Male Adolescents and Physician Sex Preference

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Objective: To investigate the physician sex preference of male adolescents and to explore the factors that may moderate this preference.

Design: Anonymous survey.

Setting: An adolescent clinic associated with a large pediatric hospital centrally located within a metropolitan Midwestern city.

Participants: The 67 male adolescent patients in the convenience sample ranged in age from 10 to 18 years, and 43.3% were African American, 40.3% were white, and 16.4% were classified as “other.” More than half of the subjects reported being raised by a single mother with just enough money to meet their basic needs.

Intervention: None.

Main Outcome Measures: Among the variables investigated were expressed physician sex preference and participant connectedness to a male and/or female parent or role model.

Results: More subjects reported a preference for a female physician (50.8%) than for a male physician (39.4%) when the examination was a physical or medical checkup. The preference for a female physician during a genital examination was also higher (49.2%) than preference for a male physician (39.1%). Analysis of variance revealed significant ethnic group differences in physician sex preference (F2,64 = 12.02, P<.001). African American males had a significantly higher preference for a female physician than did whites or those who identified themselves as other. Neither socioeconomic status nor age demonstrated a statistically significant effect.

Conclusions: This preliminary investigation has provided evidence that ethnicity of the adolescent and the sex of the examining physician may contribute significantly to the success of the health care interaction.


Editor’s Note: I hope this preliminary study will stimulate other investigators to assess physician-patient sex fit in a variety of ethnic groups and for male and female adolescents.

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ARCH PEDIATR ADOLESC MED/VOL 154, JAN 2000 WWW.ARCHPEDIATRICS.COM

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THE IMPORTANCE OF MALE GENITAL EXAMINATION

There are several reasons for the recommendation that male adolescents have a genital examination conducted by a physician. The most common malignancy for men between the ages of 15 and 34 is testicular cancer. Despite the fact male adolescents are informed about testicular cancer and the self-examination practices to detect irregularities early, they do not practice testicular self-examination. Though the evidence is inconclusive, genital trauma has been thought to be a possible cause of testicular cancer. Because research has shown that the rate of unreported genital injury is high, a physician examination of a patient’s genitals during a routine visit is imperative.

The American Cancer Society recommends that an annual clinic examination of the genitals as well as monthly testicular self-examination should be initiated during puberty. Though the incidence rate of testicular cancer has increased 200% in recent decades, patient training in testicular self-examination is lagging behind the media push for breast examinations. Today, male adolescents may hear of the important self-examination process from their school health teacher or their primary care physician. However, the embarrassment of health teachers, physicians, and patients may result in miscommunication of important information.

Because adolescents and parents are open to more comprehensive adolescent medical services, medical professionals need to emphasize testicular cancer prevention in early adolescence to promote health awareness trends into adult life. Clinic variables, such as clinic accessibility and the physician’s ability to communicate with teens, must be ideal to attract male adolescents to preventive medical services, as it is sometimes difficult to get these patients into the clinic at all.

PARENT-CHILD CONNECTEDNESS

A young male’s connectedness to and interaction with his parents affects the way he perceives and interacts with...
the world. A male adolescent’s connectedness to his father may affect how he interacts with other adult males. Male adolescents who feel attached to a father are more confident in their ability to function in society.18 Males raised by a single mother in an absent-father household have also been found to be more dependent on peers than children from dual parent households.19 This absent-father effect may differ cross culturally.20

PURPOSE OF THE STUDY

This study was designed to investigate the physician sex preference of male adolescents and to explore the factors that may moderate this preference. It has been the experience of physicians in the clinic used for recruitment that the preference of male adolescents for a physician of a specific sex seems to be moderated by ethnicity. In trying to find support for this anecdotal evidence, it was found that there is no existing information in the literature that has examined this area. This study provides a baseline for future investigation. Understanding the factors that moderate male adolescents’ preference of physician sex will help physicians increase the comfort level of male adolescents seeking medical care. The anonymous questionnaires employed in this study examined the effects of the following variables on physician sex preference: (1) type of medical examination, (2) participant connectedness to a male and/or female parent or role model, and (3) family variables.

