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Research Article

THE EFFECT OF INTIMACY AND SPIRITUALITY ON WOMEN'S DOCTOR PREFERENCES IN GYNECOLOGY AND OBSTETRICS EXAMINATIONS

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Abstract: *This study aimed to address the factors affecting Turkish women's doctor preferences in gynecology and obstetrics examinations. This descriptive and cross-sectional survey study was completed with a total of 572 women aged 18 years and older. Data were collected using the Descriptive Information Form, the Body Intimacy in Gynecology and Obstetrics Scale (BIGOS), and the Spirituality Scale (SS). The proportion of women who had previously had a gynecology and obstetrics examination with a female doctor was 50.7%, and the proportion of women who would prefer a female doctor for future examinations was 53.0%. It was determined that those who had ever been examined by a female doctor and those who would prefer a female doctor scored higher on both the spirituality and privacy scales than those who preferred a male doctor ($p<0.05$). Among the women, 51.6% stated that they preferred a female physician because of comfort, 28.14% because of privacy, 25.0% because of embarrassment, and 18.0% because of their faith. Logistic regression revealed that not having a previous women's health examination, low scores on the SS, and high scores on the BIGOS were effective in preferring a male physician ($p<0.05$). The results showed that women who reported higher levels of comfort, privacy, and spirituality were more likely to prefer female doctors. It is important to consider women's cultural and spiritual values in the delivery of healthcare services, as these factors are statistically associated with preferences and perceptions observed in this study; however, no causal relationship can be inferred due to the study's correlational design.*

Keywords*: Woman, doctor, examination, spirituality, intimacy*

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1. Introduction

Regular gynecological and obstetric check-ups are essential components of preventive healthcare and play a critical role in maintaining women's reproductive health, detecting gynecological cancers early, diagnosing infections, and ensuring maternal and fetal well-being during pregnancy [1]. Despite the medical necessity of these examinations, it is known that gynecological examinations often cause embarrassment and discomfort for many women experience significant emotional distress in clinical settings, particularly when intimate body areas are exposed. The perception of these procedures as invasive, shame-inducing, or uncomfortable often leads to avoidance behaviours, delaying diagnosis and treatment [2].

Research on the influence of religion and spirituality on patients and their decisions is mixed. In a study of Muslim women, almost all female participants reported that they would prefer a female doctor for gynecology examinations [3]. A study conducted in Jordan reported that male surgeons were generally preferred for cardiovascular and orthopedic procedures, while female surgeons were preferred

for gynecological, obstetric, plastic, and breast surgeries [4]. In Lebanon, Kassouf et al. [2024] found that female physicians were seen as more compassionate and better communicators, which contributed to their preference in women's health contexts [5] Similarly, a study in Israel with Ethiopian women reported that highly religious participants showed a stronger preference for female physicians compared to their secular counterparts [6]. These regional findings offer valuable comparative insights into how religious commitment and gender norms influence women's health-seeking behaviors across Middle Eastern societies. However, their implications must be interpreted through the lens of Turkey's unique sociocultural framework. While Turkey shares a Muslim-majority population with Jordan and a tradition-based society similar to Lebanon and Israel's conservative groups, its healthcare system is shaped by both modern secular governance and centralized religious guidance from the Diyanet [7]. The Diyanet's position—allowing male doctors only when no female specialist is available—indirectly reinforces religious norms around bodily privacy and modesty. Therefore, unlike in decentralized or pluralistic religious systems, Turkish women's preferences may reflect not only personal belief but also institutional religious interpretations. By examining Turkey within this regional but distinct context, our study aims to bridge the gap between spirituality, intimacy, and physician gender preference [6]. Turkey, like many societies, reflects elements of patriarchal structure in both family life and institutional practices, which may influence women's healthcare experiences [7]. As a predominantly Muslim country, religious guidance is largely shaped by the Presidency of Religious Affairs [Diyanet], a centralized state institution. While Diyanet affirms that women may be examined by male physicians if no female specialist is available, this position may indirectly influence public perception by reinforcing gendered expectations in intimate care settings. The Turkish Religious Affairs Institution states that if there is no gynecologist of the same sex who is an expert in the field, a doctor of the opposite sex can be examined [7]. In fact, it is known that the spiritual and psychosocial needs of individuals are often as important as physical needs, if not more important [8]. The spiritual dimension should be addressed in healthcare because consensual decision-making between doctor and patient is one of the cornerstones of the current healthcare model. Knowing the patient's values and needs in the spiritual dimension supports the adequate provision of holistic care and has become an ethical task in practice [9].

