

Vervolgens zijn er verklaringen gezocht voor de geconstateerde verschillen. Indien het opleidingsniveau van de patiënt, het soort klacht en het aantal klachten per consult, en de (on)zekerheid van de huisarts over de diagnose in aanmerking worden genomen, komt er een ander beeld naar voren. Dit geldt met name voor de verschillen tussen de vrouwelijke en mannelijke huisartsen uit de reguliere zorg. Deze vallen dan weg (de verschillen zijn niet meer statistisch significant). De verschillen tussen Aletta artsen en reguliere artsen blijven grotendeels bestaan. Een uitzondering hierop is dat het verschil in lange consulten (> 10 minuten) verdwijnt. Dit is voor het grootste deel toe te schrijven aan het gemiddeld groter aantal klachten van Aletta patiënten per consult.
Het principe 'vermijding van medicalisering' wordt deels weerspiegeld in de behandeling door de Aletta artsen, met name in het voorschrijfgedrag van de

Aletta huisartsen. De andere principes komen niet naar voren in de verrichtingen van de huisartsen.

Verschillen in arts-patiënt communicatie

In hoofdstuk 7 worden de verschillen in communicatiestijl van de drie groepen huisartsen nagegaan. De wijze waarop patiënten worden bejegend (op verbale en non-verbale wijze), is via video-opnamen van spreekuurconsulten van vrouwelijke patiënten van 15 jaar en ouder onderzocht. In totaal zijn 405 consulten geobserveerd van vier Aletta artsen, en acht vrouwelijke en acht mannelijke artsen uit de reguliere zorgverlening. Dit is gebeurd met behulp van een observatieprotocol, waarbij het affectief en instrumenteel gedrag van huisartsen én patiënten is geanalyseerd. Onder affectief gedrag wordt verstaan verbale aandacht, zoals instemming tonen, parafraseren, meeleven; bezorgdheid tonen en geruststellen; sociaal gedrag, bijvoorbeeld persoonlijke opmerkingen, grapjes en complimenten maken; en afkeurende opmerkingen. Instrumenteel gedrag omvat het geven van informatie, stellen van vragen en adviseren over medische en psychosociale onderwerpen; vragen om verduidelijking; geven van aanwijzingen.
Deze twee soorten gedrag corresponderen met de twee belangrijkste doelstellingen van het medisch consult, te weten het creëren van een therapeutische relatie (caring) en het uitwisselen van informatie, teneinde het gezondheidsprobleem op te lossen (curing). Daarnaast zijn nog globale maten gebruikt voor affectief en patiëntgeoriënteerd gedrag.

Tijdens consulten in de Aletta praktijk wordt het meest gepraat, de huisarts heeft hierin het grootste aandeel. In consulten in de reguliere zorg van vrouwelijke en mannelijke huisartsen wordt minder gesproken. De patiënten van de vrouwelijke niet-Aletta artsen praten 't meest in vergelijking tot andere patiënten. Het feit dat de Aletta artsen het meest praten is een gevolg van het geven van meer informatie, voorlichting en advies aan hun patiënten (instrumenteel gedrag), met name op medisch gebied. Dit is een belangrijk aspect van de vrouwenhulpverlening, want het kan bijdragen aan het bevorderen van de eigen verantwoordelijkheid en zelfredzaamheid. In het Vrouwengezondheidscentrum is dan ook een speciaal informatiecentrum gevestigd, waar hulpverleners en patiënten terecht kunnen met vragen.
Tussen de andere vrouwelijke en de mannelijke artsen zijn weinig verschillen gevonden in communicatief gedrag. Wel is een belangrijk verschil dat de vrouwelijke artsen in verhouding meer aandacht geven aan psychosociale dan

medische zaken tijdens de informatie-uitwisseling in vergelijking tot hun mannelijke collega's uit de reguliere zorg.

