Sex of Physician: Patients' Preferences and Stereotypes

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Patients' preferences for physicians of a particular sex tend to skew sex distributions of clinical populations in training and practice settings. A study was developed to explore these preferences and potential reasons for them. Of 185 adult patients surveyed at four family practice residency clinics, 45% expressed a preference for sex of physician; 43% of women and 12% of men preferred a female physician, while 31% of men and 9% of women preferred a male physician. Patients who stated no overall preference often expressed one in specific clinical situations, eg, anal or genital examinations. Patients who preferred female physicians reported humane behaviors as more characteristic of female physicians, and those who preferred male physicians reported humane behaviors as more characteristic of men; patients who had no overall sex preference did not sex stereotype physicians on these behaviors ($F=59.34$, $P<.01$). Patients who preferred male physicians reported technical competence behaviors as more characteristic of male physicians; others did not sex stereotype physicians on these behaviors ($F=15.4$, $P<.01$). Patients rated humaneness and comprehensiveness as being of high priority, but no relationship was found between priorities for aspects of care and preferences for sex of physician. Areas for future investigation include assessing preferences in other populations and exploring sex differences in physician behavior during office encounters and correlating these differences with patient satisfaction. **J Fam Pract 1990; 30:441-446**

It has been observed in the lay literature that patients express a preference for physicians of their own sex. Studies indicate that the sex distribution of patients' visits is also skewed,[1–3] with women making up 66% to 82% of visits to female physicians and only 54% to 60% of visits to male physicians. Indeed, at the residency program where this study was conducted, female residents see women in 60% to 70% of their patient encounters, while male residents see women 50% of the time. Such maldistribution may compromise the training of both male and female physicians and may also increase the demand for female physicians and reduce opportunities for male physicians.

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Patients' individual choice of physician may explain this difference in makeup of male and female physicians' populations. A number of studies have looked at patient preferences for sex of physician. For example, such preferences have been related to patient sex, age, social class, and income.[4,5] Reports vary with regard to female patients' preference for male physicians, ranging anywhere from 11% to 75%.[6–8] Some studies show that 16% to 34% of female patients prefer a female physician.[6–9] Women under 20 years of age tend to express a preference for female physicians.[5] Data are relatively scarce regarding male patients' preference for sex of physician. Two studies indicate that about 80% of male patients prefer a male physician.[4,6] Preference is directly related to income and class, with patients of higher socioeconomic status expressing a preference for male physicians.[4,5] The majority of these data are at least 10 years old. A more recent study by Ackerman-Ross[10] contradicts some of these early data and reports that both male and female patients in general prefer a physician of their own sex; preference was unrelated to patient age in the family practice setting that was studied.[10]

Preference for sex of physician is strengthened in specific clinical settings including visits that require genitalia examinations,[4,7–9] visits that involve discussion of personal problems,[8,11] and visits for counseling.[11,12] Because of the conflicting, scarce, and dated data regarding preference for sex of physician, the first purpose of this study was to determine male and female patients' preferences, both in general and for specific problems. It was expected that most patients would have no preference for sex of physician, but a higher number of patients would express a preference when the specific problem involved counseling, required a genitalia examination, or was very serious.

Many of the earlier studies on preference for sex of physician suffered from limited access to female physicians; in some settings patients were not free to choose their own physician. Other findings suggest that as little as one encounter with a female physician may markedly increase a female patient's expressed preference for a female physician.[4,9] The second purpose of this study was to determine whether increased experience with female physicians is related to patients' expressed preference.

Documenting that patients express preferences for sex of physician and demonstrating some patient characteristics related to these preferences do not address the question of why preferences exist. Differing expectations of physician behavior based on sex stereotypes and differing patients' priorities regarding physician characteristics are potential reasons for these preferences.

Bem[13] has shown that technical competence and compassion or humaneness are traits that are sex-role stereotyped, with humaneness viewed as a feminine trait and competence as a masculine trait. The third purpose of this study, therefore, was to determine whether patients stereotype physicians by sex, ie, to determine whether female physicians are viewed as more humane than male physicians, and whether male physicians are viewed as more technically competent. It was expected that these views would be widely held, but that those patients with a female physician preference would feel more strongly than other patients that humaneness is an attribute of female physicians. Patients with a male physician preference were expected to feel more strongly that technical competence is a male physician attribute.