Gynecological and obstetric examinations are widely acknowledged to cause significant anxiety in women due to their sensitive and intimate nature. This anxiety may arise before or during the examination, often related to embarrassment, fear of pain, or concerns about privacy and exposure. Studies have shown that women with higher levels of examination-related anxiety are more likely to delay or avoid gynecological check-ups [10,11]. In addition to psychological distress, examination anxiety may trigger physiological responses such as increased heart rate, sweating, and muscle tension, which can interfere with accurate assessment and patient comfort [12]. Addressing these pre-examination reactions through effective communication, empathetic care, and gender-sensitive clinical environments may help reduce women's anxiety and improve participation in preventive health services. In light of the factors mentioned above, it can be posited that the culture in which women reside, their personal beliefs, and their criteria for privacy all exert an influence on their reproductive health behaviors and treatments. It is of particular importance that women feel at ease during these examinations. It is crucial to respect the autonomy of women who prioritize the privacy of their bodies and adhere to religious beliefs that may differ from societal norms. Otherwise, difficulties may arise in the follow-up of women's reproductive health. Conversely, women's bodily privacy must be upheld in all instances. A review of the literature reveals the existence of studies on the privacy preferences of Muslim women in relation to their physician gender, yet there is a dearth of research examining the intersection of privacy and spirituality in this context. Although existing literature has addressed women's gender preferences for physicians and the role of modesty and religious norms, few studies have explored the combined effect of spirituality and body intimacy on these preferences. In cultures

where bodily modesty and spiritual purity are emphasized, the presence of a male physician may be perceived as a violation of that autonomy. For women who adhere to conservative religious norms, clinical settings that disregard gender preferences may challenge their internal boundaries and lead to avoidance behaviour. Spirituality is a deeply rooted aspect of individual identity and behavior, particularly in societies with strong religious traditions such as Turkey. In reproductive healthcare, where physical exposure and intimate examinations are involved, spirituality may shape women's emotional comfort, perceived modesty, and sense of bodily integrity. Investigating spirituality in this context helps uncover how inner beliefs influence clinical decisions, including physician gender preference. Without acknowledging these factors, healthcare delivery may unintentionally overlook core values that guide patient behavior, leading to avoidance or anxiety during essential examinations. To clarify the scope of this study, three key concepts are defined. Spirituality refers to a personal sense of meaning, purpose, or connection to higher values, guiding how individuals approach health decisions [13]. Privacy involves the right to control bodily exposure and personal information in healthcare settings [14]. Intimacy, in gynecology, reflects the emotional and physical sensitivity women experience during examinations [1]. Although related, these concepts are distinct; this study explores how each contributes to women's preferences for physician gender in gynecological care. This study aims to quantitatively examine the relationship between Turkish women's spirituality, body intimacy/privacy perceptions, and their physician gender preferences in gynecological and obstetric examinations. Data were collected via structured online surveys, including validated scales, to assess specific dimensions such as the preferred gender of the physician, underlying reasons [e.g., comfort, privacy, faith], and their associations with sociodemographic factors.

2. Materials and Methods

2.1. Methodology

This descriptive and cross-sectional study was conducted with an online survey in October and November 2024. The study population consisted of women aged 18 years and older who could read and write Turkish and used at least one social media platform. The power of the sample to represent the population was calculated using the G-power program. The sample size estimation was based on the primary research question: **"**Is there a statistically significant relationship between women's spirituality levels and their body intimacy/privacy perceptions in gynecology and obstetrics examinations?" To calculate the required sample size, a correlation coefficient of r = 0.203, reported by Sakhaei et al. (2020), was used as the effect size. That study investigated the relationship between spirituality and patient privacy perceptions among nursing students, a population comparable in age and cultural context to our sample. Given the conceptual overlap with our study—which also examines the link between spirituality and bodily privacy—we considered this effect size to be a conservative and appropriate estimate for power analysis. Using G*Power software, a minimum sample size of 94 participants was determined to achieve a power of 95% with an alpha level of 0.05 (We did not use Cohen's d for power analysis, as this was a correlational study. Instead, we used a correlation coefficient (r = 0.203) from a conceptually similar study [13] as the effect size input in G*Power. This value represents a small-to-moderate effect, which is appropriate for social science research. However, to ensure maximum diversity and generalizability, the final study was conducted with 572 women. We chose to expand our sample to 572 participants for several reasons:

- To increase statistical power and generalizability, particularly given the sociocultural diversity in women's spirituality and privacy experiences in Turkey.
- To enable multivariate analyses [e.g., logistic regression], which require larger sample sizes to detect stable and reliable effects.

- To better represent a wide range of socio-demographic subgroups [age, education, marital status, income, belief systems], which were important variables in the study.

No stratified or targeted recruitment strategies [e.g., advertisement, quota sampling] were used. Therefore, the sample reflects a convenience sample and may overrepresent younger, more educated, and digitally active women, which is acknowledged as a limitation.

Inclusion criteria: The study's inclusion criteria are as follows: [a] voluntary participation, [b] proficiency in Turkish [speaking, reading, and writing], [c] age over 18, and [d] having a social media account

Exclusion criteria: Exclusion criteria were as follows: [a] male gender, [b] women who did not wish to participate, [c] women without basic internet literacy, and [d] incomplete responses [i.e., participants who failed to submit the full survey via the online form].

2.2. Data Collection Tools

Descriptive Information Form, Body Intimacy in Gynecology and Obstetrics Scale, and Spirituality Scale (SS) were used as data collection tools.

Descriptive Information Form: This is a researcher-developed instrument consisting of 11 closed-ended questions designed to assess the participants' socio-demographic and background characteristics. The items included questions on age, marital status, education level, employment status, spouse's education level, family income level, religious belief status, history of gynecological or pregnancy examinations, gender of previous physicians, gender preference for future examinations, and reasons for physician gender preference. This form provided contextual data for subgroup analyses [10].

