Despite the established efficacy of colorectal cancer (CRC) screening (Levin et al., 2008; Winawer et al., 2003), more than half of the people for whom guidelines are relevant have not been tested (American Cancer Society, 2009). Although CRC screening is predicted by several sociodemographic and structural factors, such factors are difficult to modify and appear better suited to identifying at-risk groups than to capacitating interventions (Magai, Consedine, Neugut, & Herschman, 2007). A focus on modifiable factors has been called for (Guessous et al., 2010), and changing attitudes may be one particularly cost-effective approach (Winawer et al., 2003).

Viewed in that light, the fact that so few studies of CRC embarrassment exist is surprising (Inadomi, 2008; Klabunde et al., 2005; McAlearney et al., 2008; Walsh et al., 2004). Greater embarrassment predicts a lower frequency of intimate examinations (Kinchen et al., 2003; Shaw, Williams, Assassa, & Jackson, 2000; Shinn et al., 2004), including cancer screenings (Bleiker et al., 2005; Consedine, Magai, & Neugut, 2004; Denberg et al., 2005; Harewood, Wiersema, & Melton, 2002). Several considerations limit the ability of prior research to inform understanding of CRC screening. First, researchers are unclear about what aspect(s) of CRC screening contexts are embarrassing and, therefore, deterring. Second, the literature regarding ethnic and gender differences in CRC screening embarrassment is scattered and inconsistent. Finally, although some studies have been conducted among women, the potential relevance of physician gender among samples of men and women remains unclear.

Gender and Ethnic Differences in Colorectal Cancer Screening Embarrassment and Physician Gender Preferences

Nathan S. Consedine, PhD, Maike K. Reddig, MSc, Inga Ladwig, MSc, and Elizabeth A. Broadbent, PhD

Described by the established efficacy of colorectal cancer (CRC) screening (Levin et al., 2008; Winawer et al., 2003), more than half of the people for whom guidelines are relevant have not been tested (American Cancer Society, 2009). Although CRC screening is predicted by several sociodemographic and structural factors, such factors are difficult to modify and appear better suited to identifying at-risk groups than to capacitating interventions (Magai, Consedine, Neugut, & Herschman, 2007). A focus on modifiable factors has been called for (Guessous et al., 2010), and changing attitudes may be one particularly cost-effective approach (Winawer et al., 2003).

Viewed in that light, the fact that so few studies of CRC embarrassment exist is surprising (Inadomi, 2008; Klabunde et al., 2005; McAlearney et al., 2008; Walsh et al., 2004). Greater embarrassment predicts a lower frequency of intimate examinations (Kinchen et al., 2003; Shaw, Williams, Assassa, & Jackson, 2000; Shinn et al., 2004), including cancer screenings (Bleiker et al., 2005; Consedine, Magai, & Neugut, 2004; Denberg et al., 2005; Harewood, Wiersema, & Melton, 2002). Several considerations limit the ability of prior research to inform understanding of CRC screening. First, researchers are unclear about what aspect(s) of CRC screening contexts are embarrassing and, therefore, deterring. Second, the literature regarding ethnic and gender differences in CRC screening embarrassment is scattered and inconsistent. Finally, although some studies have been conducted among women, the potential relevance of physician gender among samples of men and women remains unclear.