

# Self-Reported Comfort of Collegiate Athletes With Injury and Condition Care by Same-Sex and Opposite-Sex Athletic Trainers

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**Context:** Athletes may experience similar comfort concerns as patients in other allied health care fields.

**Objective:** To address athlete comfort with injury and condition care provided by same-sex and opposite-sex athletic trainers.

**Design:** Cross-sectional survey design.

**Setting:** Three National Collegiate Athletic Association Division I university athletic programs were invited and agreed to participate. Universities were selected by geographic location and affiliation with 3 National Athletic Trainers' Association districts.

**Patients or Other Participants:** A total of 685 athletes (341 women, 344 men) completed questionnaires (277 in the Mid-America District, 282 in the Far West District, and 126 in the Southeast District).

**Main Outcome Measure(s):** Questionnaires consisted of 17 injuries and conditions common to both female and male athletic trainer scenarios. Three sex-specific items were added to each scenario. Responses were scored on a 5-point scale anchored by 1 (*very uncomfortable*) and 5 (*very comfortable*). Participants were asked to indicate the reason for any degree of discomfort. Internal consistency, determined by Cronbach al-

pha, was .93 for the female athletic trainer scenario and .95 for the male athletic trainer scenario.

**Results:** We found significant injury and condition category-by-sex interactions for general medical conditions ( $F_{1,683} = 578.9, P < .001$ ), psychological conditions ( $F_{1,683} = 136.2, P < .001$ ), injuries to the upper body ( $F_{1,683} = 175.7, P < .001$ ), injuries to the mid-body ( $F_{1,683} = 199.1, P < .001$ ), and injuries to the lower body ( $F_{1,683} = 4.9, P < .001$ ). For gender-specific injuries and conditions, we found a difference between the mean ratings in both female athlete comfort ( $t_{340} = -26.350, P < .001$ ) and male athlete comfort ( $t_{340} = -26.350, P < .001$ ) when athletes were provided care by a female athletic trainer and a male athletic trainer. Overall, athletes appeared to be more comfortable when provided care by a same-sex athletic trainer. The most common reason reported for discomfort was gender related.

**Conclusions:** Both athletes and athletic trainers should be aware that athletes do experience discomfort, especially if the injury or condition is intimate in nature. It may be necessary to have athletic trainers of both sexes accessible to athletes to optimize the treatment received.

**Key Words:** comfort level, same-sex health care, opposite-sex health care

## Key Points

- Both athletes and athletic trainers should be aware that athletes may experience discomfort when treated by a clinician of the opposite sex.
- Athletes appeared to be more comfortable when provided care by a same-sex athletic trainer. The most common reason reported for discomfort was gender related.
- Athletic training facilities should consider having athletic trainers of both sexes accessible to athletes to optimize the treatment received.

Female and male athletic trainers exhibited similar levels of comfort in providing athletic training care to female and male athletes.<sup>1</sup> However, female and male athletic trainers displayed differences regarding self-reported comfort in caring for specific injuries and issues of female and male athletes.<sup>2</sup> As injuries and health-related issues become more intimate in nature, athletic trainers report more comfort when caring for athletes of the same sex. These findings are consistent with previous investigations of physician comfort levels.<sup>3,4</sup>

This issue of comfort has become increasingly important since the enactment of Title IX, which dramatically affected

the participation of girls and women in sport and physical activity. From 1972 to 1992, the numbers of women participating in collegiate sports increased from 16 000 to 160 000.<sup>5</sup> During this time period, the number of women in the field of athletic training also increased, most likely as a result of the increase in women collegiate athletes and the need to address their health care concerns.<sup>6,7</sup> In 1974, female certified athletic trainers totaled approximately 16, and by 1997, women accounted for 6049 (43%) of the certified athletic trainers in the National Athletic Trainers' Association.<sup>8</sup>

As an allied health care provider, the athletic trainer's primary responsibility is to assist athletes in maintaining optimal

health.<sup>9</sup> In many cases, athletic trainers are required to work with athletes of both sexes. Approximately 47% of the women surveyed in 1996 by the Women in Athletic Training Committee<sup>10</sup> indicated that they were the head athletic trainer or assistant athletic trainer for both women's and men's teams, whereas approximately 66% of men indicated that they were the head athletic trainer or assistant athletic trainer for both women's and men's teams.<sup>11</sup> Thus, both female and male athletes could find themselves receiving treatment from an athletic trainer of either sex.