With regard to priorities for medical care, Fletcher et al[14] asked patients to prioritize eight characteristics of good medical care by the method of paired comparisons. For all patients continuity of care was ranked first. Comprehensiveness, availability, compassion, and expertise were clustered in the second to fifth places. Sex differences in priorities were not reported. Thus, no data exist on the relationship between preference for sex of physician and priorities for medical care. The fourth purpose of this study was to determine the priority that patients place on physician technical competence compared with physician humaneness, and to explore the relationship between these priorities and sex preference. If the analysis described above provides evidence of sex stereotyping of physician humaneness and technical competence, then the relative priorities patients place on these characteristics may be related to patients' preferences for sex of physician. It was hypothesized that patients with a female physician preference would place a higher priority on physician humaneness than other patients; conversely, patients with a male physician preference would place a higher priority on technical competence than other patients.

METHODS

Based on the literature review and the hypotheses outlined above, a four-part questionnaire was developed. Part 1 was designed to explore whether a relationship exists between preference for sex of physician and type of patient problem. Patients were asked to respond to each of ten problems on a 5-point scale, 1 = strongly prefer a man physician, 3 = no preference, 5 = strongly prefer a woman physician. Two problems were identified in each of five areas: acute-minor (flu, sore throat), acute-serious (severe chest pain, blood poisoning), chronic (arthritis, high blood pressure), behavioral (family problem, depression), and problems that generally result in an anal or genital examination (hemorrhoids, unusual discharge from vagina or penis).

Part 2 was designed to assess whether two attributes of particular interest in this study, humaneness and technical competence, were stereotyped according to sex of physician. Modifying items used in previous studies, five statements were selected to describe technical competence, eg, "The doctor gives me the best possible medical care"; and five statements were selected to describe humaneness, eg, "The doctor has a genuine interest in me as a person." Patients were asked to respond to each of these 10 statements on a five-point scale from 1 = more like a man physician to 5 = more like a woman physician. An elementary linkage analysis (ELA)[15] was performed on the correlations of these responses to identify items for inclusion when creating factor scores for sex stereotyping of competence and humaneness.

Part 3 was designed to measure the relative priorities patients placed on five attributes of physician behavior that are generally believed to be important components of good medical care: competence, humaneness, comprehensiveness, availability, and continuity. A descriptive sentence for each attribute was taken from the study by Fletcher et al[14] of patients' priorities for medical care: competence—your doctor should possess good technical

skills; humaneness—your doctor should be understanding and easy to talk to; comprehensiveness—your doctor should be able to manage a wide variety of medical problems; availability—you should be able to get in touch with your doctor when you need to; continuity—you should see the same doctor at every visit. Three other attributes in that study, coordination, cost, and convenience, were dropped because they were the lowest rated attributes and not personal attributes of physicians. To force choices among several valued alternatives, the method of paired comparisons[16] was used to establish patients' priorities for the five selected attributes. This method matched each of the five attributes with every one of the remaining four. Patients were asked to choose one of the two attributes in each of the resulting 10 pairs. The pairs were systematically varied, including their order of appearance and their left-to-right location, to avoid bias related to manner of presentation. Using this method, priority scores were assigned to each of the attributes for each of the patients.

Part 4 contained questions regarding demographic characteristics of the patient and preference for sex of physician for overall health care. Two final questions assessed the number of appointments patients had had with male and female physicians in the last 10 years.

Data were collected in the four family practice residency clinics of the University of Wisconsin–Madison Family Practice Residency Program with 12 family physician faculty (8 male, 4 female) and 42 residents (26 male, 16 female). During a 2- to 3-day study period at each clinic, all patients 18 years or older were asked to complete the questionnaire. To reduce potential bias of sex of person administering the questionnaire, both male and female research assistants were used. A total of 232 patients were approached, and 32 (14%) refused to participate, most commonly citing lack of time. An additional 15 questionnaires were returned incomplete, resulting in 185 usable questionnaires. Chi-square tests and analysis of variance were used in the analyses, with $P<.05$ used for identifying statistical significance.

