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Do Patients Prefer Male or Female Physicians/Counselors During Family Planning, Pregnancy and Birth Process? A Sample from Turkey

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ABSTRACT: The aim of this study is to investigate women's preferences regarding the gender of the team that provides health care in gynecology and obstetrics, and to find out the factors affecting their preferences. The data of this research were collected from 3 hospitals and 14 small health units. and t tests were used for the statistical evaluation of the data. The study participants are 324 females at the age of 15 to 49, who consulted any of the family planning units of the hospitals or health centers for a family planning method or for the continuation of the method they were already using. 388 participants (49 in the informed group and 339 in the uninformed group) responded to the questions in the questionnaire related with the process of pregnancy and birth. Two hundred forty two (74.69 %) of the counselees that participated in our study preferred female physicians/counselors. 160 patients (47.2%) who were among the uninformed group and preferred the same-sex health staff for medical care and 16 patients (32.6 %) who were among the informed group and expressed the same preference reported that females would understand them better and they would be more comfortable with female physicians. Culture affects not only our perceptions, values and feelings but also our communication with ourselves and other individuals. As a result, taboo communication is experienced between health care team and the patient in the field of gynecology and obstetrics. In the provision of family planning counseling services, counselees prefer female counselors because they have good communication skills. Patients prefer female physicians due to their pregnancy and birth experiences, too.
KEYWORDS: Gender, communication, family planning, pregnancy, birth

AİLE PLANLAMASI, GEBELİK VE DOĞUM SÜRECİNDE HASTALARIN TERCİHİ KADIN DOKTORLAR MI ERKEK DOKTORLAR MI? TÜRKİYE'DEN BİR ÖRNEK

ÖZET: Bu çalışma jinekoloji ve obstetrik alanında hizmet almak için başvuran kadınların hizmet aldıkları sağlık ekibinin cinsiyetleri ile ilgili tercihleri ve bu tercihlerde etkili olan unsurları belirlemek amacıyla yapılmıştır. Araştırmanın verileri 3 ayrı hastane ve 14 sağlık ocağından sağlanmıştır. Verilerin istatistiki olarak değerlendirilmelerinde $\chi 2$ ve t testinden yararlanılmıştır. Hastanelerin aile planlamaları üniteleri ve sağlık ocaklarından herhangi bir aile planlaması yöntemi almak ya da kullandıkları yöntemin devamlılığını sağlamak için başvuran 15-49 yaş arası 324 kadın araştırmaya katılmıştır. Gebelik ve doğum süreci ile ilgili olarak 388 kişi (49'u bilgilendirilmiş, 339'u bilgilendirilmemiş grubu oluşturacak şekilde) soru kağıtlarını yanıtlamışlardır. Araştırmamıza katılan danışanların %74.69'unun kadın doktorları / danışmanları tercih ettikleri görülmüştür. Bilgilendirilmemiş grupta olan ve kendileri ile aynı cinsten bir sağlık ekibinden tıbbi bakım almak isteyen hastaların 160'ı (%47.2) ile bilgilendirilmiş grupta olan ve aynı isteği ifade eden hastaların 16'sı (%32.6) kadınların kendilerini daha iyi anlayacağını ve kadınlara karşı daha rahat olabileceklerini ifade etmişlerdir. Kültür, algılarımızı, değerlerimizi, duygularımızı etkilediği gibi, kendimiz ve diğer bireylerle olan iletişimimizi de etkilemektedir. Buna bağlı olarak, jinekoloji ve obstetrik alanında sağlık ekibi ile hasta arasında tabu iletişimi yaşanmaktadır. Aile planlaması danışmanlık hizmetlerinin sunumunda iyi iletişim becerilerine sahip oldukları için kadın danışmanlar tercih edilmektedir. Hastalar gebelik ve doğum deneyimleri için de kadın doktor tercih etmektedir.
ANAHTAR KELİMELER: Cinsiyet, iletişim, aile planlaması, gebelik, doğum.

1. Giriş

The cultural, economic and political structure of a society influences individuals' perception of diseases.

Modern and traditional life styles coexist in Turkey, a country that has a structure of social and cultural variety. Life perspectives of metropolitan people show some similarities with those in the Western countries. However, people living in the suburbs of metropolitan cities and in rural areas of the country adopt relatively more conservative and traditional viewpoints. Family ties are still strong, and these ties are influential on the formation of social values, attitudes, desires and targets. Although it can be said that laws are quite liberal in respect of gender equality, what dominates the social life in many aspects is the patriarchal ideology (1).