Body Intimacy in Gynecology and Obstetrics Scale (BIGOS): Body Intimacy in Gynecology and Obstetrics Scale was developed by Değirmen and Şaylıgil in 2014. It is a thirty-seven-item, five-point Likert-type scale consisting of "General Privacy," "Rights and Privacy," "Ethics and Privacy," and "Clinical Privacy" sub-dimensions. All of the statements in the dimensions are positive, and the answers given to each item were summed by scoring between 1-5. The mean values were then calculated for each item. The higher the average score obtained from the scale, the more sensitive the participants are about privacy in the relevant area. In the reliability analysis for the dimensions of the scale, Cronbach's Alpha value was determined as 0.840 [14].

Spirituality Scale (SS): Demirci (2017) developed a 5-point Likert-type scale with a unidimensional structure consisting of 6 items to evaluate the degree of individuals' spiritual experiences. The scale measures the extent to which individuals experience their spiritual beliefs in their daily lives. For example, "My belief gives me peace of mind." The Cronbach's alpha coefficient was 0.88, and the test-retest coefficient was 0.60. Low scores on the scale indicate a high level of spirituality. This is because the items are structured such that stronger agreement (e.g., selecting "strongly agree") corresponds to lower numerical values, resulting in a lower total score for individuals with higher spirituality [15]. The unidimensionality of the scale was confirmed through exploratory factor analysis in the original validation study. The Body Intimacy in Gynecology and Obstetrics Scale [BIGOS], developed by Değirmen and Şaylıgil (2014), is a 37-item instrument with a four-factor structure: General Privacy, Rights and Privacy, Ethics and Privacy, and Clinical Privacy. The original study confirmed this multidimensional structure through factor analysis, and reported good internal consistency (Cronbach's alpha = 0.84). While both the BIGOS and SS were developed and validated in Turkish populations, they have not yet been cross-culturally adapted. Nonetheless, both scales are appropriate for measuring culturally sensitive concepts such as bodily privacy and spirituality in Turkish women.

2.3. Data Collection

Participants were recruited using an online convenience sampling method. The survey link was distributed via the researchers' social media accounts [Instagram, Facebook, WhatsApp, LinkedIn] and shared within professional and personal networks. No financial or other incentives were offered. The inclusion criteria were being female, over the age of 18, able to read and write Turkish, and having internet access. Participation was entirely voluntary, and informed consent was obtained online before accessing the survey. The form was designed to ensure anonymity and required completion of all items to be submitted. A total of 596 participants accessed the online survey. Of these, 24 submitted incomplete responses and were excluded from the analysis. Therefore, the final sample consisted of 572 women. This attrition rate [approximately 4%] was within acceptable limits for online surveys and was considered in the interpretation of findings. All data were collected anonymously through Google Forms. No identifying information or IP addresses were recorded. The responses were stored securely in a password-protected Google Drive account accessible only to the research team. The dataset was used solely for academic research purposes and handled in accordance with ethical standards and data protection regulations. In the item regarding physician gender preference, participants were allowed to select more than one reason [e.g., comfort, privacy, embarrassment, faith], as multiple factors may influence their decision simultaneously.

Prior to distributing the survey, the full questionnaire was internally reviewed by a small group of 8 women representative of the target population to ensure that the items were comprehensible and that the online format was user-friendly. No major issues regarding clarity or understanding were reported, and no revisions were necessary.

2.4. Data Analysis

The data were analyzed using the Statistical Package for the Social Sciences [SPSS] version 21. In descriptive statistics, the mean, standard deviation, minimum, and maximum values are provided for numerical variables, while the number and percentage values are provided for categorical variables. A t-test was conducted to ascertain whether a significant discrepancy existed between the two groups. The analysis of variance (ANOVA) was employed to examine the differences between three or more groups. Subgroups exhibiting differential outcomes were subjected to a Tukey test for statistical evaluation. Pearson's correlation was employed to ascertain the relationships between the scales, while logistic regression analysis was utilized to identify the independent variables that exert an influence on the dependent variable. A p-value of less than 0.05 was deemed statistically significant. In our study, the variables were distributed homogeneously and exhibited a normal distribution. The variables under investigation were found to be distributed homogeneously and exhibited a normal distribution. The normality of the distribution was examined using the Kolmogorov-Smirnov test, and the homogeneity of the variances was evaluated using Levene's test. In our study, the Cronbach alpha value for the Spirituality scale was 0.93, and the Cronbach alpha value for the Body Privacy in Gynecology and Obstetrics Scale was 0.92.

2.5. Ethical Considerations

Ethical approval for the study was obtained [E-14679147-663.05-800554]. The study was conducted in accordance with the principles of the Declaration of Helsinki. The purpose of the study was explained in writing to the women participating in the study before they took part in the online survey, and a declaration of participation was obtained.

2. Results

The mean age of the participants in our study was 32.25±12.42 years. Of the participants, 39.3% (n:255) were between the ages of 18-25, 55.4% (n:317] were single, 68.2% (n:390) were university graduates and above, and 67.9% (n:216) of the participants' spouses were university graduates and above. In addition, 42.5% (n:243) of the participants had moderate income, 37.4% (n:214) had poor income, 44.4% (n:254) were employed, and 89.7% (n:513) were Muslim.