RESULTS

A high proportion of the sample were women (69%), reflecting the approximate proportion of male-to-female adult visits at the residency clinics. The mean age was 34 years, and the sample was relatively well educated (49% having had more than 12 years of schooling) and had a relatively high household income (49% greater than $20,000/yr). The sample was 92% white, and 74% were currently employed.

Overall Preference

With regard to overall health care, 31% of men and 43% of women preferred physicians of their own sex, and 12% and 9%, respectively, preferred physicians of the opposite sex. Fifty-seven percent of the men compared with 47% of the women expressed no sex preference for overall care. Thus, men and women were significantly different in their expressed preferences ($\chi^2 = 23.79$, 2 *df*, $P<.001$). No statistically significant relationships were found between overall preference and patient age, income, or education.

Experience with Female Physicians

The study sample had extensive experience with female physicians. Thirty-eight of 58 (66%) men and 105 of 127 (83%) women had at least two visits with female physicians in the past 10 years. Ninety-six percent of the sample had two or more visits with male physicians over the same period. Patients who expressed a preference for male physicians reported less experience with female physicians; 40% had no more than one visit with female physicians compared with 24% of those with no preference and 13% of those with a preference for a female physician ($\chi^2 = 8.56$, 2 *df*, $P<.02$).

Clinical Problems

Preferences for a male or female physician for specific clinical problems were tabulated. In general, patients did not express a preference with regard to any of the six problems in the three strictly medical areas (acute-minor, acute-serious, or chronic); 73% expressed no preference with regard to any of the problems. Sixty-three percent of those who preferred a male physician for their overall health care expressed no sex preferences regarding these problems, and 50% of those preferring female physicians overall expressed no preferences. Only 6% of patients who expressed no physician sex preference for overall care expressed some preference on one or more of the medical problems.

For problems involving anal or genital examinations, 67% of patients indicated a preference for a specific sex of physician. Thirty-seven of 58 (64%) men expressed a male physician preference for these problems; 72 of 127 (57%) women expressed a female preference. Only 5 of 58 (9%) men and 12 of 127 (9%) women preferred opposite-sex physicians for these problems. An expressed preference for sex of physician for overall care was even more strongly related to sex preferences for these clinical situations: 70% of those with an overall preference for a male physician also preferred a male physician for these exam-

inations and 87% with an overall preference for a female physician expressed a similar preference here.

For the two behavioral problems, depression and family problems, 51% of patients expressed a preference for sex of physician, with 41% preferring a woman and 9% preferring a man. Those with an overall preference for a female physician were most likely to prefer a woman also for these problems (73%), but 28% of patients with no overall preference and 13% of those with an overall preference for a male physician also preferred a woman in these situations.

These data on shifts in patient preference in relation to the clinical problem might be summarized as follows: the highest numbers of patients expressed a physician preference for anal or genital examinations (67%), mostly for same sex; for behavioral problems 41% expressed a preference for a woman, and only 9% for a man; and few expressed a preference regarding medical problems regardless of severity (9% prefer a man and 18% prefer a woman).

Physician Behavior Stereotypes

Patients' responses on whether each of 10 behaviors describing humaneness and competence was more characteristic of a male physician or of a female physician were analyzed using elementary linkage analysis.[15] Three rather than two independent factors were identified: humaneness (3 items, Cronbach's alpha = .76), technical competence (4 items, Cronbach's alpha = .54) and a factor labeled "hurriedness" (3 items, Cronbach's alpha = .66). This last scale was composed of two humaneness items, "interrupts me" and "leaves me with unanswered questions," and one technical competence item, "seems disorganized."