A number of authors have examined patient preference for female or male health care professionals,<sup>12</sup> with a disparity in results. Some have indicated no sex preference<sup>13,14</sup>; others have revealed a preference for same-sex practitioners, in particular obstetricians and gynecologists.<sup>15–19</sup> Also, it has been reported that women patients prefer women nurses<sup>20</sup> and that younger females may prefer female nurses more often than older females.<sup>21</sup> Ackerman-Ross and Sochat<sup>22</sup> found that the clinical complaint of sexual dysfunction elicited the most polarity, indicating a same-sex physician preference, whereas the complaint of sore throat elicited the least polarity. Similarly, Kerssens et al<sup>12</sup> found virtually no sex preferences for health professionals considered more “instrumental” (eg, surgeons or anesthesiologists), but sex preference was stronger for those health professionals more likely to be engaged in intimate and psychosocial health concerns. That is, women have been found to prefer female health care providers for issues of sexual health and psychosocial issues<sup>23</sup>; men also demonstrated this trend toward male health care provider preference but to a lesser degree.<sup>12</sup> Because of this sex bias or preference, patients may be less willing to disclose medical information<sup>24,25</sup> or to reveal private thoughts or emotions<sup>12</sup> when their physician is of the opposite sex. In fact, Chur-Hansen<sup>21</sup> found that the degree of intimate disclosure was a predictive measure of same-sex preference.

Although a considerable number of researchers have examined patient preference for female or male health care professionals, the reasons for such preferences have not been identified. A commonly reported reason for same-sex physician preference is embarrassment about being treated by a physician of the opposite sex.<sup>26,27</sup> Additionally, Kerssens et al<sup>12</sup> found that the majority of patients who preferred female health professionals indicated that they are more likely to open up to females than males, whereas patients who preferred male health professionals gave the same reasons in favor of males.

Athletes may experience similar comfort or discomfort concerns with athletic trainers as do patients with other allied health care professionals; however, we found no literature in this regard. Our purpose was to address the self-reported comfort in athletes with injury and condition care provided by same-sex and opposite-sex athletic trainers. Our first hypothesis was that athletes would report more comfort when provided care by same-sex athletic trainers. We also examined the underlying reasons for discomfort related to these injuries and conditions. Our second hypothesis was that gender-related reasons (ie, discomfort with opposite-sex athletic trainers) would be more commonly reported.

## METHODS

### Subjects

Three National Collegiate Athletic Association Division I university athletic programs were invited and agreed to partic-

ipate in this study. The universities chosen for this investigation were selected for their geographic location (based on Mid-America, Far West, and Southeast Districts) and their affiliation with 3 National Athletic Trainers' Association districts (5, 8, and 9). Written permission was obtained from the athletic director at each university to contact coaches of all men's and women's athletic teams. Coaches were contacted either by telephone or e-mail to explain the study and to schedule a day and time, either during practice or a team meeting, to solicit the athletes' participation.

### Instrumentation

To generate an item pool for the Gender Comfort with Athletic Trainer Questionnaire, a list of 17 non-gender-specific athletic injuries and conditions common to athletes was created with the assistance of 3 certified athletic trainers, one of whom was an athletic training education program director. These 17 items were presented to the athletes using 2 scenarios: (1) receiving treatment from a female athletic trainer and (2) receiving treatment from a male athletic trainer. In addition, 3 gender-specific items were added to each respective scenario. This created 2 questionnaires (with 40 items each), 1 for the female athlete and 1 for the male athlete. Each scenario was prefaced with these instructions: “The following is a list of 20 injuries or conditions you may experience during sport participation. Relate each of these to your comfort level in receiving care from a female athletic trainer (or respective male athletic trainer).”

To allow for greater variability, responses to the questionnaires were scored on a 5-point Likert-type scale anchored by 1 (*very uncomfortable*) and 5 (*very comfortable*). In conjunction with each item, 4 possible reasons for any discomfort were provided. An athlete who reported being (1) *very uncomfortable* or (2) *uncomfortable* in receiving care for any injury or condition was asked to circle the most influential reason for discomfort. The categories of reasons for discomfort included *gender related*, *level of confidence in athletic trainer*, *level of experience of athletic trainer*, and *other*.