A significant correlation was found between the participants' Spirituality Scale total scores and marital status, educational status, spouse's educational status, employment status, and belief status ($p<0.05$, Table 1). In addition, a significant relationship was found between age and BIGOS total score and all sub-factor scores, educational status and BIGOS total score and all sub-factor scores except BIGOS sub-factor 3, spouse education status and BIGOS sub-factor 1 and 2 scores, and belief status and only BIGOS sub-factor 4 ($p<0.05$, Table 1).

The relationship between the socio-demographic characteristics of the participants, the total score of the spirituality scale, and the total and sub-factor scores of the body privacy in the gynecology and obstetrics scale are shown in Table 1.

Table 1. Socio-demographic Characteristics and the Relationship with Spirituality Scale Total Score and Body Intimacy in Gynecology and Obstetrics Scale Total and Sub-Factors Scores

(N:572)	n	%	SS Total Score	BIGOS Total Score	BIGOS Factor 1	BIGOS Factor 2	BIGOS Factor 3	BIGOS Factor 4
Age								
18-25 (1)	255	39.3	22.26±5.51	151.22±20.42	34.37±4.90	20.69±3.42	20.04±3.17	76.11±11.44
26-35 (2)	179	31.3	21.59±6.19	156.75±14.78	35.46±4.43	21.88±2.63	20.88±2.80	78.54±9.55
≤30 (3)	168	29.4	23.01±5.95	154.05±16.24	34.14±4.44	20.96±3.07	20.66±2.70	78.28±9.68
F			2.521	4.958	4.163	7.723	4.467	3.395
p			0.081	**0.007 (2-1)**	**0.016 (2-1.2-3)**	**0.000 (2-1.2-3)**	**0.012 (2-1)**	**0.034 (2-1)**
Marital Status								
Single	317	55.4	21.80±5.77	152.95±16.26	34.79±4.79	21.04±3.26	20.37±3.06	76.75±10.85
Married	255	44.6	22.85±5.96	154.82±16.26	34.45±4.46	21.26±2.94	20.63±2.79	78.46±9.78
t			-2.138	-1.252	.858	-.846	-1.089	-1.954
p			**0.033**	0.211	0.395	0.398	0.277	0.051
Education Status								
High School graduates at most	182	31.8	23.73±5.33	150.60±21.62	33.88±5.43	20.42±3.58	20.18±3.24	76.12±12.10
University degree and above	390	68.2	21.59±6.00	155.27±15.38	35.00±4.19	21.48±2.82	20.63±2.78	78.16±9.47
t			4.098	-2.953	-2.682	-3.841	-1.695	-2.193
p			**0.000**	**0.003**	**0.008**	**0.000**	0.091	**0.029**
Husband Education Status*								
High School graduates at most	102	32.1	23.78±5.56	151.98±17.21	33.67±4.74	20.66±3.15	20.15±2.62	77.51±10.35
University degree and above	216	67.9	21.10±6.33	155.39±15.42	34.85±4.23	21.59±2.71	20.68±2.84	78.27±9.68
t			3.654	-1.774	-2.231	-2.721	-1.603	-.642
p			**0.000**	0.077	**0.026**	**0.007**	0.110	0.521

Table 1. Continued.

(N:572)	n		SS Total Score	BIGOS Total Score	BIGOS Factor 1	BIGOS Factor 2	BIGOS Factor 3	BIGOS Factor 4
Family Income status*								
Poor (Income less than expenditure) (1)	214	37.4	22.59±5.92	152.49±19.00	34.66±4.97	20.86±3.31	20.22±2.94	76.75±10.86
Medium (Income equal to expenditure) (2)	243	42.5	22.14±5.72	155.19±15.84	34.45±4.30	21.38±2.95	20.76±2.84	78.59±9.66
Good (Income more than expenditure) (3)	115	20.1	21.94±6.16	153.22±18.96	35.02±4.74	21.18±3.10	20.39±3.11	76.63±10.98
F			0.555	1.390	0.587	1.633	1.978	2.303
p			0.574	0.250	0.556	0.196	0.139	0.101
Employment status								
Yes	254	44.4	21.28±6.31	154.54±18.08	34.66±4.72	21.39±3.29	20.74±3.02	77.76±10.52
No	318	55.6	23.06±5.38	15317±17.43	34.62±4.60	20.94±2.97	20.28±2.87	77.31±10.33
t			-3.644	0.923	0.083	1.688	1.851	0.507
p			**0.000**	0.356	0.934	0.092	0.065	0.612
Belief Status								
Does not believe	59	10.3	12.29±5.65	149.71±24.94	34.49±5.94	20.88±4.13	19.88±3.85	74.46±14.43
Muslim	513	89.7	23.41±4.70	154.25±16.66	34.66±4.48	21.18±2.99	20.56±2.81	77.86±9.81
t			-16.845	-1.866	-0.265	-0.680	-1.670	-2.386
p			**0.000**	0.063	0.791	0.497	0.096	**0.017**

X: Mean, SD: Standard Deviation, t: t-test, F: One Way ANOVA, * 318 people responded to this question. **1,2,3: Groups with differences. SS: Spirituality Scale, BIGOS: Body Intimacy in Gynecology and Obstetrics Scale

Among the participants, 69.1% (n=395) reported undergoing a gynecological or pregnancy examination, while 50.7% (n=247) indicated that the gender of the In the gynecological or pregnancy examinations that the participants had undergone, the doctor was female in 53.0% (n:303) of cases. Furthermore, 53.0% (n:303) of the participants stated that they preferred a female doctor in their gynecological or pregnancy examination.