Gender distinction shapes the lives of both women and men and this distinction goes beyond being a mere difference. We can closely relate with gender the distinctive value attached culturally to woman life and being a woman, which affects woman health and woman life (2). Although gender differences are not clearly set in the field of health, in most societies, women have limited opportunity to access and control resources to protect their own health and have limited role in decision mechanisms given the distribution of power (3). Particularly, in relation to sexual and reproductive life, women hold limited power and ineffective position in decision-making processes (4).

Talk about women's sexuality has been considered shameful in the Turkish society. Women's bodies and sexuality are kept under control not only in the familial sphere, but also by the Turkish state discourse (5).

Whereas culture affects our perceptions, values and feelings on one hand, it influences our communication with ourselves and other individuals, on the other hand. As a result of this, in our country, taboo communication is experienced between health care team and the patient in the field of gynecology and obstetrics.

A great majority of the messages aimed to be sent to the target groups through communication activities in the scope of health training are of highly private and personal nature. Even, in some parts of the society, these messages might be evaluated as "confidential or forbidden message". Those are the messages that can only be shared by the people who are very close to and have mutual trust for each other. Interpersonal communication through which people share this kind of messages is also referred to as "taboo communication". In order to provide this communication which is generally limited to one resource and one receiver, an environment of trust should be secured firstly. Such environment that could be regarded as a communication barrier mostly due to its failure to provide easy and rapid flow of information, when evaluated in better conditions, makes an important contribution to strengthen the effectiveness of convincing and persuasive characteristics of the shared message.

The health care team plays a significant role in the establishment of reliable and supportive communication environments, and should be well aware of this role. Related surveys have clearly demonstrated that the society shares this same expectation (6).

Gender is a characteristic that is associated with variation in communication style. Studies have shown that female and male physicians tend to differ in terms of certain characteristics in their communication with patients (5, 7-9). A growing body of research provides evidence that female physicians practice differently than male physicians and that the style and content of visits differ by physician gender. Reasons for these differences may be related to gender socialized differences between men and women that persist even when professional roles are adopted (9, 10).

Field studies show that female patients were more expressive with their feelings, liked emotionally supportive conversations more than the males, and had more collaborative expressions. Another observation is that female patients were more inclined to answer the questions, accepted more explanatory remarks, and talked to a same-gender-physician more comfortably and rendered more information particularly about psycho-social subjects (11-13).

There is strong evidence that physician-patient communication is a good predictor of patient compliance, adherence to treatment, clinical outcomes and general patient satisfaction. Patient satisfaction is an important dimension of the quality of care and an useful outcome measure (14).

The relevant literature shows that there is a complex relation between physician gender and patient satisfaction. In some studies, while the patients having female physicians were found more satisfied, some others were reported to be satisfied with their male physicians (10, 15).

The aim of this study is to investigate women's preferences regarding the genders of the team which provides health care in the field of gynecology and obstetrics, and to find out the factors affecting their preferences.

2. Materials and Methods

Upon the required permission from the relevant institutions, data regarding the Project titled "Patient-Health Care Team Communication in Gynecology and Obstetrics" and numbered 200111012, supported by Scientific Research Projects of Eskisehir Osmangazi University, have been collected from 3 different hospitals and 14 health centers since the individuals of concern are covered by different social security institutions.

The researchers explained the aim of the study, and drew up the consent forms.

The women involved in the study were asked to fill out the questionnaire composed of multiple choice and open-ended questions. For the participants who can not answer the questions by themselves due to their education level, the researchers asked the questions and recorded the answers.

The study participants are 324 females at the age of 15 to 49, who consulted any of the family planning units of the hospitals or health centers for a family planning method or for the continuation of the method they were already using.

Three hundred eighty-eight participants (49 women who joined pregnancy training programs formed the informed group of our research, and 339 women who did not join such programs were defined as the uninformed group) responded to the questions in the questionnaire related to the process of pregnancy and birth.

Statistical Analysis

Considering the measurement levels of variables, the methods of arithmetic mean, standard deviation, frequency and percentage were used when analyzing the data, and defining the participants' situations in terms of the given variables. To this end, SPSS 21.0 Program was used in the study.

