Patient Sex Role and Preference for a Male or Female Physician

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A study was undertaken to test whether a patient's sex role, as measured by the Bem Sex Role Inventory, is associated with preference for a male or female physician. One hundred ninety-three patients completed a physician preference survey and the Bem Sex Role Inventory. Thirty-six percent of patients preferred a physician of a specific sex. For women, sex role was associated with preference for a female physician ($\chi^2 = 16.14$, $P < .01$). Women with an androgynous sex role who gave a preference always chose a female physician; three fourths of women with an undifferentiated sex role who gave a preference always chose a female physician. Regardless of sex role, men who gave a preference always chose a male physician. For women, these findings support the hypothesis that sex role is associated with preference for a female physician. **J Fam Pract 1990; 30:559-562.**

Recent studies indicate that 35% of patients prefer to consult a physician of a specific sex. While women tend to prefer female physicians, and men, male physicians,[1,2] the reasons for these preferences are not well understood. Possible explanations include medical diagnoses presented,[2] female physicians' attitudes[3–5] and communication styles,[6] patients' beliefs about the sex role of physicians[7] or about the qualifications of male or female practitioners,[8] and "irrational, cultural and personal forces."[9]

Biological sex is a genetic trait, whereas sex role, a psychological construct, is a set of preferences, skills, personality attributes, self-concepts, and behaviors that is felt to be appropriate for a man or a woman. Traditional psychological theory described masculine and feminine sex roles. In the early 1970s, the androgynous sex role was defined as a combination of masculine and feminine qualities.[10–13]

Prior work has linked sex role to specific behaviors. The study reported here tested the hypothesis that preference for a male or female physician is associated with a patient's sex role.

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METHODS

Group Health of Spokane is a nonprofit staff model health maintenance organization affiliated with Group Health Cooperative of Puget Sound. Twenty-two family physicians and two general internists provide primary care for approximately 29,000 members. The Health Assessment Unit is the center for health education at Group Health.[14] At the time of this study, both new and established enrollees could receive a health risk evaluation and personal consultation with a health educator at the Health Assessment Unit. Patients requesting this health assessment service between January 1, 1986, and August 1, 1986, and who did not yet have a family physician were eligible to participate in this study. Data were collected by two full-time health educators as part of their routine 1-hour assessment interviews with patients. Both educators were female and agreed to gather data for this study.

The routine health and medical data collected on all participants in the health assessment program were obtained. After obtaining informed consent, participants were asked to complete a written physician preference survey and the Bem Sex Role Inventory. The survey requested information regarding physician preference (prefer man, prefer woman, or no preference), prior experience with Group Health providers, and additional comments.

The Bem Sex Role Inventory is a tool to identify a person's sex role: male, female, androgynous, or undif-

TABLE 1. ADJECTIVES IN BEM SEX ROLE INVENTORY

Masculine	Feminine
Defend my own beliefs	Affectionate
Independent	Sympathetic
Assertive	Sensitive to needs of others
Strong personality	Understanding
Forceful	Compassionate
Have leadership abilities	Eager to soothe hurt feelings
Willing to take risks	Warm
Dominant	Tender
Willing to take a stand	Love children
Aggressive	Gentle
Self-reliant	Yielding
Athletic	Cheerful
Analytical	Shy
Make decisions easily	Flatterable
Self-sufficient	Loyal
Individualistic	Soft-spoken
Masculine	Feminine
Competitive	Childlike
Ambitious	Do not use harsh language
Act as a leader	Gullible

ferentiated (not strongly male or female).[15] The inventory contains 40 adjectives and asks participants to rank themselves on a 7-point scale according to how closely each adjective describes their behavior. These adjectives describe stereotypical male or female behavior (Table 1).

Results were scored following Bem's guidelines.[16] Raw scores for masculinity and for femininity were calculated as the mean value of the participant's responses to "masculine" and "feminine" adjectives. Each subject was assigned a sex role by comparing his or her raw scores with the median masculinity and femininity scores for the sample. The median raw scores for this sample group (4.95, 4.85), rather than for Bem's normative sample (4.90, 4.95), were used to classify subjects into sex role categories. Following the median split technique, all patients with scores above both masculinity and femininity medians were counted as having an androgynous sex role; all patients with scores below both medians, an undifferentiated sex role. Patients with a masculinity score above the median and a femininity score below the median were considered to have a male sex role. Patients with a femininity score above the median and a masculinity score below the median were considered to have a a female sex role.

The validity of the inventory has been supported by studies showing that androgynous persons display high levels of both instrumental functioning (eg, assertiveness, willingness to take risks, ability to make decisions) and expressive functioning (eg, nurturance, understanding, gentleness).[17,18] At least 24 independent studies provide further validation of the Bem Sex Role Inventory by exploring behavioral correlates of persons with masculine, feminine, or androgynous sex roles.[19]

Data Analysis

Data were recorded in a computerized database. Marital status was treated as a dichotomous variable: either married (or living together) or not married (or not living together). Age was grouped by birthdays before or after 1945 (pre-WW II and post-WW II generations), ie, younger than 41 years, older than 41 years.