The Spirituality Scale score of the participants who had not undergone a gynecological or pregnancy examination was found to be higher, and a significant relationship was identified between the two variables ($p<0.05$, Table 2). The scores of female doctors in the gynecological or pregnancy examination group were higher than those of male doctors. Furthermore, a significant relationship was found between the Spirituality Scale score, the BIGOS total score, and the BIGOS sub-factor 4 scores ($p<0.05$, Table 2). Furthermore, the scores of those who indicated a preference for a female doctor for a pregnancy examination were higher, and a significant relationship was identified between the Spirituality Scale score, BIGOS sub-factor 3, and BIGOS sub-factor 4 scores ($p<0.05$, Table 2).

The relationship between the participants' gynecological and pregnancy examination and doctor preference characteristics, the total score of the spirituality scale, and the total and sub-factor scores of the body privacy in the gynecology and obstetrics scale are shown in Table 2.

Table 2. The Relationship between Participants' Gynecological and Pregnancy Examination and Physician Preference Characteristics and Spirituality Scale Total Score and Gynecology and Body Intimacy in Gynecology and Obstetrics Scale Total and Sub-Factors Scores

N:572	n	%	SS Total Score	BIGOS Total Score	BIGOS Factor 1	BIGOS Factor 2	BIGOS Factor 3	BIGOS Factor 4
Gynecological or Pregnancy Examination Status								
No	177	30.9	23.11±5.06	152.39±19.65	34.70±4.79	20.80±3.25	20.39±3.03	76.49±11.31
Yes	395	69.1	21.90±6.18	154.41±16.78	34.61±4.58	21.29±3.06	20.53±2.90	77.96±9.97
T			2.287	-1.258	0.216	-1.751	-0.523	-1.566
p			**0.023**	0.209	0.829	0.080	0.601	0.118
Gender of the Doctor in the Gynecological or Pregnancy Examination So Far*								
Female (1)	247	50.7	22.94±5.33	155.82±16.76	34.91±4.44	21.41±3.01	20.67±2.83	78.83±9.75
Male (2)	158	32.4	20.80±6.86	151.14±16.64	34.20±4.43	20.87±3.21	20.22±2.95	75.85±10.31
Both (3)	82	16.8	22.36±5.71	153.50±21.60	34.89±5.54	21.06±3.45	20.44±3.30	77.11±
F			6.317	3.421	1.237	1.482	1.092	4.083
p			**0.002 (1-2)**	**0.033 (1-2)**	0.291	0.228	0.336	**0.017 (1-2)**
Doctor's Gender Preference Status in Gynecological or Pregnancy Examination								
Female (1)	303	53.0	23.73±4.88	155.38±18.10	34.76±4.84	21.43±3.29	20.55±3.03	78.63±10.17
Male (2)	35	6.1	20.71±6.51	153.88±16.68	35.09±5.82	21.51±3.14	20.51±3.25	76.77±11.40
Both (3)	234	40.9	20.61±6.47	151.70±16.92	34.43±4.18	20.71±2.85	20.38±2.77	76.17±10.45
F			21.142	2.869	0.504	3.792	0.219	3.825
p			**0.000 (1-2.1-3)**	0.058	0.604	**0.023 (1-3)**	0.804	**0.022 (1-3)**

X: Mean, SD: Standard Deviation, t: t-test, F: One Way ANOVA, * 487 people responded to this question. **1,2,3: Groups with differences. SS: Spirituality Scale, BIGOS: Body Intimacy in Gynecology and Obstetrics Scale

Participants' reasons for preferring a female doctor are illustrated in Figure 1.

