Male Adolescents and Physician Sex Preference

Christopher J. Van Ness, MA; Daryl A. Lynch, MD

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 ($F_{2,64} = 12.02, P < .001$). 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.

Catherine D. DeAngelis, MD

A SPECIFIC CLINIC variable that may influence the physical examination of males’ genitalia is physician sex. Previous research has indicated that the expressed physician sex preference of adult males varies with the intimacy level of the examination performed. Fennema et al$^3$ found it unlikely that patients would express a physician sex preference when the examination was for a chronic or acute medical problem. However, patients were likely to express a preference when a genital or rectal examination was involved. Weyrauch et al$^2$ found that when men expressed a preference for physician sex, almost all requested a male. Heaton and Marquez$^3$ found that 39% studied would request a male physician, 12% indicated that they would refuse a female physician, and 2% stated that they would request a female physician for a genital examination.

ADOLESCENT PREFERENCES FOR PHYSICIAN SEX

A literature search of social science (Psyclit) and medical (MEDLINE) databases yielded no studies of the physician sex preference of male adolescents for genital examination. The only article on children and physician sex preference found had to do with patient satisfaction. It reported that a child’s satisfaction with a
PARTICIPANTS AND METHODS

PARTICIPANTS

This cross-sectional study used convenience sampling for recruitment. Study participants were male adolescents between the ages of 10 and 18 years who were patients attending an adolescent clinic in a large Midwestern city.

INSTRUMENTS

The Inventory of Parent and Peer Attachment

This instrument is designed to assess parent-child connectedness, which is defined as an adolescent’s perceptions of the affective and cognitive dimensions of relationships they have with their parents. The mother and father subscales each consisted of 23 items scored on a 3-point Likert scale. The alphas for internal reliability ranged from .87 (mother attachment) to .89 (father attachment). This inventory has demonstrated convergent validity with other measures of family environment and processes. Williams and McGee found the parent attachment measures to be associated with adolescents’ perceived strengths. Williams and McGee also developed the short forms of the subscales used in this study.

Physician Sex Preference and Demographics

The researchers also developed an anonymous questionnaire that queried additional areas. Questions were designed to investigate physician sex preference for different types of examinations. Participants were asked to indicate their physician sex preference for a physical or medical checkup and for a genital examination, as well their age, ethnicity, and family variables such as primary caregiver while growing up. Specifically, participants were asked to indicate (1) if they had a close adult in their life, (2) the nature of the relationship with this close adult, and (3) whether they resided with this person. In the measure of socioeconomic status, it was assumed that adolescents would not have access to an actual family income estimate. Information pertaining to socioeconomic status was gathered using a proxy that asked the adolescent to approximate the ability of the family to financially meet their basic needs. These items were not standardized measures.

PROCEDURE

Participants were asked to complete the questionnaire. The questionnaire packet, which included an informational letter and the questionnaire instrument, was supplied to each male patient. A nurse provided the prospective participant with the questionnaire materials in an envelope. The patient was briefed by the nurse on the purpose of the research and was asked to read the materials contained in the envelope. The informational letter inside the packet explained the purpose of the research, invited them to fill out the questionnaire, and requested that they deposit the questionnaire materials into a nearby container. All prospective participants received the same materials and returned the materials in the same fashion regardless of whether they participated in the study. Participation was voluntary and responses were completely anonymous.

Data collection continued for 4 weeks. At the end of each week a researcher removed the sealed box and replaced it with a new sealed box. The questionnaires were removed and the data were compiled and analyzed using commercial software (Power System Simulator for Engineering 8.0 for Windows; Power Technologies Inc, Schenectady, NY). Statistical analyses were conducted to test for significant group difference in the physician sex preference and parent-child connectedness by ethnicity, whether the family had enough money to meet basic needs, and the sex of primary caregiver while growing up.

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. 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. This absent-father effect may differ cross culturally.

### 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

<table>
<thead>
<tr>
<th>Questionnaire Item</th>
<th>Response Category, No. (%)</th>
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<tbody>
<tr>
<td>In general, would you prefer a male physician for a physical or medical checkup?</td>
<td>Yes 26/66 (39.4)</td>
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<tr>
<td>In general, would you refuse a male physician for a physical or medical checkup?</td>
<td>Yes 11/66 (16.7)</td>
</tr>
<tr>
<td>In general, would you prefer a female physician for a physical or medical checkup?</td>
<td>Yes 33/65 (50.8)</td>
</tr>
<tr>
<td>In general, would you refuse a female physician for a physical or medical checkup?</td>
<td>Yes 11/65 (16.9)</td>
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<tr>
<td>In general, would you care whether a female or male physician examined you?</td>
<td>Yes 25/64 (39.1)</td>
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Table 1. Physician Sex Preferences for Physical or Medical Checkup.
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 ($F_{2,64} = 12.02$, $P<.001$). 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-

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<th>Table 2. Physician Sex Preferences for Genital Examination</th>
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<tr>
<td>Questionnaire Item</td>
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<tr>
<td>Would you prefer a male physician for an examination of your privates or genitals?</td>
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<tr>
<td>Would you refuse a male physician for an examination of your privates or genitals?</td>
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<tr>
<td>Would you prefer a female physician for an examination of your privates or genitals?</td>
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<tr>
<td>Would you refuse a female physician for an examination of your privates or genitals?</td>
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<td>Would you care whether a female or male physician examined your privates or genitals?</td>
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<th>Table 3. Physician Sex Preferences for Genital Examination Published Compared With Present</th>
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<td>Study</td>
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<tr>
<td>Fennema et al</td>
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<td>Heaton and Marquez</td>
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<td>This study</td>
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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 preferences. 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.

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REFERENCES