Chi square test (χ^2) was used to determine whether there is a statistically significant relation between the demographic characteristics of the participants and given variables. In the contingency tables (cross tables) which were designed to this end, empty cells and frequencies expected below 5 were observed. Excess amount of level numbers belonging to the relevant variables caused that situation. Cell number of the frequency that was mostly expected below 5 exceeded 25 % of the total cell number. In such situations, variable levels have been integrated in a way that will be eligible for the aim of the researcher. After these arrangements were finalized, results of the analysis were presented in the contingency tables and chi square test results. Further, in order to compare the ratios of two groups, "t test regarding the difference between ratios" was used.

3. Results

Educational status of 324 women who consulted an expert for benefiting from family planning service are as follows: 7 women (2.2 %) are illiterate, 197 women (60.8 %) hold a primary school, 39 (12 %) a secondary school, 50 (15.4 %) a high school, 31 (9.6 %) a university degree.

Whereas 279 (86.1 %) out of 324 women are housewives, 45 (13.9 %) of them have a job with an income.

Two hundred fifty-three (90.7 %) of the housewives and 31 (68.9 %) of the women who have a job with an income indicated that they consulted female consultants. 26 (9.3 %)

of the housewives and 14 (31.1 %) of the women who have a job with an income indicated that they consulted male consultants. It was observed that most of the housewives (90.7 %) consulted female consultants for family planning methods.

Two hundred twenty (78.8 %) of the housewives and 22 (48.9 %) of the women who have a job with an income stated that they preferred female consultants. 39 (14 %) of the housewives and 10 (22.2 %) of the women who have a job with an income stated that they preferred male consultants. 20 (7.2 %) of the housewives, and 13 (28.9 %) of the women who have a job with an income stated that gender was not important for them. It was found that the majority of the housewives preferred to see female counselors.

The study found a statistically significant relation between women's occupation and the gender of the person from whom they want to receive family planning counseling service (χ^2=24,384 df = 2 p<0.001). The women prefer female counselors in this field.

The clients who applied for a family planning service stated that female consultants were sympathetic (n=260 80.2 %), concerned (n=222 68.5 %), patient/calm (n=198 61.1 %), respectful (n=179 55.2 %), polite (n=172 53.1%) and unprejudiced (n=149 46 %). It was observed that the most of the counselors displayed positive attitudes.

The study also looks for the relation between gender and good communication skills of family planning counselor that provided service to women. Table 1 illustrates the statistically significant findings in this respect.

Table 1

The relation between gender and good communication skills of family planning counselor that provided service to women

Gender – Good communication Skills of Counselor	statistics analysis results		
Efficient listening	χ^2=5,006	df=1	p=0,025
Making explanations	χ^2=13,145	df=1	p<0.001
Giving Feedback	χ^2=10,616	df=1	p=0,001
Responsiveness to questions	χ^2=6,124	df=1	p=0,013
Acknowledging needs by intuition	χ^2=8,266	df=1	p=0,004
Friendly approach	χ^2=14,055	df=1	p<0.001
Empathetic Approach	χ^2=7,542	df=1	p=0,006
Appreciating the ability of communicating without speaking (body language) and its importance	χ^2=9,463	df=1	p=0,002
Respect and understanding for the individual's rights and personality	χ^2=12,872	df=1	p<0.001
Taking an approach of sensitivity and gaining confidence	χ^2=6,809	df=1	p=0,009
Avoiding from judging the person, being respectful and polite	χ^2=7,563	df=1	p=0,006
Encouraging the person to ask questions	χ^2=15,364	df=1	p<0.001

The majority of the counselors that provided family planning service is female. It has been observed that these counselors are furnished with good communication skills.

The informed group was composed of 49 participants who joined pregnancy training program concerning the process of pregnancy and birth, and the uninformed group covered 399 women who did not participate in these programs.

Among the patients of uninformed group, 2 (0.6 %) are illiterate, 3 (0.9 %) are literate, 124 (36.6 %) are graduates of primary school, 30 (8.8 %) are graduates of secondary school, 83 (24.5 %) are graduates of high school and 92 (28.6 %) are university graduates.

Of the informed group patients, 1 (2 %) holds a primary school, 4 (8.2 %) hold a secondary school, 12 (24.5 %) hold a high school, and 32 (65.3 %) hold a university degree.

In the uninformed group, there are 227 (67 %) housewives, and the remaining 112 (33 %) patients have an income-yielding-job.

As for the informed group, whereas 14 (28.6 %) of the patients are housewives,

35 (71.4 %) of them have an income-yielding-job.