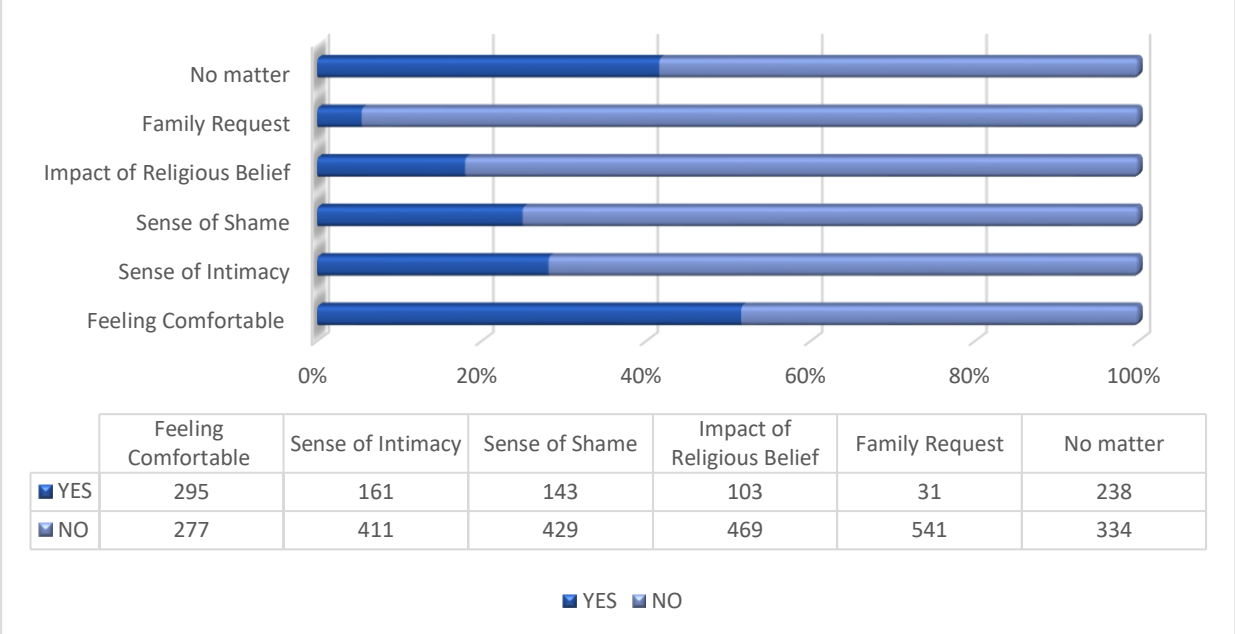

Figure 1. Participants' Reasons for Preferring a Female Doctor

The Spirituality scale total score of the participants in our study was above the average (22.27±5.88). In addition, the total score (153.78±17.73) and the mean score of all sub-factors of the Body Privacy in Gynecology and Obstetrics Scale (34.64±04.64), (21.14±03.13), (20.49±02.94) and (77.51±10.41), respectively. The mean scores of the participants' Spirituality Scale Total Score and Body Intimacy in Gynecology and Obstetrics Scale Total Scores are shown in Table 3.

A significant weak positive correlation was found between the total score of the spirituality scale and the total score and all sub-factor scores of the Body Intimacy in Gynecology and Obstetrics Scale ($p<0.01$, Table 3).

Table 3. The Relationship Between the Total Score of the Spirituality Scale and the Total Score and All Sub-Factors Scores of the Body Intimacy in Gynecology and Obstetrics Scale

Scales (572)	$\bar{X} \pm SS$	Score Range		1	2	3	4	5	6
SS Total Score (1)	22.27±05.88	6-30	r	1	.313**	.164*	.230**	.238**	.332**
			p		.000	.000	.000	.000	.000
BIGOS Score (2)	153.78±17.73	39-185	r		1	.680**	.814**	.808**	.926**
			p			.000	.000	.000	.000
BIGOS(General Intimacy) Sub 1 (3)	34.64±04.64	9-45	r			1	.500**	.509**	.418**
			p				.000	.000	.000
BIGOS (Rights and Intimacy) Sub 2 (4)	21.14±03.13	5-25	r				1	.673**	.672**
			p					.000	.000
BIGOS (Ethics and Intimacy) Sub 3 (5)	20.49±02.94	5-25	r					1	.664**
			p						.000
BIGOS (Clinical Intimacy) Sub 4 (6)	77.51±10.41	20-90	r						1
			p						

X: Mean, SD: Standard Deviation, r=Pearson correlation coefficient, *p< 0.05, **p< 0.001. SS: Spirituality Scale, BIGOS: Body Intimacy in Gynecology and Obstetrics Scale

The results of the logistic regression analysis regarding the participants' preferences for a male physician are presented in Table 4.

Table 4. Results of Logistic Regression Analysis on Women's Choice of Female Doctors

Variables	B	S.E.	Sig.	Exp(B)	95% C.I.for EXP(B)	
					Lower	Upper
Not having any Gynecological and Obstetric Examination (1)	,598	,195	**,002**	1,819	1,242	2,664
SS Total	,090	,017	**,000**	1,094	1,058	1,130
BIGOS Total	-,106	,047	**,023**	,899	,821	,986
BIGOS Sub Factor 1	,092	,057	,107	1,096	,980	1,225
BIGOS Sub Factor 2	,181	,074	**,015**	1,199	1,037	1,386
BIGOS Sub Factor 4	,124	,053	**,019**	1,132	1,021	1,255

B: Regression coefficient, SE: Standard error, Wald: Chi-square value, df: degrees of freedom, p: Level of significance ($p<0.05$), Exp (B): Odds ratio (OR). . SS: Spirituality Scale, BIGOS: Body Intimacy in Gynecology and Obstetrics Scale

Among the variables identified as statistically significant, a history of never having undergone a pelvic examination was found to increase the preference for a female physician by a factor of 1.819, while a higher score on the spirituality scale was associated with a 1.096-fold increase in preference for a female physician. Similarly, an increase of one unit on the BIGOS Total score was linked to a 0.899-fold increase in preference for a female physician, while an increase of one unit on the BIGOS sub-

factor 2 score was associated with a 1.199-fold increase and an increase of one unit on the BIGOS sub-factor 4 score was linked to a 1.132-fold increase. ($p<0.05$, Table 4).