Wat betreft affectief gedrag blijken de Aletta artsen de meeste verbale aandacht te geven aan hun patiënten, zoals het tonen van instemming, empathie (zowel verbaal als nonverbaal, via oogcontact, meeleven met en zich inleven in de patiënt), en parafraseren.
Uit eerder onderzoek kwam naar voren dat het aankijken van patiënten door de arts een belangrijk middel is om interesse in de patiënt en diens problemen te tonen en om de patiënt aan te moedigen over problemen te praten die anders verborgen zouden blijven. Uit dit onderzoek blijkt dat de Aletta artsen hun patiënten veel meer aankijken dan de andere huisartsen, zowel vrouwen als mannen.
Ook wat betreft andere aspecten van affectief gedrag blijken Aletta artsen hoger te scoren. Hoewel alle huisartsen in het algemeen weinig geïrriteerd zijn en meestal vriendelijk zijn, komen de Aletta artsen nog minder geïrriteerd en nog vaker vriendelijk over dan de andere huisartsen.
Voor het overige komt de communicatiestijl van de drie groepen huisartsen vrijwel overeen. Er is bijvoorbeeld geen verschil in patiënt-georiënteerd gedrag.

De patiënten van Aletta en van andere vrouwelijke huisartsen lijken meer op elkaar in het consult dan op patiënten van mannelijke huisartsen. Ze zijn wat minder vaak geïrriteerd en nerveus dan patiënten van mannelijke artsen, en ze zijn wat vriendelijker. Overigens geldt, net als bij de huisartsen, ook voor de patiënten dat irritatie weinig voorkomt. Maar Aletta patiënten zijn assertiever en tonen, net als hun artsen, meer verbale aandacht dan andere patiënten.
Verder valt op dat patiënten van vrouwelijke niet-Aletta artsen meer vertellen over psychosociale onderwerpen dan andere patiënten, en meer medisch relevante informatie geven in vergelijking met patiënten van hun mannelijke collega's.

Samenvattend kan de communicatiestijl van de Aletta artsen het best wordt omschreven als caring én curing, corresponderend met affectief en instrumenteel gedrag. De principes van de vrouwengezondheidszorg worden voor een deel weerspiegeld in de verbale en nonverbale communicatie met hun patiënten. De meeste kenmerken van de Aletta artsen passen ook bij de andere vrouwelijke huisartsen. Het communicatief gedrag van de mannelijke artsen is in de meeste opzichten wat minder uitgesproken. De verschillen tussen de huisartsen worden weerspiegeld in de communicatiestijl van hun patiënten.

Principes in de praktijk

In hoofdstuk 8 staat de vraag centraal hoe de principes van de vrouwengezondheidszorg worden toegepast in de praktijk. Hiervoor zijn dezelfde video-opnamen gebruikt als voor het onderzoek naar de arts-patiënt communicatie. Deze vraag wordt beantwoord aan de hand van een speciaal daartoe ontworpen observatie-protocol, het 'Women's health care Analysis System'. De vijf principes zijn ieder geoperationaliseerd in een aantal subcategorieën en vormen zo 5 schalen: rekening houden met de sekse-identiteit en sekse-rollen; rekening houden met de persoonlijke en sociale positie; respect tonen; stimuleren van zelfredzaamheid en verantwoordelijkheid; vermijden van medicalisering.
Het bleek dat de eerste vier schalen een goede betrouwbaarheid hebben. De schaal voor 'vermijding van medicalisering' was echter niet bruikbaar, in de verdere analyses is daarom gebruik gemaakt van de globale score voor dit principe.
Eerst worden de subcategorieën afzonderlijk beschreven. De verschillende aspecten van het principe 'rekening houden met de sekse-identiteit en sekse-rollen' wordt door beide groepen vrouwelijke huisartsen weinig, maar ongeveer op gelijke wijze toegepast. In hun consulten wordt vaker dan bij mannelijke huisartsen duidelijk dat ze patiënten stimuleren om te praten over problemen die schaamte oproepen of waarop een taboe rust. Ook houden ze vaker rekening met de gevoelens en eerdere ervaringen van patiënten dan mannelijke huisartsen. Aletta artsen laten vaker zien dat ze rekening houden met de sekse-identiteit van de patiënt.
De aspecten die horen bij het principe 'rekening houden met de persoonlijke en sociale positie' worden eveneens vaker door vrouwelijke artsen toegepast dan door hun mannelijke collega's. Dat betreft met name het betrekken van de leefsituatie bij de klachten die gepresenteerd worden, en het verband laten zien daartussen.
Alle huisartsen blijken in grote mate 'respect te tonen' voor de patiënt. De belangrijkste verschillen die zijn gevonden betreffen de vraag of patiënten tevreden zijn over het consult, en het accepteren van de normen en waarden van de patiënt. Dit wordt vaker gedaan door vrouwelijke artsen (Aletta en niet-Aletta artsen).
'Het stimuleren van verantwoordelijkheid en zelfredzaamheid' wordt vaker duidelijk in consulten van Aletta artsen dan van andere artsen, en dan met name in het vragen naar de mening van de patiënt en het geven van alternatieven en informatie. Verder betrekken beide groepen vrouwelijke huisartsen de patiënt vaker bij een beslissing, en vragen ze meer naar wat de patiënt zelf heeft gedaan aan het probleem.