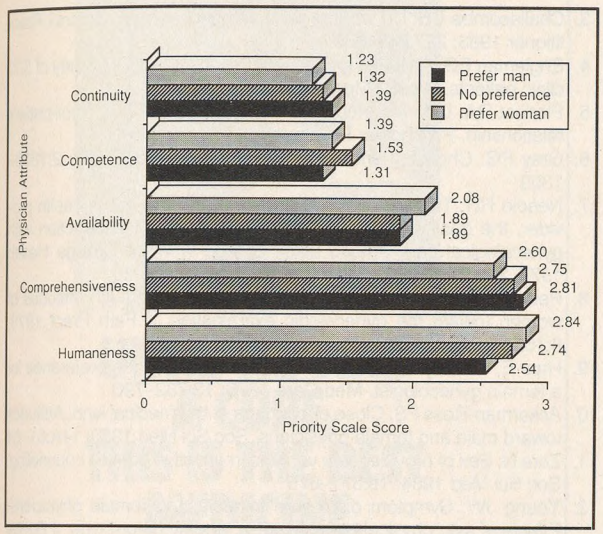
The mean response for the humaneness scale indicated that these behaviors were seen as somewhat more pronounced in a female physician (mean 3.22, a scale score of 3 on the 5 point scale indicating the sexes were about the same with regard to humaneness). Seventy-nine of 185 (43%) recorded humaneness as neutral, but another 43% saw it as somewhat or strongly characteristic of a female physician. Only 12% viewed it as somewhat or strongly characteristic of a male physician. Analysis of variance comparing scale scores for the three overall preference groups found significant sex stereotyping. For the group of patients who preferred a male physician, mean humaneness was 2.69 compared with 3.12 for the no-preference group and 3.63 for the group that preferred a female physician ($F=59.34$, 2,181 *df*, $P<.01$, $Eta^2=39.6$). Patients with a preference for a man viewed humaneness as a male physician trait, patients with no preference viewed it neutrally, and patients preferring a woman viewed it as a female physician trait.

Patients in general felt that technical competence was neutral with regard to sex of physician (mean 2.96). When comparing overall physician preference groups, however, differences again were found. The group of patients who preferred a man rated technical competence at 2.65 compared with 3.0 for the group with no preference, and 3.07 for the group who preferred a woman ($F=15.4$, 2,182 *df*, $P<.01$, $Eta^2=14.5$). Although the groups with no preference or preference for a woman viewed technical competence in a neutral way, those who prefer a man viewed technical competence as more characteristic of a male physician. Thus, strong empirical support was found for the hypotheses regarding stereotypes and preferences.

Finally, when analyzing the data on the hurriedness factor, patients tended to view this behavior as somewhat characteristic of a male physician (mean 2.78). When the overall preference groups were compared, the group that preferred a man rated hurriedness at 2.91 compared with 2.87 for the group with no preference and 2.59 for those who preferred a woman ($F=9.08$, 2,182 *df*, $P<.01$, $Eta^2=9.1$). Patients who preferred a man or expressed no overall preference viewed these behaviors as only mildly characteristic of a male physician, but those who preferred a woman viewed them as much more characteristic of a male physician.

Priorities for Physician Attributes

Most patients' responses regarding priorities of the five physician attributes were internally consistent, ie, a patient's top priority was always chosen over the remaining four, the next highest was always chosen over the remaining three, and so forth. Using Kendall's coefficient of consistence, the mean coefficient for the sample was .84.[16] The relative priorities patients placed on various attributes of a personal physician can be seen in Figure 1. Patients placed a high priority on physician humaneness and equally high priority on physician comprehensiveness, with technical competence ranked fourth out of five. The mean priority of humaneness for the group preferring a female physician for their overall health care was slightly higher than the other two groups, and the mean priority for comprehensiveness was slightly higher for the group preferring a male physician compared with the others, but analyses of variance identified no significant differences between the preference groups on priorities for medical care. Almost equal proportions of men and women rated the humaneness attribute the highest (31% and 30%). Similarly, 31% of men and 29% of women rated comprehensiveness highest. While it is clear that patients do vary on the priorities they place on these attributes, and that patients are consistent in their ranking of these priorities, the relative priority of these attributes does not appear to be related to overall preference for sex of physician.