3. Discussion

The finding that most participants preferred female physicians in gynecological settings aligns with previous research linking gender preference to modesty, comfort, and religious values. This preference appears to be particularly strong among women with high levels of spirituality, for whom bodily privacy and emotional safety are central. Rather than repeating the importance of female physician preference, these findings highlight the need for culturally sensitive practices that acknowledge patients' spiritual and privacy-related concerns.

The impact of spiritual values on women's perception of privacy during gynecological examinations has emerged as a significant area of research. The available evidence indicates that individuals with high spiritual values experience greater feelings of body privacy and embarrassment during gynecological examinations [16]. The findings of this study indicate that women's experiences of spirituality and privacy are intertwined, with both constructs being perceived as highly significant and mutually reinforcing. Additionally, the findings indicated that the majority of women expressed a preference for female doctors during gynecological and obstetric examinations. In societies where women's perception of privacy regarding health services is strong, there is a tendency to prefer a female doctor, a preference that is supported by various international studies. These studies confirm that women prefer female doctors for gynecological and obstetric examinations [3,6,17]. A study conducted in Turkey revealed that women's perception of privacy and gender preferences in healthcare services are significant, with women generally preferring female healthcare providers [18]. This is associated with factors such as ensuring privacy and cross-gender empathy [19]. Nevertheless, the findings also demonstrate the strength of women's perception of privacy in relation to health services within the community. The intimate nature of gynecological examinations leads women to prefer to be examined by female physicians to feel comfortable in this process. This can be viewed as an illustration of women's heightened sensitivity to bodily privacy. This relationship, in conjunction with the observed increase in women's respect for bodily privacy due to their spiritual values, has been found to result in feelings of reduced safety and heightened anxiety during the examination [20]. These findings underscore the necessity for health professionals to adopt a more sensitive approach, taking into account women's spiritual values and privacy perceptions.

One of the most significant findings of the study is the relationship between the gender choice of obstetrician-gynecologists, religious affiliation, and the perception of privacy. The correlation between religious observance and a greater sense of bodily privacy among Turkish women was found to be positively associated with their inclination to select a female obstetrician-gynecologist. The preference for a female doctor is not merely a personal choice; it is also a reflection of the social and cultural dynamics at play [3]. This indicates that spiritual values exert an is related to individuals' psychological and emotional states [21]. In Turkish society, girls are typically raised by their families with the guidance that they should be mindful of the openness of their bodies. Girls who are brought up in this manner are cautioned against displaying their private parts to others, particularly men. Concurrently, the genital area is associated with shame and can be conceptualized as an area that requires concealment for women for these reasons [22]. Indeed, in this study, women primarily justified their preference for a female doctor based on shame. The study identified a positive correlation between spiritual values and women's perception of privacy; however, due to the cross-sectional design, causality cannot be inferred. [2]. It is proposed that the incorporation of spiritual values into the communication of health professionals with their patients may serve to enhance the experiences of women undergoing gynecological examinations. Furthermore, women's knowledge about their own bodies can facilitate a greater sense of comfort during

gynecological examinations. Patient education enables women to gain an understanding of the examination process and to assume an active role in it. In this context, it is recommended that health institutions provide informative materials and organize seminars for women [9].

One of the important results of this study was that women who had never had a gynecology and obstetrics examination were willing to choose a female doctor. Anxiety and fear are common before and during a pelvic examination. This examination can cause negative physical and emotional symptoms such as pain, discomfort, anxiety, fear, embarrassment, and irritability [23]. On the other hand, women who have not been examined before may be ashamed of undressing, exposing their genital areas, and experiencing self-awareness due to odor and cleanliness [24]. Therefore, they may have stated that they would prefer a female doctor.

The marital status of women has a significant impact on spiritual values and cultural perceptions. Studies show that single women have a different profile in terms of spiritual values compared to married women [9,25]. In this study, married women were found to have higher spiritual feelings. McLean et al. [2012] found that there are spiritual and cultural factors behind Muslim women's tendency to prefer a female doctor for gynecological examinations [3]. This points to how individuals' lifestyles and marital status shape their spiritual perceptions and preferences. While singleness may create less social pressure and a greater sense of spiritual freedom for some women, marriage may create a greater sense of social responsibility and expectation for women, especially in environments where social norms are more dominant [26]. In this context, addressing the impact of marital status on individuals' life experiences and value systems in a sociocultural context may contribute to a better understanding of women's spiritual and psychological needs. In this study, the spiritual values of married women were found to be higher. This finding provides a critical ground for better understanding the spiritual and psychological needs of women. In addition to spirituality and perceptions of bodily privacy, women's preferences for the gender of their physicians may also be influenced by various confounding factors. Socio-economic status, including income and education level, can shape both access to healthcare and personal health beliefs. Likewise, urban versus rural residency may affect cultural norms, healthcare accessibility, and exposure to female physicians, which can all contribute to preference patterns. Previous healthcare experiences—whether positive or negative—can also play a critical role in shaping trust, comfort, and expectations in future clinical encounters. While these variables were not the primary focus of the current study, they represent important contextual elements that may interact with the main constructs examined and should be considered in future research.