Whereas 160 (47.2 %) patients from uninformed group preferred same-gender for the follow-up of their pregnancy period and at delivery, 42 (12.4 %) stated the opposite opinion; and 137 (40.4 %) patients reported that gender was not important for them and that they always preferred gentle, considerate, experienced and professional physicians regardless of the gender.

Sixteen (32.6 %) patients in the informed group preferred same-gender health care staff, 14 (28.6 %) stated the opposite. Mentioning the same reasons with the ones in the uninformed group, 19 (38.8 %) patients reported that the gender was not important.

When the researchers compared the gender preferences of two groups for the health care staff that provided service, they found a statistically significant difference. Table 2 illustrates the statistically significant findings in this respect.

Table 2
Distribution of Informed and Uninformed Group according to their gender preferences for the health care staff

Groups	Their preferences for the gender of health care staff			T
	Female	Male	No preference	
Uninformed Group	160	42	137	339
Informed Group	16	14	19	49
T	176	56	156	388

χ^2= 9.80 df=3 p=0.020

It was also observed that almost half of the patients (47.2 %) in the uninformed group had a same-gender preference for the staff that would be involved in their antenatal follow-up and delivery.

All of the patients in the uninformed group and preferring to receive medical care from a same gender health staff together with the informed group patients, who had the same preference, reported that females would understand them better and they would be able to be more comfortable towards females.

Among the uninformed group patients who did not prefer same-gender health care staff, 27 (8 %) patients stated that they did not trust women and found female staff more prejudiced and critical. All patients in the informed group, who did not prefer same-gender health care staff explained that they shared the view of the patients in the uninformed group.

4. Discussion

Some of the earlier studies also reported a much-stronger preference for female obstetricians among female patients in obstetric-gynecology care, based largely upon gender-specific problems, as well as the embarrassment and discomfort associated with exposure to an obstetrician and the discussion of sensitive, gender-specific matters across gender lines. Female physicians have a better innate understanding of the female body (8); thus they may be more prefer than their male counterparts in obstetrics and gynecology care.

There is an increasing tendency towards the selection of same-gender-physicians in the field of gynecology and obstetrics (15).

There is an assumption in today's society that women prefer female obstetricians-gynecologists. Preferences are not static, and can change over time due to a myriad of internal and external factors (16).

In many studies, it was shown that, women preferred female physicians in gynecology and obstetrics care (17-21).

In our study 74.69 % of the counselees preferred female physicians/counselors. Our findings have been evaluated in compliance with above-mentioned studies.

As it is shown by the literature data; women, when compared with men, display more positive attitudes in both oral and behavioral forms. It was reported that when compared with the male physicians, it was more possible to interrupt female physicians' words; and that counselees provided more medical data for female physicians and asked more questions to them, and at the beginning of the communication, female physicians were focused on the individual more emotionally (22).

Those who received family planning service reported that their counselors were female and showed positive attitudes by being understanding, compassionate, patient and calm. Their statements were found complying with the literature review.

It is expressed that during visits female physicians attach more importance to patients' feelings and that they are more polite, more overt to the psychosocial aspects of the patient care and more inclined to protective care (16,23). The result of our study that negative attitudes were represented by low percentages has been supporting the above-mentioned finding.

In women-to-women consultations, physicians were reported to give more positive expressions and make more eye contact. The atmosphere between a female physician and a female patient is friendlier than the one between a male physician and a male patient. When the physicians of women patients are female, it is seen that access to data concerning these women is easier, and that they discuss psychosocial problems more often. Female physicians might be more inclined to investigate psychosocial problems related to women (13, 24). This situation might be related with the fact that female physicians are more compassionate in diagnosis of the women patients' psychosocial problems (13).

It is reported that female physicians are inclined to speak in a more emotional way, and that they take on emphatic communication attitudes in their relations with the patients (22, 24, 25). In another study, it was stated that female physicians of internal diseases were inclined to represent higher ratios of humanities than male physicians of internal diseases, and that female physicians displayed more non-verbal attitudes related to the perception of physician empathy, such as nodding and smiling (22, 25).

The majority of the counselors from whom women demand family planning service is female. It was observed that these counselors establish good communication skills. Our findings have been in compliance with the literature data.

For women, communication and satisfaction with obstetricians during initial prenatal visits has been found to be related to physician gender. Although the visits conducted by male physicians were longer, female patients reported greater satisfaction with female obstetricians (26).

