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DO PATIENTS VIEW MALE AND FEMALE DOCTORS DIFFERENTLY?

O.P. Adudu, FWACS, FMCA, DA, MBBS, Senior Lecturer/ Consultant Anaesthesiologist, Department of Anaesthesiology, University of Benin, Benin City, Edo State and O.G. Adudu, FRCS, FWACS, FICS, MBBS, Senior Consultant Surgeon/ Zonal Medical Director, General Hospital, Ogwashi-Uku, Delta State, Nigeria

Request for reprints to: Dr. O.P. Adudu, Department of Anaesthesiology, University of Benin, PMB 1154, Benin City, Edo State, Nigeria

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O.P. ADUDU and O.G. ADUDU

ABSTRACT

Background: This study was a patient survey of attitudes towards the gender of their physicians generally and in medical specialties at the University of Benin Teaching Hospital.

Objective: To determine if patients view male and female doctors differently and the factors that govern these views.

Design: It was a survey of all consenting adult patients with the ability to make independent decisions.

Setting: The University of Benin Teaching Hospital, Benin City, Edo State, Nigeria.

Subjects: A hundred patients admitted in a tertiary hospital after appropriate ethical committee approvals and patients consent were studied.

Main outcome measures: Hypothesis to test if there is gender bias by patients to doctors attending to them was raised.

Results: Fifty three percent of the hundred patients studied cared about the gender of the attending doctor, that is, showed gender bias with 42 % of them preferring male doctors to attend to them and 11% preferring female doctors to attend to them. The respondents who favoured male doctors based their preference on better style of practice and communication of male doctors. Forty seven per cent showed no gender bias, reasoning that they both possessed the same professional knowledge and were equally competent. Preferences for specific medical specialties including anaesthesia and surgery followed same pattern except in obstetrics and gynaecology and paediatrics. The associations raised to the hypothesis are in details in the text.

Conclusion: There is a need to improve awareness about the capabilities of female doctors, including anaesthesiologists, by relevant seminars and females incurring into male dominated specialties such as surgery. Female doctors should also improve on their communication and style of practice.

INTRODUCTION

The increasing presence of females in professions hitherto regarded as the exclusive preserve of males such as medicine and engineering is no longer surprising (1-3). In the United States of America, more than half of the medical students are women (4) and by the year 2000, one physician in five was a woman (1). In Nigeria, a developing country in Africa, there is a decline in the number of patients who assume that every female attending to them is a

nurse and every male nurse is a physician. There are reports in the literature about patients' preferences for gender of doctors in obstetrics and gynaecology (3,5), psychiatry (6), and anaesthesia (7) although gender research is limited. There are no reports on patients' attitudes to the gender of doctors attending to them in specialties studied. This is important as patients' opinions and attitudes can reveal problems which should be addressed.

It is important to understand factors that govern patient views on physician competency

and practice. This paper is a contribution in that direction as it seeks to identify attitudes of patients in six medical specialties including anaesthesia, surgery, internal medicine, paediatrics, obstetrics and gynaecology and ophthalmology. The aim was to determine gender bias if any, the role gender plays in confidence reposed in doctors by their patients and to establish any influencing factors. The study also reveals Nigerian patients' views on preferences for doctors in six medical specialties.

MATERIALS AND METHODS

The quantitative study was limited to the University of Benin Teaching Hospital, Benin - a 455 bed tertiary health institution in Nigeria, subserving 150 health centres and hospitals in the Southern sub-region. The patient population was stratified by wards into paediatric male and female wards. Paediatric patients were excluded from the study due to inability to make independent decisions. Psychiatric patients and patients who were too ill medically to participate were also excluded. This left a total of 292 patients admitted in the hospital in July 2003, the period of study. Thirty four per cent (100 patients) of the patient population was sampled based on good statistical representation due to inability to survey all patients. Fifty four males and forty six females were recruited into the study out of a total of 158 and 134 respectively after approval by the medical ethics committee.

The sample instrument used was close structured questionnaires distributed on a one to one basis by Assistant Chief Nursing Officers in charge of the relevant wards in the hospital. This was to ensure a high level of patient cooperation and compliance and to provide explanations to unavoidable technicalities, including obtaining patient consent after relevant education on need for study. The questionnaires were self-administered except for three patients who were illiterate. The questions asked included patients' demographic characteristics, preference for gender of doctors attending to them generally and in six medical specialties including anaesthesia, surgery, obstetrics and gynaecology, ophthalmology, paediatrics and internal medicine. Questions were also asked on the reasons for their choice and on patients' attitude, the industrious nature of male and female doctors and patients' social class.