De vrouwelijke artsen hebben meer aandacht voor preventie en er wordt vaker een vervolgconsult afgesproken, vooral door Aletta artsen. De laatsten wijzen ook vaker op de voor- en nadelen van medicijnen of een verwijzing naar andere hulpverleners.

De toepassing van de principes is vervolgens nagegaan aan de hand van de gevormde schalen, waarbij rekening is gehouden met het aantal gepresenteerde problemen en of het een eerste of herhaalconsult betrof. In de toepassing van de twee eerste principes (rekening houden met sekse-rollen, -identiteit, met de persoonlijke en sociale situatie) verschillen de huisartsen niet, hoewel er wel aanwijzingen lijken te zijn dat vrouwelijke artsen ze vaker toepassen. De drie resterende principes (respect tonen; stimuleren van zelfredzaamheid en verantwoordelijkheid; vermijding van medicalisering) blijken vaker in de praktijk van Aletta artsen dan van andere artsen zichtbaar.
De principes van de vrouwengezondheidszorg komen het duidelijkst naar voren in de dagelijkse praktijk van vrouwelijke artsen, en dan met name van de Aletta artsen.

Conclusies en aanbevelingen

Ten slotte worden de belangrijkste resultaten in het slothoofdstuk (9) besproken, maar niet dan nadat eerst is ingegaan op enige belangrijke methodologische aspecten. Aan bod komen onder andere de gegevensbronnen, de wijze van gegevensverzameling zoals registratie en video-observatie, de selectie van de huisartspraktijken en patiënten, en de generaliseerbaarheid van de resultaten. Vervolgens worden op basis van de resultaten aanbevelingen gedaan op het terrein van de opleiding van (huis)artsen, toekomstig onderzoek en gezondheidszorgbeleid.

Omdat de Aletta praktijk de enige huisartspraktijk is waar vrouwengezondheidszorg wordt toegepast is de vergelijking noodzakelijkerwijze beperkt tot de Aletta praktijk versus (21) reguliere praktijken (23 vrouwelijke en 27 mannelijke huisartsen). Echter, er is zoveel mogelijk gepoogd de vergelijkbaarheid te vergroten, zoals via selectie van groepspraktijken; het gebruik van dezelfde meetinstrumenten in de Aletta Studie als in de Nationale Studie; het gebruik van multi-level analyse. De generaliseerbaarheid wordt met name beperkt door de afwijkende samenstelling van de praktijkpopulatie van Aletta, met hun relatief hoge aantal psychische en sociale problemen. Zij lijken een specifieke subgroep te vormen van de 'jonge, hoog opgeleide, alleen wonende, werkende Nederlandse vrouwen zonder kinderen'. Hoewel in het onderzoek rekening is