To estimate internal consistency and to eliminate items having low item-remainder correlations, the questionnaires were initially administered to 30 National Collegiate Athletic Association Division I athletes (15 women, 15 men). The Cronbach alpha was .93 for the female athletic trainer scenario and .95 for the male athletic trainer scenario. As a result of this pilot study, we decided that it was not necessary to delete any items from the questionnaire. Face validity of the questionnaire was confirmed by experts in the field of athletic training (2 athletic training program directors, 1 athletic training faculty member, and female and male senior-level athletes).

### Procedures

The Gender Comfort with Athletic Trainer Questionnaire was administered by one of the investigators to a combined total of 708 athletes at the 3 universities. The questionnaire was prefaced with an explanation of the study, including its risks, benefits, time requirements, confidentiality, the voluntary nature of completing the questionnaire, and instructions regarding questionnaire return. To maintain confidentiality, coaches and athletic trainers were asked not to be present during the data collection, and athletes were asked to place the completed questionnaire in a collection envelope. The insti-

**Table 1. Comfort Reported by Athletes With Female and Male Athletic Trainer Scenarios (women = 341, men = 344)**

	Female			Male		
	Athletic Trainer Scenario			Athletic Trainer Scenario		
	Mean	SD	Cronbach $\alpha$	Mean	SD	Cronbach $\alpha$
General medical conditions			.81			.78
Women	4.0	0.75		2.8	0.75	
Men	3.4	0.88		3.7	0.84	
Hypertension						
Women	4.4	0.80		4.2	0.83	
Men	4.0	0.95		4.0	0.93	
Urinary tract infections						
Women	4.1	0.87		2.4	1.09	
Men	3.3	1.17		3.7	1.08	
Gastrointestinal						
Women	4.1	0.89		2.7	1.11	
Men	3.4	1.12		3.8	0.98	
Sexually transmitted infections						
Women	3.6	1.20		1.9	1.06	
Men	2.9	1.25		3.5	1.15	
Psychological conditions			.86			.78
Women	4.0	0.90		3.2	0.96	
Men	3.7	0.88		3.7	0.89	
Depression						
Women	4.1	0.94		3.3	1.14	
Men	3.8	0.99		3.6	1.09	
Addictions						
Women	3.8	1.05		3.4	1.13	
Men	3.6	1.05		3.7	1.04	
Eating disorders						
Women	3.9	1.03		3.0	1.21	
Men	3.8	1.00		3.8	1.01	
Injuries to the upper body			.93			.79
Women	4.4	0.68		3.9	0.7	
Men	4.1	0.86		4.1	0.83	
Head/neck						
Women	4.5	0.73		4.3	0.82	
Men	4.1	0.94		4.0	0.94	
Shoulder						
Women	4.5	0.75		4.4	0.77	
Men		4.1	0.88	4.2	4.2	0.89
Breast/chest						
Women	4.1	0.89		2.7	1.26	
Men	4.0	0.92		4.1	0.91	
Ribs						
Women	4.4	0.76		4.2	0.93	
Men	4.1	0.93		4.2	0.91	
Injuries to the mid-body			.91			.85
Women	4.4	0.70		3.9	0.81	
Men	4.0	0.83		4.1	0.83	
Hip						
Women	4.4	0.75		4.0	1.01	
Men	4.1	0.90		4.1	0.88	
Groin						
Women	4.2	0.84		3.2	1.26	
Men	3.6	1.09		4.0	0.95	

**Table 1. Continued**

	Female			Male		
	Athletic Trainer Scenario			Athletic Trainer Scenario		
	Mean	SD	Cronbach $\alpha$	Mean	SD	Cronbach $\alpha$
Abdominal						
Women	4.4	0.77		3.9	0.98	
Men	4.0	0.91		4.0	0.90	
Back						
Women	4.4	0.74		4.4	0.84	
Men	4.1	0.91		4.2	0.90	
Injuries to the lower body			.97			.94
Women	4.5	0.73		4.4	0.77	
Men	4.2	0.89		4.2	0.88	
Ankle						
Women	4.5	0.73		4.4	0.78	
Men	4.1	0.91		4.2	0.91	
Knee						
Women	4.4	0.76		4.4	0.81	
Men	4.2	0.90		4.2	0.89	
Gender-specific: women	3.8	1.01	.90	2.0	0.97	.86
Vagina	3.6	1.22		1.7	0.97	
Menstrual dysfunction	4.0	0.98		2.1	1.13	
Pregnancy	3.8	1.13		2.2	1.19	
Gender-specific: men	2.9	1.24	.97	3.6	1.16	.97
Testicle	2.9	1.29		3.6	1.16	
Penis	2.8	1.29		3.5	1.20	
Scrotum	2.9	1.26		3.5	1.20	

tutional review board at each university approved the study before data collection began.