We tested the hypothesis that there is gender bias by patients to the attending doctor. Also raised is the hypothesis that the more educated you are (social class), the less likely you are to have gender bias to the attending doctor.

Gender bias is exhibited if the patient has a preference for the gender of the attending doctor either male or female.

Indifference, that is, no gender bias, is exhibited when the patient has no such preference, that is, does not care if the attending doctor is male or female.

Statistical Analysis: Statistical package for social sciences (SPSS) was used for data entry and analysis. Data were subjected to statistical tests of significance (Chi square) with the following results.

RESULTS

A total of 100 patients were studied. More males 55 (55%) were admitted as patients in the surgical and medical wards in U.B.T.H. than females 45 (45%). The mean age of the patients (respondents) was 36.7 ± 14.7 years with the majority in the 21 to 30 year age group (Table 1). Fifty per cent of the respondents were married, 42% were single and 2% separated. Six per cent of them did not specify their marital status.

Forty seven per cent of the respondents were indifferent to the gender of the attending doctor, i.e. have no gender bias. Fifty three percent of patients cared about the gender of the attending doctor (i.e. showed gender bias) with 42% of them preferring male doctors to attend to them and 11% preferring female doctors (four males and seven females) (Table 2).

The reasons given for gender indifference included satisfaction that male and female doctors possessed the same professional knowledge and were equally competent. The reasons given for preference of male doctors to their female counterparts include being more industrious in 40, more confident in 42, more knowledgeable (professional - 35) and experienced including technical competence in 42, freer to talk to in 30 and more sympathetic. They also run after their patients more and are friendlier and more tender (especially by female respondents - 18). Two respondents (2%) reported traditional defilement of the body by the female touch during clinical examinations as reason for their choice of the male doctor. The reasons given for preference of female

doctors include their motherly spirit (5) and by female respondents for less embarrassment on exposure of the body during clinical examination (6).

There is no statistically significant difference between the number of patients who were indifferent

to the gender of doctors and those who exhibited gender bias i.e. $p > 0.05$, $df = 2$ (Table 2). However, male and female patients who showed gender bias, do not view male and female doctors differently (Table 2).

Table 1

Age and sex distribution of respondents

Age (years)	Male		Female		Total	(%)
	No.	(%)	No.	(%)		
18-20	9	9	5	5	14	14
21-30	20	20	10	10	30	30
31-40	8	8	11	11	19	19
41-50	7	7	12	12	19	19
51-60	6	6	4	4	10	10
61-70	4	4	3	3	7	7
71-80	0	0	0	0	0	0
81-90	1	1	0	0	1	1
Total	55	55	45	45	100	100

Mean age was 36.7 ± 14.7 years.

* The class size for the range 18 – 20 years was less than ten as in other classes because paediatric patients were not recruited into the study

Table 2

Sex of respondents as it relates to preference for doctors gender

Sex of respondents	Preference for doctors gender (%)							
	Male		Female		Indifferent		Total	
	No.	(%)	No.	(%)	No.	(%)	No.	(%)
Male	22	22	4	4	29	29	55	55
Female	20	20	7	7	18	18	45	45
Total	42	42	11	11	47	47	100	100

Table 3

Preferred gender for doctors in six medical specialities as it relates to respondent's sex

Sex of respondents	Speciality of doctors																		
	Anaesthesia			Obstetrics & Gynaecology			Ophthalmology			Paediatrics			Internal medicine			Surgery			Total
	M	F	I	M	F	I	M	F	I	M	F	I	M	F	I	M	F	I	
Male	20	8	26	12	24	21	16	7	32	16	16	21	26	4	26	33	1	19	330
Female	16	12	18	13	16	14	13	12	20	14	16	16	20	6	18	30	1	16	270
Total	36	20	44	25	40	35	29	19	52	30	32	38	46	10	44	63	2	35	600

M = Male gender, F = Female gender, I = Indifferent

Table 4

Social class of respondents

Social class	Number of respondents					
	Male		Female		Total	
	No.	(%)	No.	(%)	No.	(%)
I	5	5	3	3	8	8
II	24	24	15	15	39	39
III	11	11	7	7	18	18
IV	15	15	20	20	35	35
Total	55	55	45	45	100	100

Social class I = Professionals

Social class II = Skilled

Social class III = Semi-skilled

Social class IV = Unskilled

For specific medical specialties, more respondents preferred male to female doctors in surgery (63% - almost unanimous agreement by gender biased male patients), internal medicine (46%), anaesthesiology (36%) and ophthalmology (29%). Patients were evenly divided on doctors gender preference in paediatrics (30% preferred male doctors while 32% preferred female doctors). For obstetrics and gynaecology, more respondents (40%) preferred female doctors than male doctors (25%) (Table 3).