DISCUSSION

Approximately one half of the patients surveyed expressed a preference for sex of physician for their overall health care, with women somewhat more likely to express a preference than men. This finding differs from most of the available literature, but supports the more recent study by Ackerman-Ross.[10] These data, from a sample with high levels of experience with female physicians and high proportions of women physicians serving the practices, also indicate that experience may be related to preference. Although patients with greater numbers of visits to women were more likely to express a preference for female physicians, and patients with fewer visits to women were more likely to express a preference for male physician, a causal relationship cannot be drawn from these data. It may be that patients with a strong preference for a specific sex of physician strongly resist appointments with physicians of the other sex.

As previous studies have shown, patients' preferences for sex of physician in the present study depended on the type of clinical situation. Patients were unlikely to express a preference when faced with chronic or acute medical problems, somewhat more likely to express a preference when dealing with behavioral problems, tending to prefer a woman, and most likely to express preferences when undergoing genital or rectal examinations, usually for physicians of their own sex. The finding that fewer women (57%) than men (64%) expressed a preference for physicians of their own sex may be due to the inexperience of men with genital examinations performed by female physicians. In contrast, women have probably had more experience with pelvic examinations performed by male physicians. Nevertheless, two thirds of patients expressed a preference for a specific sex of physician for genital examinations compared with behavioral problems (51%) and medical problems (27%). The relatively high proportion of patients preferring female physicians for behavioral problems supports results from previous studies.[11,12]

The data support the hypotheses about relationships between preference for sex of physician and sex stereotyping of physician behaviors. Overall, patients tended to describe humaneness behaviors as somewhat characteristic of female physicians, but the group of patients with an overall preference for female physicians felt this association most strongly. Patients with an overall male physician preference rated technical competence as significantly more characteristic of male physicians compared with the other two groups (no preference, female physician preference) who did not stereotype these behaviors. Finally, patients tended to describe hurriedness as somewhat characteristic of male physicians, but again the group of patients who preferred a female physician felt this most strongly. Thus, patients who express a preference for a female physician may base that preference on both positive stereotypes about female physicians and negative stereotypes about male physicians.

The identification of the unexpected third factor, hurriedness, is particularly interesting in light of the work of West,[17,18] in which she documents that male physicians interrupt patients more than female physicians. Thus, the ratings on hurriedness may be the result of experience with actual physician behavior. Male physicians also are seen as more businesslike and less friendly in their encounters with patients.[19] An alternative explanation is simply that traditional male-female stereotypes are still widely held.

Physician humaneness and comprehensiveness were both top priorities in this sample, with technical competence given a relatively low priority. The high priority on comprehensiveness may reflect the values of this family practice population and may not be generalizable to other practices. It is also possible that the comprehensiveness item (manages a wide variety of medical problems) was interpreted as a technical competence item.

Fletcher et al[14] found that continuity of care was ranked first and comprehensiveness second. The population in the present study was younger (mean age 34 vs 44 years), more predominantly female (69% vs 59%), and from a family practice rather than an internal medicine practice, which may account for the differing responses. The findings in this study are similar to Van Groenestijn's data[20] on patients' priorities for the characteristics of the ideal dentist. The three most important characteristics in that study were professional skills (analogous to this study's competence or comprehensiveness factors), putting the patient at ease, and friendliness (both analogous to humaneness).

Generalization of these findings to other practices should be made with caution. First, the data were collected in family practice residency clinics. In addition, the sample was young, of fairly high socioeconomic status, and had fairly extensive experience with female physicians. Finally, this is an attitude survey; it is unclear whether patients actually choose physicians on the basis of expressed preferences.

Nevertheless, these findings have implications for training, practice, and research. Since the practices of female physicians both during and after training tend to have higher proportions of women than those of male physicians, reasons for this difference need to be explored. The findings above suggest that patients associate some physician behaviors with sex of physician. During training and in practice physicians of both sexes should display behaviors that demonstrate humaneness (eg, show interest in the patient as a person) and minimize hurriedness (eg, encourage patient questions, do not interrupt). Future studies are needed to compare male and female physician behavior during office encounters and to correlate those differences with patient satisfaction.

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