In Fraser's study, half of the participants preferred only female health care team. They added that a male physician might be involved in their care in case of any complication. They expressed that they had a preference for same-gender-health care team because a woman could understand them better (27). In some of the studies, it was shown that, women who preferred female physicians indicated that they felt more comfortable with a female physician (28-32).

In our study, the patients in the uninformed group and preferring to receive medical care from a same gender health staff together with the informed group patients, who had the same preference, reported that females would understand them better and they would be more comfortable towards females. Our findings have been assessed as compatible with these studies.

Since the consultation of health care provider-patient communication may have an outstanding effect on the following results (e.g. satisfaction, health progress, dependency), it is possible that the gender of

the participant might affect the structure, and the content of the consultation might turn into a considerably important problem (33).

Some studies prove that gender is an important factor in terms of good communication between a physician and his/her patient (13, 33-37).

Elderen pointed out that female physicians displayed more caring attitudes during vaginal examination and consultation in his/her study (21).

In some of the studies, female physicians are evaluated to be more sensitive than male physicians in emotional terms (15, 38). However, another study has shown that female physicians when compared with males are more negative on the patient autonomy and patient initiative aspects (23).

In some of the studies, it was shown that, women preferred a male physician in gynecology and obstetric care (18, 30-32). Women who preferred male physician indicated that, they felt that they had a greater opportunity to gain more information about the obstetrics care and a male physician understood them much better compared to a female physician (31, 32).

In Lai and Levy's study, a woman was examined firstly by a female physician and then by a male physician. The patient said that female physician was more hasty and impolite but the male physician behaved more gently and respectfully towards her feelings. She also stated that the female physician started examination immediately and provided no information but the male physician informed the patient on every stage of the examination (21).

In our study, among the uninformed group patients who did not prefer same-gender health care staff, 27 (8 %) patients stated that they did not trust women, and found female staff more prejudiced and critical. All the patients in the informed group who did not prefer same-gender health care staff explained that they shared the view of the patients in the uninformed group. Our findings have been evaluated in compliance with above-mentioned studies.

In some of the studies, it was reported that, for most women, a physician's gender is not of primary importance in the selection of a physician in gynecology and obstetric care (30, 39, 40). The women expressed that; experience, good interpersonal relations and communication style played important role in their physician preferences (39, 40).

In the study of Lai and Levy although some of the women preferred female physicians, they emphasized that gender was not important. The women told that they usually preferred polite, considerate and experienced physicians without considering the gender (21).

In our study, nearly 40 % of the patients in the uninformed and informed group stated that a physician's gender was not important, giving the same reasons with those identified in the above-mentioned studies. Our findings have been evaluated in compliance with these studies.

5. Conclusion

Culture affects not only our perceptions, values and feelings but also the communication with ourselves and other individuals. As a result, taboo communication is experienced between health care team and the patient in the field of gynecology and obstetrics.

As female physicians reflect their gender-related roles and responsibilities (protection, listening, affection, care) to their duties in the field of health, they are more preferred for gynecologic care, which is deemed as a special situation for women.

Women's tendency to see the ones who are different as the other, make them prefer a female physician for their gynecologic and obstetric care. Women's attempt to stand aloof from the different and the social is not related with their biological sex but with social sex (gender).

Since sincerity in women's conversation and sharing of the experiences constitute the two main factors in women's friendship, female physicians are more preferred in gynecology and obstetrics.

In the provision of family planning counseling services, female counselors are preferred because they have good communication skills.

Patients prefer female physicians because these physicians also have pregnancy and birth experiences.

Female physicians use effective listening methods more than male physicians, and they adopt a friendlier approach.

Female physicians display emotional attitudes such as empathy, collaboration, emotional support and confidence building more than males. It has been seen that female physicians are better at listening and counseling.

Such attitudes are important in terms of supporting and continuing mutual participation.

While correct examples emphasize positive attitudes, they also ensure that negative ones are highlighted to be corrected. Therefore, similar studies should be conducted and the findings should be compared.

A study reported that for male patients the traditional labour division between male and female providers were the best predictor for a patient's gender preference. In Turkish society, generally, in order to protect the family, female members of the family are often kept under control by males. Accordingly, female patients can be under the influence of their husbands when choosing the medical professionals providing service in this field. To this end, the gender of medical professionals serving in gynecology and obstetrics and the criteria that affects this choice should be studied from the perspective of male patients and their spouses.

As every society in the world has identified gender roles governing the behaviors and activities of women and men, the research about social dimensions on health and illness should include the analysis of gender roles on daily lives.

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