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Principles and Practice of Women's Health Care

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Interest in the principles and practice of women's health care has increased during the past decade, both in mental and somatic health care.[1] In the Netherlands, a center for women's health care was established in 1980 in Utrecht. It was called "Aletta," after Aletta Jacobs (3 854-1929), 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. In her older years, she was also a fervent advocate of women's suffrage and world peace.

Women's health care is based on the philosophy of feminist health care and the definition was based on this philosophy: women's health care consciously provides 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 Iifestyle'.[2] The most important and distinctive principles of women's health care are 1) consideration of the patients' gender identity and gender roles and 2) consideration of the patient's personal and social situation. Other principles, which are already part of the body of thought that is being propagated by the Dutch College of General Practitioners, are 3) respect for the patient; 4) encouragement of the patient's own responsibility and self-determination; 5) demedicalization (prevention of labeling daily life and body problems as biomedical problems).[3] Besides, specific attention is being paid to information giving, which is an important means for realizing the principles.

The general practice Aletta is allied to the Women's Health Care Centre.

Four female general practitioners (GPs), who have qualified in the normal way, 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 be emphasized, however, that regular health care and women's health care have the same goal-improvement of the quality of care.[4,5] In the Dutch health care system people firstly visit the general practitioner for all health problems, including gynecologic problems. The GP is gatekeeper for secondary health care. If necessary, the GP refers the patient to a medical specialist, like a gynecologist.

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 1) how the principles of women's health care are applied in the doctor-patient consultations of women's health care as compared to regular health care and 2) if differences are related to the type of health care.

Additionally, a comparison was made between female and male GPs. Earlier studies have shown that GPs who provide women's health care are more like female than male regular

GPs providing regular health care.[6-8] Similarly, female patients using women's health care are more like female patients visiting female than male doctors providing regular care.

METHODS

Study Design

Consultations of female 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 to allow scoring of verbal and nonverbal behavior. Observation of videotaped consultations has been proven to be a reliable method for analyzing both verbal and nonverbal doctor-patient communication.[9-11] Although the principles of women's health care are theoretically applicable in every consultation, independent of the patient's age and presented health problems, they might not necessarily be put into practice in each consultation. Practicing the principles might be influenced by the number of health problems presented and whether the patient presents a problem for the first time or not.[12] Therefore, these consultation characteristics were accounted for. Sample Data were derived from 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.[6,7] Three groups of GPs were studied: the four female GPs of the Utrecht women's, health care practice Aletta, eight female and eight male GPs providing regular health. All practices are group practices. These latter 16 GPs participated in an earlier large-scale, international study of Dutch general practices, and they were asked to take part in the present study.[13] The mean number of consultations per GP was approximately 20, resulting in a total of 405 consultations.

In the Aletta practice, 70% of the patients agreed to participate; in the other practices, 85% agreed to participate. The reasons for nonresponse were, for all practices, for largely psychological and psychosocial problems.

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 A). On the basis of information in the literature,[1-5] each principle was divided into items that together form a scale reflecting the content of the principle. Some items were removed because of skewness (Cll, D5, and every "other" category, see Appendix A) or based on the results of factor analysis.

The scale items produced four distinguishable factors consistent with the principles "gender identity/roles," " personal/social situation," "respect for patient," and "self-responsibility." The reliability of the adapted scales was between 0.73 and 0.87 (Cronbach's alpha). The scale "demedicalization" was not satisfactory and was therefore removed from further analyses. The items were scored on a 5-point scale, indicating the extent to which they were applied: 1 =not applied; 2 = hardly applied; 3 =moderately applied; 4=mostly applied; and 5=explicitly applied.

The consultations were scored by three observers (all female social scientists) who had been trained to use WAS. The interobserver correlations (Pearson's Product Moment Correlation) were between 0.60 and 0.91.

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. To examine the possible clustering of consultations, the intraclass correlation coefficients of the scales were calculated,[14] which reflect the proportion of total variance of an observation that is associated with a single GP (Table 1). [15] The consultations of one GP were indeed more similar than the consultations of different GPs. The second problem is that all the dependent variables (application of women's health care principles) are on the level of consultations, whereas the independent variable of main interest (type of GP: Aletta Cl's and female and male regular GPs) is on the level of the participating GPs. So, the application of the principles (the lower level outcome measures) is believed to be explained by the type of GP (the higher level explanatory variable). To solve these problems, multilevel analyses were used to analyze the data. [16,17] Differences were tested for significance by means of the difference of proportions test.[18]

[TABLE 1]

RESULTS

Application of Women's Health Care Principles

The Aletta GPs and the female regular GPs seemed to apply the different items of this principle equally (Table 2). All female GE's considered the patients' gender identity and gender roles as well as the patient's feelings more often than the male GPs did. All the items, however, had low scores. The two groups of female GPs did not significantly differ in the application of the principle "consideration of the patient's personal and social situation," but they again differed from their male colleagues in some aspects. The female GPs referred more often to the living situation in relation to a health problem, and they explained more that a woman's health problems could be related to her living or working conditions.