RESULTS

SAMPLE

All participants in this study were male patients of an adolescent clinic in the central area of a large Midwestern city. Of the 81 questionnaires handed out, 67 were returned complete, for a response rate of 83%. The participants ranged in age from 10 to 18 years, with a mean age of 14.48 years. Participants were grouped into 3 ethnic categories: African American, 29 (43.3%); white, 27 (40.3%); and other, 11 (16.4%).

The socioeconomic status of the family was approximated in a single question on the questionnaire—whether their family had enough money to meet basic needs such as food, clothing, and heat. Thirty-six (58.1%) of 62 participants reported having just enough money to meet basic needs, 18 (30%) of 62 reported having more than enough money, and only 8 (12.9%) of 62 reported not having enough money.

More than half of the sample (60.9%) reported being raised by a single parent. While 34 (53.1%) of 64 reported being raised primarily by a female parent, relative, or guardian, 5 (7.8%) of 64 reported being raised primarily by a male parent, relative, or guardian. Approximately 25 (39%) of 64 participants reported being raised by both a male and female parent, relative, or guardian.

Twenty-four (42%) of 57 participants indicated that the male adult closest to them was their father or stepfather. Eleven (19.3%) of 57 respondents indicated that the close male adult in their life was a family member other than their father or stepfather, and 11 indicated that the close male adult was a friend. Nineteen percent of responding adolescents indicated never having felt close to a male adult. Although 31 (59.6%) of 52 reported living with this close male adult at some point in time, only 16 (31.4%) of 51 reported living with this person presently.

Forty-one (70%) of 59 adolescents indicated that the female adult closest to them was their mother or stepmother. Eight (13%) of 59 indicated that the closest female adult was a family member other than their mother or stepmother. Six participants reported that the closest female adult was a friend, and only 4 (6.8%) of 59 respondents reported never having felt close to a female adult. Forty-four (79%) of 56 of respondents reported ever living with this close female, and 36 (65.5%) of 55 reported living with this close female adult presently.

PHYSICIAN SEX PREFERENCE

Respondents’ physician sex preferences for a physical or medical checkup are reported first. Participants’ preferences for a male or female physician for a genital examination are then described.

Table 1 shows the statements regarding physical or medical checkups and the frequency of responses. More respondents reported a preference for a female physician than a male physician. The refusal by a patient to see a physician of a particular sex was about the same, approximately 16% for each. Less than 40% indicated that the sex of the physician mattered to them.

Table 2 shows the physician sex preference items for a genital examination and the frequency of responses. More respondents reported a preference for a female physician than a male physician for a genital examination. More respondents also indicated that they would refuse a male physician for a genital examination than a female physician. More than half of the respondents indicated that it mattered to them whether a female or male physician examined their genitals.

Table 1. Physician Sex Preferences for Physical or Medical Checkup

<table>
<thead>
<tr>
<th>Questionnaire Item</th>
<th>Yes (No. (%))</th>
<th>No (No. (%))</th>
<th>Unsure/Don’t Know (No. (%))</th>
</tr>
</thead>
<tbody>
<tr>
<td>In general, would you prefer a male physician for a physical or medical checkup?</td>
<td>26/66 (39.4)</td>
<td>29/66 (43.9)</td>
<td>11/66 (16.7)</td>
</tr>
<tr>
<td>In general, would you refuse a male physician for a physical or medical checkup?</td>
<td>11/66 (16.7)</td>
<td>43/66 (65.2)</td>
<td>12/66 (18.2)</td>
</tr>
<tr>
<td>In general, would you prefer a female physician for a physical or medical checkup?</td>
<td>33/65 (50.8)</td>
<td>20/65 (30.8)</td>
<td>12/65 (18.5)</td>
</tr>
<tr>
<td>In general, would you refuse a female physician for a physical or medical checkup?</td>
<td>11/65 (16.9)</td>
<td>47/65 (72.3)</td>
<td>7/65 (10.8)</td>
</tr>
<tr>
<td>In general, would you care whether a female or male physician examined you?</td>
<td>25/64 (39.1)</td>
<td>31/64 (48.8)</td>
<td>8/64 (12.5)</td>
</tr>
</tbody>
</table>
GROUP DIFFERENCES IN PHYSICIAN SEX PREFERENCE