**Data Analysis**

For statistical purposes, the 17 non-gender-specific items were collapsed into 5 distinct categories of injuries and conditions for both scenarios. The 3 gender-specific items were also collapsed into 1 category for both scenarios (Table 1). Cronbach alpha was used to estimate the internal consistency of each category for both scenarios. Acceptable levels of internal consistency were found for all categories in both scenarios.

We used a general linear model of a mixed-design analysis of variance to examine the interaction within each category when care was provided by a female athletic trainer or a male athletic trainer. With regard to sex-specific injuries and conditions, we used a paired-samples *t* test to examine differences when the athlete was provided care by a female athletic trainer or a male athletic trainer. Results were analyzed using a .05 level of significance. Frequencies were examined with respect to sex by reason for discomfort across injuries and conditions. All data analyses were performed with the SPSS statistical software package (version 13.0; SPSS Inc, Chicago, IL).

**RESULTS**

A total of 685 athletes from the 3 Division I universities completed the questionnaire (Mid-America = 277 athletes, 40.4%; Far West = 282 athletes, 41.2%; Southeast = 126

**Table 2. Athletes' Year in School and Sex (n = 685)**

Classification	Frequency	Percentage	Women	Men
Freshman	192	28.0	97	95
Sophomore	182	26.6	92	90
Junior	178	26.0	83	95
Senior	131	19.1	67	64
Graduate	2	0.3	2	0
Total	685	100	341	344

athletes, 18.4%). Twenty-three questionnaires were incomplete and were not used in the data analyses. Athlete classifications by year in school and sex are presented in Table 2. Participants ranged in age from 18 to 26 years (mean = 19.8 ± 1.42 years). Means for each condition category are found in Table 1. The following results are presented by categories of injuries and conditions.

The Pillai trace multivariate test indicated a significant category-by-sex interaction ( $F_{1,683} = 578.9, P < .001$ , effect size = 0.459) for “General Medical Conditions.” Women reported more comfort when provided care by a female athletic trainer (mean = 4.0) than a male athletic trainer (mean = 2.8), and men reported more comfort when provided care by a male athletic trainer (mean = 3.7) than a female athletic trainer (mean = 3.4).

A category-by-sex interaction ( $F_{1,683} = 136.2, P < .001$ , effect size = 0.166) was found for “Psychological Conditions.” Women reported more comfort when provided care by a female athletic trainer (mean = 4.0) than a male athletic

**Table 3. Reasons for Athletes' Discomfort by Sex of Athletic Trainer, % (Frequency)**

Injury or Condition	Gender Related	Level of Confidence	Level of Experience	Other
Male athletic trainer scenario				
General medical conditions				
Urinary tract infections				
Women (mean = 2.4)	95.8 (207)	2.3 (5)	0.9 (2)	0.9 (2)
Men (mean = 3.7)	55.3 (21)	15.8 (6)	21.1 (8)	7.9 (3)
Gastrointestinal				
Women (mean = 2.7)	92.6 (138)	2.0 (3)	0.7 (1)	4.7 (7)
Men (mean = 3.8)	45.8 (11)	29.2 (7)	16.7 (4)	8.3 (2)
Sexually transmitted infections				
Women (mean = 1.9)	88.0 (228)	2.3 (6)	1.2 (3)	8.5 (22)
Men (mean = 3.5)	41.8 (23)	21.8 (12)	18.2 (10)	18.2 (10)
Injuries to the upper body				
Breast/chest				
Women (mean = 2.7)	98.4 (181)	1.1 (2)	0 (0)	0.5 (1)
Men (mean = 4.1)	62.5 (5)	12.5 (1)	25.0 (2)	0 (0)
Gender specific				
Vagina (mean = 1.7)	95.1 (269)	0.7 (2)	2.1 (6)	2.1 (6)
Menstrual dysfunction (mean = 2.1)	96.7 (232)	0.4 (1)	2.1 (5)	0.8 (2)
Pregnancy (mean = 2.2)	91.0 (202)	4.1 (9)	2.3 (5)	2.7 (6)
Female athletic trainer scenario				
General medical conditions				
Sexually transmitted infections				
Women (mean = 3.6)	12.9 (8)	25.8 (16)	3.2 (2)	58.1 (36)
Men (mean = 2.9)	76.6 (98)	7.8 (10)	7.0 (9)	8.6 (11)
Gender specific				
Testicle (mean = 2.9)	87.7 (114)	3.1 (4)	4.6 (6)	4.6 (6)
Penis (mean = 2.8)	89.9 (125)	2.9 (4)	3.6 (5)	3.6 (5)
Scrotum (mean = 2.9)	89.3 (117)	3.1 (4)	3.8 (5)	3.8 (5)

