



## Letters

# Sex inequalities in ischaemic heart disease in primary care

BMJ 2001; 323 doi: <http://dx.doi.org/10.1136/bmj.323.7309.400/a> (Published 18 August 2001) Cite this as: BMJ 2001;323:400

## Clinical decision making is not necessarily guided by prejudice

**Rosalind Raine, Medical Research Council/North Thames clinical lecturer in health services research** ([rosalind.raine@lshtm.ac.uk](mailto:rosalind.raine@lshtm.ac.uk))

*London School of Hygiene and Tropical Medicine, University of London, Department of Public Health and Policy, Health Services Research Unit, London WC1E 7HT*

*Health Care Research Unit, Southampton University, Southampton SO16 6YD*

*West Anglia Resource Centre, Upwell Health Centre, Cambridgeshire PE14 9BT*

*Cambridgeshire Health Authority, Kingfisher House, Huntingdon PE29 6FH*

*Hertfordshire Primary Care Research Network, The Surgery, Letchworth, Hertfordshire SG6 4TS*

EDITOR—The paper by Hippisley-Cox et al makes an important contribution to the literature on sex differences in health service use.<sup>1</sup> Primary care physicians act as gatekeepers to specialist health services, yet this critical role in the healthcare system has been largely ignored by researchers in this field.<sup>2</sup>

Hippisley-Cox et al said that their findings suggest a systematic bias towards men in terms of secondary prevention of ischaemic heart disease. Such a conclusion is premature. The results may reflect biased decision making, but they may also have been determined by patient preferences or mutual agreement between doctor and patient. In common with other research in this area, the charge of biased decision making has been made as a result of a process of exclusion. Once it has been shown that clinical need (in this case a diagnosis of ischaemic heart disease) cannot account for the finding that women are less likely to receive a certain treatment than men (in this case, lipid lowering drugs), then the spectre of bias is raised. It would, however, be preferable to be able to demonstrate positively that clinical decision making is guided by prejudice before making claims that a service is biased.

Prejudice is very difficult to show as clinicians cannot be blinded to the sex of their patients. Alternative methods including the use of clinical vignettes, audiotaping consultations, and analysing individual patient records have been tried, but they have proved inconclusive because of their lack of context.<sup>3 4</sup> Factors shown to affect physician response, including the patient's age, ethnic group and social class, information on the presenting complaint, comorbidity, and medical history, as well as organisational and structural features, may be missing.<sup>5</sup>

Other methods need to be used to examine the extent to which inequalities, such as those reported by Hippisley-Cox et al, are due to bias. Qualitative studies, including observations of clinician-patient encounters and interviews with health professionals, patients, and their carers, are needed. Assessing clinicians' judgments at two or more points in a given clinical interaction may also help in assessing when diagnostic hypotheses are generated and how long they are adhered to in spite of contradictory information. Such techniques will clarify the extent to which differences in patient's expectations or demands, mutual agreement, and clinician prejudice influence the clinical decision making process. Such research must be undertaken to avoid unfairly tainting clinicians with the damaging label of prejudice.

## References

1. Hippisley-Cox J, Pringle M, Gown N, Meal A, Wynn A. Sex inequalities in ischaemic heart disease in general practice: cross sectional survey. *BMJ* 2001; **322**: 832–834. (7 April.)
2. Raine R. Is there really gender bias in health care use? *J Health Serv Res Policy* 2000; **5**: 237–249.
3. Schulman K, Berlin J, Harless W, Kerner J, Sistrunk S, Gersh B, et al. The effect of race and sex on physicians' recommendations for cardiac catheterization. *N Engl J Med* 1999; **340**: 618–626.
4. Kee F, McDonald P, Kirwan J, Patterson C, Love A. Urgency and priority for cardiac surgery: a clinical judgment analysis. *BMJ* 1998; **316**: 925–929.
5. Clarke JA, Potter DA, McKinlay JB. Bringing social structure back into clinical decision making. *Soc Sci Med* 1991; **32**: 853–866.

## Designating sex specific total cholesterol targets may be useful

**Sarah Wild** ([shw@soton.ac.uk](mailto:shw@soton.ac.uk)), lecturer in public health medicine, **Carol Whyman**, audit facilitator, **Marilyn Barter**, clinical governance nurse facilitator, **Kate Wishart**, general practice facilitator, **Christine Macleod**, consultant in public health medicine

*London School of Hygiene and Tropical Medicine, University of London, Department of Public Health and Policy, Health Services Research Unit, London WC1E 7HT*

*Health Care Research Unit, Southampton University, Southampton SO16 6YD*

*West Anglia Resource Centre, Upwell Health Centre, Cambridgeshire PE14 9BT*

*Cambridgeshire Health Authority, Kingfisher House, Huntingdon PE29 6FH*

*Hertfordshire Primary Care Research Network, The Surgery, Letchworth, Hertfordshire SG6 4TS*

EDITOR—Hippisley-Cox et al described sex inequalities in measurement of risk factors and treatment of ischaemic heart disease in primary care in the Trent region.<sup>1</sup> We collected similar data from a 50% sample of people with ischaemic heart disease (defined by disease codes) of 35–75 years of age from 13 general practices in north Cambridgeshire and west Norfolk in 1999. We had 415 women and 790 men in our sample. We present our findings for comparison and provide a further analysis by use of statins.

In our sample the difference ( $P=0.8$ ) in the proportion of women (66%,  $n=273$ ) and men (67%,  $n=532$ ) with any record of total cholesterol concentration was not significant. The odds ratio for cholesterol measurement for men versus women adjusted for age, diabetes, hypertension, obesity, smoking status,