The physician sex preference scale was recorded to provide an index of overall physician preference. Each item response was recorded according to the following: would refuse female or prefer male physician (0), unsure or don’t know (1), or would refuse male or prefer female physician (2). The score generated for each respondent ranged from 0 (preference for a male physician only) to 16 (preference for female physician only).

Analysis of variance was used to test the effect of socioeconomic status and age on physician sex preference. Neither socioeconomic status nor age demonstrated a statistically significant effect.

Analysis of variance was then used to investigate physician sex preference differences between ethnic groups. The analysis revealed significant group differences in physician sex preference ($F_{2,54} = 12.02, P<.001$). Post-hoc tests showed that African American males had a significantly higher preference for a female physician than did whites or those who identified themselves as other.

Further analyses were conducted to attempt to account for this difference. More than half (64.3%) of the African American males indicated that they were raised primarily by a female parent, relative, or guardian. Less than 50% of whites and those who identified themselves as other (44.0% and 45.5%, respectively) indicated that they were raised primarily by a female parent, relative, or guardian. The level of parent-child connectedness, although in the direction consistent with the sex of primary caregiver findings, did not differ significantly across ethnic groups.

COMPARISON WITH PREVIOUS FINDINGS

The increase in expressed preference of the group across examination situations was supportive of previous research findings in adult groups. Table 3 shows the differences between physician sex preferences for genital examination previously published and the preferences found in this study. Participants in the previous studies cited were all aged 18 years or older, and participants in this study were 18 years or younger. The frequency of individuals stating a physician sex preference for all genital examination was about 52% in all studies. While the preference for a male physician in this study did not differ much from Heaton and Marquez, male physician preferences found here were lower than those found by Fennema et al. The largest difference found between the findings of this study and previous results was in the frequency of female physician preference. While less than 10% of older males indicated that they would prefer a female physician for a genital examination, almost half of the respondents in this study indicated a preference for a female physician.

COMMENT

Socioeconomic status and age were not found to significantly moderate the physician sex preference of male adolescents. The effect of socioeconomic status on physician sex preference should be investigated in the future using a more extensive measure of the family financial situation. To examine change in physician sex preference as age increases, future studies must include both adult and adolescent participants.

A unique finding of this study was the significantly higher preference for female physicians among African American male adolescents. Though African American males differed from whites and those in the other category in the sex of the primary caretaker and the level of connectedness to their father or father figure, these findings were not statistically significant. There is also need for further investigation into the cultural variables and child-rearing situations that moderate disparity in physician sex preference. Future studies may investigate whether being raised by a single female parent and lack-
ing a feeling of an emotional bond to a father or other male role model affects the comfort level of young males with same-sex physicians.

These results should be interpreted with caution. The small number of participants, coupled with the low response rate and the convenience sample recruitment method, limit the ability of these data to generalize to other samples. While the convenience sample of clinic attendees is not adequate for conclusive findings, this was a preliminary investigation that provided new information not previously found in the literature. Replication with a larger, nonclinic sample is needed for more definitive results.

CONCLUSIONS

Physicians are in the position to deliver health care information that is valued by adolescents. When adolescents are satisfied with their physician, they keep appointments more consistently. The recommended frequency of genital examinations for male adolescents will be attained more easily when physicians are sensitive to sex preference. Based on these preliminary findings, sensitivity to the physician sex preference of male adolescents may be an important factor of a successful health care interaction. Future studies should investigate how the ethnicity of male adolescents and fear of a same or opposite sex examiner moderates clinic attendance.

Accepted for publication June 3, 1999.

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REFERENCES