trainer (mean = 3.2), whereas men reported no apparent difference in comfort when provided care by a male athletic trainer (mean = 3.7) or a female athletic trainer (mean = 3.7).

A category-by-sex interaction ( $F_{1,683} = 175.7, P < .001$ , effect size = 0.205) was found for "Injuries to the Upper Body." Women reported more comfort when provided care by a female athletic trainer (mean = 4.4) than a male athletic trainer (mean = 3.9), whereas men reported no apparent difference in comfort when provided care by a male athletic trainer (mean = 4.1) or a female athletic trainer (mean = 4.1).

A category-by-sex interaction ( $F_{1,683} = 199.1, P < .001$ , effect size = 0.226) was found for "Injuries to the Mid-Body." Women reported more comfort when provided care by a female athletic trainer (mean = 4.4) compared with a male athletic trainer (mean = 3.9), and men reported more comfort when provided care by a male athletic trainer (mean = 4.1) compared with a female athletic trainer (mean = 4.0).

A category-by-sex interaction ( $F_{1,683} = 4.9, P < .05$ , effect size = 0.007) was found for "Injuries to the Lower Body." Women reported more comfort when provided care by a female athletic trainer (mean = 4.5) compared with a male athletic trainer (mean = 4.4), whereas men reported no apparent difference in comfort when provided care by a male athletic trainer (mean = 4.2) or a female athletic trainer (mean = 4.2).

For the category "Gender-Specific Injuries and Conditions," a paired-samples  $t$  test revealed a difference between the mean ratings in female athlete comfort when provided care by a female athletic trainer and a male athletic trainer ( $t_{340} = -26.350, P < .001$ ). Women reported more comfort when provided care by a female athletic trainer (mean = 3.8) than a male athletic trainer (mean = 2.0). A paired-samples  $t$  test

also revealed a difference between the mean ratings in male athlete comfort when provided care by a female athletic trainer and a male athletic trainer ( $t_{340} = -26.350, P < .001$ ). Men reported more comfort when provided care by a male athletic trainer (mean = 3.6) than a female athletic trainer (mean = 2.9).

With regard to reasons for discomfort, only those injuries and conditions reflecting an overall mean rating of less than 3.0 (indicating that the athlete was uncomfortable or very uncomfortable) were reported (Table 3). For care provided by a male athletic trainer, a greater proportion of women than men selected *gender related* as the reason for discomfort. For care provided by a female athletic trainer, a greater proportion of men than women selected *gender related* as the reason for discomfort. The most frequent reason specified in the *other* category was that it would be embarrassing to be treated by an athletic trainer of the opposite sex.

## DISCUSSION

We sought to address the self-reported comfort of athletes with injury and condition care provided by same-sex and opposite-sex athletic trainers. As hypothesized, women athletes appeared to be more comfortable in all categories of injuries and conditions when provided care by a female athletic trainer than when care was provided by a male athletic trainer. These findings are consistent with those in other allied health care fields, in which a preference was found for physicians of the same sex<sup>15-19,22,23</sup> and nurses of the same sex.<sup>20,21</sup> However, within the "Injuries to the Lower Body" category, the interaction, although significant, should not be viewed as very

meaningful because of the small effect size. This result is not surprising because of the less intimate nature of the lower body (eg, knee and ankle) and because of the findings of Drummond et al,<sup>2</sup> who found no significant differences between the mean ratings for female and male athletic trainers in caring for injuries and issues considered to be less intimate in nature (eg, hypertension and ankle, knee, back, and shoulder injuries). However, significant differences were found with regard to groin and sex-specific injuries and issues, indicating less comfort in caring for intimate injuries in athletes of the opposite sex.

