Sex Preference in Patient Selection of a Family Physician

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A Patient Panels Registry was developed to study patient identification with family physicians in a large health maintenance organization. There was a clear correlation between the sex of the patient and the sex of the physician. Female patients were 1.49 times as likely as males to select a female physician. Male patients were 1.14 times as likely as females to select a male physician. Women physicians were found to have panels consisting of 66.4 percent female patients, while panels of the male physicians were 53.8 percent female. In order to interact most effectively with both male and female patients, family physicians must be able to recognize their own sex biases as well as those of their patients.

Medical schools are graduating greater numbers of female physicians, many of whom are entering family medicine residency programs.[1,2] Societal change, in particular the women's movement, has spurred interest in sex related attitudes within the physician-patient relationship.[3-5] There are many reasons for preferring a physician of a particular sex, such as fear of disrobing before a physician of the opposite sex or a belief that physicians of one sex or the other are more professional and better trained, or more understanding and respectful.[6] Male physicians have been accused of unconscious bias, patronizing behavior, condescending attitudes, and sex role stereotyping of female patients.[7-9] Demonstration of such biases has been limited by the difficulties involved in studying them.[10,11] One survey of clinic patients showed a general patient preference for male physicians, although younger women, black women, and patients who had previously consulted female physicians were more favorable toward women physicians.[12] A survey of female patients of both male and female gynecologists showed that 33.9 percent responded "yes" to the question "Would you prefer a woman gynecologist?" while 36.2 percent responded "no difference."[13] Another recent survey of women showed no patient preference with regard to the sex of a physician for discussion of sexual matters or for breast and pelvic examinations.[14] In the psychotherapeutic relationship, the gender of both patient and therapist is thought to be an important factor.[15]

The Kaiser-Permanente Medical Care Program is the nation's largest health maintenance organization. Health plan membership in San Diego during this study was 235,000. In the San Diego area, the full-time family practice staff includes 38 physicians (nine of whom are female), 14 female nurse practitioners, and 4 male physician's assistants. Family practice modules of seven or eight providers offer primary care services in three locations. Members are encouraged to choose a primary physician for their family and to contact that physician for their health care needs. Most family physicians see children, although parents have the

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Table 1. Overall Composition of Panels by Sex of Patients and Sex of Physician

	Physician				
	Male		Female		
	No.	(%)	No.	(%)	Total
Female Patients	20,202	(71.0)	8,268	(29.0)	28,470
Male Patients	17,369	(80.6)	4,179	(19.4)	21,548

option of taking their children to a pediatrician. Nurse practitioners or physician's assistants share in the care of the patient for well care and for appropriate acute and chronic illness. Approximately 30 percent of all visits to the family practice department are provided by nurse practitioners and physician's assistants. When a patient's physician is not available, the module assumes responsibility for the patient's care. Patients are free to choose any family physician and those who have no physician preference are assigned one at the location of their choice. Such patients are distributed equally unless a physician's appointment backlog warrants otherwise. Some patients volunteer their desire for a physician of a certain sex or age, or one who speaks Spanish; such wishes are usually accommodated. This report provides rather striking empirical evidence of gender correlation in the selection of a primary physician.

Methods

The Patient Panels Registry was designed to provide descriptive data on the patient population served by each family physician and by each module. Since August 1979, every patient visit to the Department of Family Practice during regular office hours has been included. The clinic processing record is the standard "check-in" form used for all office visits in the Kaiser-Permanente system. Only minor modification of patient and provider information entered by the appointment clerks was necessary to permit use of this form as the basic data collection instrument for the Patient Panels Registry. The patient's medical record number, date of birth, sex, and home zip code, as well as the designated primary physician and the provider for the current visit, are the elements included. When a previously registered patient makes another visit anywhere in the department, the panels are updated. Any change in patient or provider data is reflected in the monthly report. Patients are deleted from one panel and added to another simply by claiming a different primary physician on a subsequent visit. Panel summaries are generated monthly and distributed to each module where individual providers can review the reports.

Results

During the first six months of registration, a total of 82,707 visits were made to the Department

Table 2. Composition of Individual Panels by Sex

Male Physicians	Patients Registered	Patients % Male	Patients % Female
APP	1,589	46.3	53.7
BIR	1,909	45.3	54.7
CAU	1,218	47.0	53.0
CON	1,173	47.8	52.2
DRI	1,755	47.0	53.0
ELL	1,697	45.7	54.3
HOG	1,358	47.3	52.7
NAG	1,160	51.6	48.4
NUR	1,441	46.7	53.3
SKI	1,118	46.8	53.2
TOM	1,889	43.5	56.5
KEL	653	47.9	52.1
DEL	1,646	46.9	53.1
THO	1,423	44.0	56.0
MCC	1,445	43.7	56.3
MOR	1,452	43.8	56.2
SAA	1,400	45.9	54.1
WAL	1,609	47.0	53.0
ARO	1,487	45.9	54.1
ROB	952	46.5	53.5
DON	980	45.8	54.2
FEL	1,213	47.0	53.0
GOL	969	49.6	50.4
RAY	1.218	44.3	55.7
SAB	986	47.6	52.4
SHA	788	49.9	50.1
SHE	1,365	43.7	56.3
MOS	923	47.8	52.2
DIA	759	44.0	56.0
Total for Male Physicians	37,571	46.2%	53.8%
Female Physicians	**Patients Registered**	**Patients % Male**	**Patients % Female**
PET	1,097	31.0	69.0
SCH	1,486	28.7	71.3
SID	1,662	35.9	64.1
KRA	1,350	37.8	62.2
KIN	1,516	31.9	68.1
NOC	1,801	33.8	66.2
CUE	1,077	36.7	63.3
LIL	1,353	32.0	68.0
GOE	1,105	34.6	65.2
Total for Female Physicians	12,447	33.6%	66.4%
Total—All Physicans	50,018	43.3%	56.7%

of Family Practice. These visits were made by 50,018 different patients, 56.7 percent of whom were female. Patients 12 years old or less comprised 4.6 percent of the patients, ranging from 0.7 to 13.8 percent of individual physicians' panels. The overall composition of panels of male and female physicians is presented in Table 1. Female patients were 1.49 times as likely as males to select a female physician. Male patients were 1.14 times as likely as females to select a male physician. Female physicians had panels consisting of 66.4 percent females and 33.6 percent males while male physicians' panels were 53.8 percent female and 46.2 percent male. Due to the large sample size, these differences are highly significant. Sex composition of individual panels is presented in Table 2. It is also notable that, even among physicians of the same sex, the differences in male-female composition of panels was significant. The range of female patients in male physicians' panels was 48.4 to 56.5 percent, while the range of female patients in the female physicians' panels was 62.2 to 71.3 percent. Even the male physician with the highest proportion of female patients (56.5 percent) did not approach the female physician with the lowest proportion of female patients (62.2 percent), who incidently was the most recent female physician to join the department.

Comment

A clear correlation exists between sex of the physician and sex of the patient when members are allowed free choice in the selection of a family physician. Highly significant differences are evident in the male-female ratios even for physicians of the same sex, presumably due to individual physician characteristics as perceived by the patient. These differences could be due primarily to the preferences of male patients or to the preferences of female patients, or both. Such preferences seem particularly important in family practice, where all members of a family are encouraged to see the same physician. Family medicine training programs should help residents become aware of their own sex biases, as well as those of their patients, so that the new family physician will be able to interact effectively with both male and female patients.

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