gehouden met de afwijkende kenmerken van Aletta patiënten, blijft dit een probleem dat niet opgelost is.
Dit onderzoek is van belang omdat de Aletta artsen worden gezien als de voorlopers en drijvende kracht van de vrouwengezondheidszorg, een vrij recent soort gezondheidszorg die is gericht op de verbetering van de kwaliteit van de gezondheidszorg voor vrouwen. Echter, ook vrouwelijke (en mannelijke) huisartsen die reguliere zorg verlenen zijn hier structureel mee bezig, gebaseerd op het gedachtengoed dat wordt uitgedragen door het Nederlands Huisartsen Genootschap. Hun streven, speciaal van de vrouwelijke artsen, naar het verbeteren van de gezondheidszorg voor vrouwen, lukt te worden uitgedrukt in de weinige verschillen die zijn gevonden tussen de Aletta huisartsen en de andere vrouwelijke huisartsen.
De vergelijking tussen vrouwengezondheidszorg en reguliere zorg is in maatschappelijk en wetenschappelijk opzicht van groot belang, niettegenstaande de genoemde beperkingen.

Een verklaring voor de toch redelijk grote overeenkomst tussen de Aletta artsen die vrouwengezondheidszorg verlenen en de huisartsen die reguliere zorg verlenen kan zijn dat alle huisartsen, óók de Aletta artsen, eenzelfde beroepsopleiding tot huisarts hebben gevolgd. Echter, in hun dagelijkse praktijkuitoefening gebruiken de Aletta artsen de principes van de vrouwengezondheidszorg als leidraad. Een andere verklaring is dat de andere vrouwelijke artsen ook structureel werken aan de verbetering van de kwaliteit van de gezondheidszorg voor vrouwen.

Op basis van de resultaten van het onderzoek wordt gesteld dat het gezondheidszorgbeleid maatregelen moet nemen op het gebied van (1) (huis)artsopleiding; (2) arbeidsvoorwaarden; (3) verspreiding van de principes van de vrouwengezondheidszorg over de reguliere zorg op grotere schaal.
Dit heeft met name betrekking op de belangrijkste en meest onderscheidende aspecten in de vrouwengezondheidszorg zijn: veel informatie geven; minder voorschrijven van medicijnen; en meer communicatieve vaardigheden als verbale aandacht en oogcontact. Aanbevelingen aangaande deze aspecten worden hieronder samengevat.

Opleiding
De wijze waarop de principes van de vrouwengezondheidszorg worden toegepast in de praktijk zouden geïntegreerd kunnen worden in de opleiding tot huisarts en in het basiscurriculum van toekomstige artsen (huisartsen en medisch specialisten).
In het Centrum voor Vrouwengezondheidszorg Aletta wordt op academisch niveau kennis ontwikkeld en toepasbaar gemaakt, vooral in de eerste lijn. Het

overbrengen van deze kennis zou kunnen worden uitgebreid naar andere hulpverleners, ook in de tweede lijn.
Ook nodig is meer aandacht voor goede informatieverstrekking, omdat juiste informatie kan bijdragen aan de eigen verantwoordelijkheid en zelfredzaamheid van de patiënt.
Bovendien is en blijft het nodig om de communicatieve vaardigheden te verbeteren, omdat dit een verhoging van de kwaliteit van zorg met zich brengt.

Onderzoek
Dit onderzoek is grotendeels gericht op contacten van vrouwelijke patiënten met vrouwelijke of mannelijke huisartsen, omdat in de Aletta praktijk voornamelijk vrouwen patiënt zijn. Interessant zou zijn om in een volgend onderzoek ook consulten van mannelijke patiënten met vrouwelijke en mannelijke artsen te bestuderen. Tevens kan dan - voor vrouwelijke patiënten - een vergelijking in de tijd worden gemaakt. In het licht van de veranderende houding ten opzichte van de vrouwengezondheidszorg lijkt dit zeer zinvol.
Voorts zou moeten worden onderzocht in welke mate part-time werken bijdraagt aan verschillen tussen vrouwelijke en mannelijke huisartsen, gezien het feit dat ook steeds meer mannen part-time willen gaan werken.
Tenslotte is het interessant na te gaan via internationaal onderzoek in hoeverre de structurele kenmerken van de gezondheidszorgsystemen de gezondheidszorg, bijvoorbeeld arts-patiënt communicatie, beïnvloeden.