Similarly, male athletes reported more comfort when provided care by a fellow male for the categories of “General Medical Conditions,” “Injuries to the Mid-Body,” and “Gender-Specific Injuries and Conditions.” Men appeared to be equally comfortable when provided care by either a female or male athletic trainer for “Psychological Conditions,” “Injuries to the Upper Body,” and “Injuries to the Lower Body.” Again, injuries to the upper and lower body could be described as less intimate in nature and, therefore, less threatening in terms of creating feelings of discomfort. This finding is similar to previous findings indicating the degree of intimacy in an interaction as a predictor of same-sex preference.<sup>12,21,22</sup>

We were surprised, however, to learn that men appear to be equally comfortable with same-sex or opposite-sex care in regard to the category “Psychological Conditions.” This finding is contrary to the findings of Kerssens et al,<sup>12</sup> who established that patients were more likely to reveal private thoughts and emotions to a health care professional of the same sex. Yet this result is similar to that of Pikus and Heavey,<sup>28</sup> who found that among males who voiced a sex preference in a psychotherapist, most preferred a therapist of the opposite sex. Men may feel that they would appear weak if they disclosed intimate emotions to other males, but further research is necessary to substantiate this supposition.

We hypothesized that the most common underlying reason reported for discomfort when provided athletic training injury and condition care would be *gender related*. Based on the overall categorical means (Table 1), female and male athletes appeared to report some degree of comfort when provided care by both female and male athletic trainers, as illustrated by means that were predominately greater than 3.0. However, upon closer inspection of specific means (ie, those injuries or conditions with a mean rating of less than 3.0), both female and male athletes report less comfort when the injuries and conditions appear to be of a more intimate nature. Both female and male athletes most commonly reported *gender related* reasons for discomfort (Table 3).

Specifically, female athletes reported some degree of discomfort when receiving care from a male athletic trainer for urinary tract infections, gastrointestinal conditions, sexually transmitted infections, injuries to the breast/chest, and all 3 gender-specific injuries and conditions. Of those women who reported discomfort, a range of 88% to 98.4% reported *gender related* as the reason for their discomfort. Similarly, male athletes reported some degree of discomfort when receiving care from a female athletic trainer for sexually transmitted infections and all 3 gender-specific injuries and conditions. Of those men who reported discomfort, a range of 76.6% to 89.9% reported *gender related* as the reason for their discomfort. This perception of discomfort when receiving care by an athletic trainer of the opposite sex may be culturally based. Specifically, female and male athletes may have underlying cultural

reservations regarding treatment of more intimate injuries and conditions by an athletic trainer of the opposite sex. This perception is perhaps embedded and, therefore, not likely to change during the course of a collegiate athletic career.

We found it interesting that, of those athletes who reported some degree of discomfort, very few chose a reason other than *gender related*. Athletes appear to feel a level of confidence in their athletic trainers, even at the prospect of being treated for injuries and conditions of an intimate nature. Also, athletes appear to feel comfortable with the levels of experience of their athletic trainers. This finding is notable in light of the results of Drummond et al,<sup>2</sup> who found that level of experience was the most common reason given by athletic trainers for discomfort in treating athletes. The most frequent response given in the other category was embarrassment, which is consistent with the work of previous researchers focusing on physician sex preference.<sup>26,27</sup> It is possible that the high frequency of gender-related responses may imply embarrassment; however, further research is necessary to ascertain this.

## Limitations

This was a quantitative study, and although reasons were examined for levels of discomfort, more in-depth information could be gathered through qualitative methods. Through qualitative methods, we could also seek suggestions from athletes as to how discomfort with opposite-sex treatment in athletic training care could be reduced or eliminated. In addition, through qualitative methods, we could examine the reasons for athlete comfort, which could be used to enhance the care provided by athletic trainers.

## CONCLUSIONS

Overall, our findings indicate potential problems in communication between the athlete and the athletic trainer. Although further research is necessary to thoroughly examine the issue of disclosure, it may be implied that discomfort reported in care provided by an athletic trainer of the opposite sex could lead to the exacerbation of specific injuries and conditions if they are not disclosed and treated. This research indicates potential practical implications. For instance, both athletes and athletic trainers should be made aware that athletes *do* experience discomfort, especially if the injury or condition is more intimate or embarrassing. We know from previous research that athletic trainers report similar feelings of discomfort.<sup>1,2</sup> It may be necessary, if possible, to have athletic trainers of both sexes accessible to athletes to optimize the treatment that is received. We encourage athletic trainers and coaches alike to be sensitive to the treatment needs and treatment comfort levels of their athletes.

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