All GPs appeared to respect their female patients highly. Most of the items of this principle were applied in every consultation, but the most by the Aletta GPs. They 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, had a more egalitarian attitude, and like the female regular GPs, more often showed acceptance of the patient's norms and values.

The Aletta GPs differed especially from the male GE's with respect to the "encouragement of the patient's self-responsibility and self-determination." The Aletta GPs and also the female regular GPs more often involved their patients in decision-making and also asked their patients what they had done to help thlemselves to get better more often. 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 both the female and male regular GPs.

[TABLE 2]

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 "selfresponsibility" during consultations more often than the regular GPs did (Table 3). 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 3]

DISCUSSION

The five principles of women’s health care were operationalized in several items to form WAS. The research questions concerned differences in the application of the five principles in general practice.

Some limitations 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 section of this article, 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 our first attempt to operationalize the principles of women’s health care.

Because of 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 as to 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, find these principles easier to handle and apply than male Gl’s do.

Most of the time all GPs showed respect for their patients. 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 b:y the Aletta GPs. In consultations with female GPs the principle “accept the patients norms and values,” was visible more often 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 situations 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 own health.

The previously 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 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 principle “respect for the patient” 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 seems difficult to recognize the items of this principle, probably because they are 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. Still, it is important for GPs to recognize 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. Moreover, the way in which Cl’s handle problems that women feel embarrassed to talk about is very important.

Although GPs should persist in asking about embarrassing problems to discover the real problem, they must also consider the woman’s feelings and perception of her problems. lmprovement of this scale, eg, by refining the items, is necessary. Whether the scale for the principle “consideration of the patient’s personal and social situation” also should be amended needs to be investigated further.

In general, 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 male doctors. Female doctors look more like each other than like male doctors. The principles are more visible in women doctors’ daily practicing, and even more in the practicing of the Aletta GPs. Although the differences are small, regular health care might benefit by applying some of the distinguishing aspects of women’s health care. The results could be integrated in the medical school curricula and postgraduate training.

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APPENDIX

Appendix A
WOMEN'S HEALTH CARE ANALYSIS SYSTEM

	1	2	3	4	5
A. Gender identity/roles					
1. go into shame/taboo problems					
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					
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					

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

TABLES

Table 1. INTRACLASS CORRELATION COEFFICIENTS (r) FOR GENERAL PRACTITIONER BEHAVIOR CONCERNING WOMEN'S HEALTH CARE

GP Behavior	*Intraclass, r*
Gender identity/roles	0.04*
Personal/social situation	0.10†
Respect for the patient	0.30†
Self-responsibility	0.19†

*$P < 0.05$.
†$P < 0.001$.

Table 2. PERCENTAGE OF ITEMS OF THE PRINCIPLES OF WOMEN'S HEALTH CARE THAT WERE MODERATELY OR MORE OFTEN APPLIED DURING CONSULTATION BY TYPE OF HEALTH CARE

	Aletta GPs (N = 89)	*Female GPs (N = 164)*	*Male GPs (N = 152)*
Gender identity/roles			
Continue about shame/taboo	10.1*	11.6†	4.6
Pay attention to gender-specific presentation	9.0	7.9	6.6
Consider feelings/experiences	13.5*	10.4†	4.6
Consider gender nature	12.4*	7.9	3.3
Personal/social situation			
Consider psychic status	66.3	69.5	59.2
Consider consequences illness	61.8	65.9†	55.3
Ask about living situation	70.8	69.5	61.8
Refer to living situation	61.8*	61.6†	47.4
Show relation problem-life	58.4*	50.9†	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†‡	92.7	88.8
Look at the patient	100.0†‡	92.1	87.5
Encourage to tell the story	95.5‡	89.6	82.9
Clear information	97.8‡	93.3	93.4
Egalitarian attitude	100.0‡	98.2	94.1
Ask about patient satisfaction	58.4†‡	39.6	23.7
Accept patient norms/values	43.8‡	39.6†	20.4
Self-responsibility			
Shared decision-making	77.5‡	67.1†	53.9
Ask for self-treatment	49.4‡	39.0†	25.7
Ask for patient's opinion	57.3†‡	43.3	37.5
Give alternatives/information	78.7†‡	56.7	55.3
Stimulate to share problems	5.6	6.1	3.9

*P <0.05 Aletta GPs versus male GPs.
†P <0.05 female GPs versus male GPs.
‡P <0.05 Aletta GPs versus female GPs.

Table 3. MEAN SCORES 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*†	3.58	3.29
Self-responsibility	2.88*†	2.54†	2.32

*P <0.05 Aletta GPs versus female GPs.
†P <0.05 Aletta GPs versus male GPs.
‡P <0.05 female GPs versus male GPs.