To clarify the relationships between the variables of age, marital status, sex role, and preference, cross-tabulation with calculation of chi-square values was performed. The criterion for statistical significance was $\alpha = .05$. In the analysis of sex role and preference for a physician of a specific sex, the data for men and women were analyzed separately.

RESULTS

Eight hundred twenty health assessments were done at the Health Assessment Unit during the study period. Six hundred seventeen patients were referred by their current physician and were not eligible (approximately 60%), or were seen by a health educator who did not assist in data collection (approximately 35%), or refused to participate (approximately 5%). Two hundred three survey forms were completed and returned. Ten forms were excluded from analysis for the following reasons: five were grossly incomplete, three were lost, one was illegible, and one was from a nonmember of Group Health of Spokane. One hundred ninety-three persons were included in the study group.

The study group was 37% male. Mean age was 40 years, with a range of 19 to 72 years. Ninety-five percent was white, 2% Asian, 2% Native American, and 1% black.

Sex role distribution by biological sex is shown in Table 2. Men were more often classified as exhibiting a male sex role, and women as exhibiting a female sex role. The classifications androgynous and undifferentiated taken together accounted for approximately 53% of both men and women's sex roles.

Thirty-five percent of the men expressed a preference for a physician of a particular sex. Of the men expressing a preference, 100% preferred to see a male physician. No significant relationships between sex role, age, marital status, and preference were found for the sample of men.

Table 3 shows the relationship between sex role and preference for a physician of a specific sex for the sample of women. Chi-square tests indicate that there is an asso-

TABLE 2. PERCENTAGE OF MEN AND WOMEN WITH EACH SEX ROLE

Sex Role	Men (n = 71)	Women (n = 122)
Androgynous	25	29
Undifferentiated	28	22
Female	15	30
Male	31	18
Total	99*	99*

$\chi^2 = 8.22$, 3 df, $P < .04$.
*Total is less than 100 because of rounding.

ciation between sex role and preference, $P < .01$. Thirty-six percent of the women expressed a preference for a physician of a particular sex. Of the women expressing a preference, 25% preferred to see a male physician, while 75% preferred to see a female physician. Forty-five percent (15/33) of the women who preferred a female physician were classified as having an androgynous sex role. All of the women with an androgynous sex role who expressed a preference did prefer to see a woman physician. The percentage of women with no preference was higher for women with a female sex role than for women in the other three sex role categories (78% vs 56% to 59%, respectively).

DISCUSSION

The results of this study support the hypothesis that sex role identity is associated with preference for a physician of a specific sex. For women, preference for a female physician is significantly related to sex role. For women with the androgynous sex role who expressed a preference, there was a 100% likelihood of choosing a female physician. These findings indicate that male family physicians will be unlikely to treat all members of a family that contains women with the androgynous sex role. In these cases, the definition of "the family" in family practice is affected by the relationship of sex role and preference for a female physician.

This information adds to understanding the physician-patient relationship, which is particularly relevant for family medicine.[20,21] It may help family physicians better understand a woman's request to see a female physician. The knowledge that preference for a female physician can be related to psychological factors such as sex role may reduce the sense of personal rejection felt by a male physician presented with such a request. The knowledge that many of their female patients have an androgynous sex role may interest some female physicians in applying sex role theory to interpreting certain patient interactions.

This topic is of increasing interest because of the growing presence of women in medicine,[22,23] and because family physicians of each sex do not see the same proportion of male and female patients. At Group Health of Spokane, female family physicians have patient panels averaging 75% female; male family physicians, 55% female. (These figures refer to patients assigned to a specific physician, not to patient visits.) Where male and female physicians share a practice or office, issues of patient preference could be accentuated. Since a majority of patients (64%) claimed no preference for a specific sex physician, most people may be content to see a male physician. But in areas underserved by women physicians, women who prefer to see a female physician may have no choice but to consult a male physician.

Future research might consider whether an unfulfilled (and perhaps unspoken) preference for a female physician in such cases compromises the physician-patient relationship or delays necessary medical care. Other areas of interest include the strength of preferences for a male or female physician and whether stated preferences actually correlate with selection of a family physician.

These findings are different from those of Owen and Fennema.[2] Their study reported a higher percentage of men preferring a female physician (28% compared with 0% in this study), and a lower percentage of patients preferring a physician of a specific sex (52% compared with 64%). Variations in study design, sample selection, and data collection may account for these different results.

That only 25% percent of the patients presenting to the

TABLE 3. WOMAN'S SEX ROLE AND PHYSICIAN PREFERENCE

Preference	Woman's Sex Role				
	Androgynous	Undifferentiated	Female	Male	Total
Male	0	3	3	5	11
Female	15	9	5	4	33
No preference	21	15	29	13	78
Total	36	27	37	22	122

$\chi^2 = 16.14$, 6 df, $P < .01$.

Health Assessment Unit actually participated may have produced a sample skewed to include more persons with no preference or biased in some other way, since only those patients who had not yet chosen a family physician were asked to participate. The low number of men in the sample provided inadequate power to detect for men a significant relationship between sex role and other variables.

In conclusion, this study demonstrates that while most patients give no preference for a physician of a specific sex, for women, sex role as measured by the Bem Sex Role Inventory is significantly associated with preference for a female physician. These findings have implications for the practice of family medicine and for the physician-patient relationship.

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