The reasons adduced for these specialty preferences were similar to those mentioned under general preferences. In addition, male surgeons were preferred for greater technical competence and the suitability of their greater physical strength. Also female obstetricians and gynaecologists were preferred for gender sensitivity and less social embarrassment during clinical examinations.

There was association between patient gender and specialty preferences of gender of doctors with male and female respondents preferring male doctors generally, especially in surgery (Table 3 r_s range = 0.992 to 0.999).

Social class of patients studied is as indicated in Table 4. There was no association between economic status and preferences for gender of doctors.

The attitude of patients who have doctors other than their choice in terms of gender preference attending to them is that none would outrightly refuse but two (2%) would be uncooperative.

DISCUSSION

Patients admitted in a tertiary health institution in Benin City, Nigeria, showed gender bias with 42% of them favouring male doctors. Style of practice including skills and effective communication were influencing factors for this. It accounted for female patients not being more likely to prefer doctors of their own gender unlike male patients. This view contrasts with reports in the literature (2,8). The hypothesis that the more educated you are, the less likely you are to have a pre-existing bias was invalidated as non-bias was also found among less educated patients (Table 4). Therefore, there was no association between economic status and doctors' gender preference.

However, patient gender and doctors gender were associated. For the male patients, gender concordance, in agreement with other studies (9), played a role while for the females, gender sensitivity of the more sympathetic and tender male doctors played roles as is also reported in literature (10). Socio-cultural factors also influenced choice of the male doctor with greater competence and strength suitability for surgery adduced by patients being a misconception that needs to be clarified. This can be done by more female doctors veering into general surgery. Presently, there are no resident or consultant general surgeon in the study centre. Other social reasons include embarrassment on

body exposure as reason for preference of the female obstetrician and gynaecologist (gender specificity) by both male (for their wives) and female patients in the study. This agrees with findings in the literature (11-13). This preference for female obstetricians and gynaecologists by patients is at variance with their preference for male surgeons based on greater competence and strength. It suggests that patients have limited knowledge about the scope of obstetrics and gynaecological practice to include surgical procedures.

It is surprising that in the gender sensitive paediatrics specialty, the traditional motherly role of female paediatricians was cited as reason for their preference by only a marginally greater third of patients. It confirms that female doctors need to improve their style of practice and communication.

The number of patients with no gender bias for anaesthetists (44%) contrasts with that found in literature (14). It is encouraging however that 20% of patients in the study preferred female anaesthetists when compared with 0.69% of patients reported to prefer female anaesthetists (14). Preference for female doctors in anaesthesiology ranked third following preference for same in obstetrics (1st) and paediatrics (2nd). Female anaesthetists therefore fared better than their colleagues in ophthalmology (4th), internal medicine (5th) and surgery (6th) in this regard. This is in spite of the "hands on" (15) "behind the scene" (16) peculiarities of the specialty of anaesthesia. Special attention must still be paid to improve the public image of the anaesthetist by public education and improved interaction with patients by pre- and post-operative (14) ward rounds and care.

The attitude of patients when attended to by doctors of unpreferred gender was that of subtle behaviour rather than outright refusal as is also reported in the literature (3). It suggests low awareness about patients' rights in the environment.

CONCLUSION

A study of patients preferences on the gender of the attending doctor revealed gender bias in majority of the patients (53%) with male doctors being preferred by 42% of them. Factors that govern these views include patient gender as related to

gender concordance (by male patients) and gender sensitivity of male doctors to female patients. It also includes socio-cultural factors and the better style of practice and communication of male doctors. Specialty specific preferences for doctors gender by patients favoured male surgeons and female obstetricians and gynaecologists. Female anaesthetists ranked third in order of preference to female obstetricians (1st) and paediatricians (2nd).

There is a definite need for female doctors to improve their practice skills and communication style, especially in surgery where only 2% preferred female surgeons. Anaesthesiologists need to be encouraged to continue to improve on their public image as findings in the study which were better than in literature reports suggest. In addition, a public awareness campaign on the capabilities of female doctors with more of them veering into male dominated specialties such as surgery will clarify misconceptions.

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