Gezondheidszorgbeleid
Gezien de voorkeur van veel vrouwelijke patiënten voor een vrouwelijke huisarts zouden maatregelen moeten worden genomen om het aantal vrouwelijke huisartsen te vergroten. Want er wordt verwacht dat, ondanks het feit dat steeds meer vrouwen een medische studie volgen, in de toekomst slechts 30% van hen daadwerkelijk als huisarts zal gaan praktizeren. De mogelijkheid tot part-time werken moet worden gegeven om werk en kinderen te kunnen combineren.
In het licht van de kosten van de gezondheidszorg is het voorschrijfgedrag van huisartsen belangrijk. Dit onderzoek laat zien dat vrouwelijke artsen, met name de Aletta artsen, minder medicijnen voorschrijven, maar wel meer diagnostiek (laten) doen. In hoeverre dit een verlaging respectievelijk een verhoging van de kosten voor de gezondheidszorg meebrengt en de kwaliteit van de gezondheidszorg beïnvloedt, zou onderwerp van verdere studie moeten zijn.

De wijze waarop de principes van de vrouwengezondheidszorg zouden moeten verspreid over de reguliere zorg is nog steeds onderwerp van discussie. Inbedding in opleiding, nascholing, protocols en standaarden zou een goede manier zijn. Een andere mogelijkheid zou zijn te streven naar 'integratie vanuit coöpe-

ratie', waarbij het Vrouwengezondheidszorg Aletta zou functioneren als een onafhankelijk instituut, en tevens kan bijdragen aan het verspreiden en implementeren van kennis op het gebied van vrouwengezondheidszorg.
Voor de integratie is van belang dat de reguliere zorg, met name de tweedelijns gezondheidszorg, meer ontvankelijk zou moeten zijn voor de kennis en ervaring van de vrouwengezondheidszorg.
Het blijkt dat niet alleen de vrouwengezondheidszorg, maar ook de reguliere zorg al veel heeft gedaan ter verbetering van de kwaliteit van zorg. Niettemin zou het wenselijk zijn sommige aspecten van de vrouwengezondheidszorg te integreren in de reguliere zorg, om de kwaliteit van de gezondheidszorg te bevorderen voor vrouwen én mannen, kortom voor iedereen.

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CURRICULUM VITAE

Atie Muinen werd geboren op 23 juli 1947, in Utrecht. Tegelijk met haar zagen twee zusjes, Ineke en Lia, het levenslicht! In 1965 behaalde zij het diploma Gymnasium beta. Daarna ging zij naar de Laboratoriumschool, waar zij in 1967 het diploma 'Algemeen Klinisch Analist' behaalde. Als bacteriologisch analist was zij gedurende vijf jaar werkzaam in het Diakonessenhuis te Utrecht. Na haar verhuizing naar Gouda, werkte zij 15 jaar als part-time bacteriologisch analist op het Laboratorium van de Goudse Ziekenhuizen. Intussen was zij in 1982 begonnen met de deeltijdopleiding Sociologie aan de Universiteit Utrecht. Deze studie zette zij, na het behalen van het propaedeutisch examen, voort aan de Universiteit van Amsterdam. Daar behaalde zij in 1989 haar doctoraal examen Sociologie. Sinds 1988 werkt zij, met enige korte onderbrekingen, op het NIVEL (Nederlands instituut voor onderzoek van de gezondheidszorg), eerst als stagiaire, student-assistent en assistent-onderzoeker en sinds 1990 als onderzoeker.
Sinds 1992 houdt zij zich bezig met onderzoek naar verschillen tussen vrouwelijke en mannelijke huisartsen, wat heeft geleid tot het schrijven van dit proefschrift. De communicatie tussen arts en patiënt heeft haar speciale aandacht, wat blijkt uit haar huidige onderzoek naar verschillen in arts-patiënt communicatie in Europese landen.
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