Educational attainment represents a further critical factor influencing the formation of individuals' spiritual values. To illustrate, a study revealed a correlation between educational attainment and religious beliefs. Individuals with higher levels of education tend to espouse a less dogmatic and more questioning approach to religion [27]. In this study, while the spirituality values of individuals with a higher level of education were found to be lower, their body privacy was observed to be higher. This indicates that individuals with higher levels of education are better equipped to assess the information they encounter critically and are more capable of adapting their spiritual values in response to this process. As a result, the study's findings may overrepresent the views of individuals with greater access to technology and higher health literacy. This demographic skew may influence reported levels of spirituality, bodily privacy awareness, and doctor gender preferences. The influence of marital status and education level on spirituality and privacy perception should be considered within the broader cultural context. In traditional societies like Turkey, marriage often reinforces expectations around modesty and religious behavior, which may increase sensitivity to bodily privacy [3]. Similarly, higher education is linked to greater bodily awareness and autonomy, potentially reducing spiritual conformity while increasing privacy sensitivity [25]. These patterns reflect socio-cultural dynamics that merit further exploration in future studies. Therefore, caution is warranted in generalizing the results to

populations with different socio-demographic characteristics, particularly women from rural areas or those with limited internet access. Education may facilitate the acquisition of knowledge and awareness regarding the control and rights associated with one's own body. This enables individuals to gain a deeper comprehension of the significance of bodily privacy, thereby facilitating more judicious decision-making in this domain.

Incorporating spiritual values into patient communication can be supported through culturally sensitive training programs, the use of patient-centered interview models that include spiritual history [e.g., FICA tool], or providing optional spiritual care services in collaboration with religious officials or trained counselors. Studies have shown that such approaches improve patient trust, satisfaction, and compliance in sensitive areas like reproductive health [28, 29].

Limitations

One key limitation of this study is the use of an online survey, which may have introduced selection bias. The sample was largely composed of younger and more educated women, likely due to the voluntary and digital nature of participation, limiting generalizability to the broader female population in Turkey. Although this method enabled wide access and a high number of respondents, it excluded individuals with limited internet access or lower digital literacy.

While data collection was carried out meticulously and questionnaires were reviewed individually, some responses were excluded based on incompleteness or inconsistency. The measurement tools used—the BIGOS and the Spirituality Scale—have not undergone international validation or cross-cultural adaptation, making the findings specific to the Turkish context. Future research should incorporate internationally validated instruments for comparative purposes. Additionally, although religious affiliation was assessed, the degree of religiosity or religious practice was not measured. Including more detailed indicators in future research would enhance understanding of how varying belief systems affect women's health-related behaviors. Another limitation is the lack of distinction between gynecological examinations during and outside of pregnancy. These contexts differ in clinical purpose and emotional experience; analyzing them together may have obscured more specific associations. Furthermore, the term "gynecological or pregnancy examination" was not clearly defined in the survey, which may have led to variation in interpretation.

4. Conclusion

This study highlights the potential influence of privacy concerns, spiritual values, and certain socio-demographic characteristics on women's preferences regarding the gender of physicians in gynecological and obstetric examinations. Associations were observed between spirituality and privacy scores and factors such as marital status, education level, employment status, and belief orientation. These findings suggest that personal and cultural sensitivities may play a role in shaping healthcare preferences in intimate medical settings. These findings should be interpreted within the cultural context of Turkey, where religious values, gender roles, and perceptions of bodily privacy may differ significantly from those in other societies. As such, the generalizability of these results to populations in more secular or culturally distinct settings may be limited. Future cross-cultural studies are needed to examine whether similar associations hold in different contexts

This study highlights the interplay between spirituality, privacy, and women's preferences in health service delivery. The findings reveal that privacy concerns and spiritual values strongly influence women's choice of healthcare providers, particularly their preference for female physicians.

From a practice perspective, healthcare professionals should be trained to provide gender-sensitive and culturally responsive care that respects women's privacy and spiritual needs. The inclusion of private consultation spaces, respectful communication, and gender-appropriate staffing can enhance women's comfort and service satisfaction.

In education, nursing and medical curricula should integrate modules on cultural competence, spirituality in healthcare, and gender-sensitive communication to help future professionals understand diverse patient expectations.

At the policy level, health administrators and decision-makers should ensure institutional arrangements—such as female staff availability in sensitive units and privacy-protective infrastructure—are prioritized in health service planning. Implementing such policies would not only improve women's access to care but also strengthen equity and trust within the healthcare system.

By linking spirituality, privacy, and women's health preferences, this study contributes meaningful evidence for designing more inclusive and culturally grounded healthcare systems.

Ethical statement:

Ethical approval for the study was obtained from Dicle University [Date: 25.10.2024 / Number: E-14679147-663.05-800554]. The study was conducted in accordance with the principles of the Declaration of Helsinki. The purpose of the study was explained in writing to the women participating in the study before they took part in the online survey, and a declaration of participation was obtained.

Conflict of interest:

The authors must notify of any conflicts of interest.

Authors' Contributions:

E.YA.: Conceptualization, Methodology, Writing - Original draft preparation (%50)
N. K: Writing - Original draft preparation (%30).
M.A.Ş.: Formal analysis (%20).
All authors read and approved the final manuscript.

Generative AI statement:

The authors declare that no Gen AI was used in the creation of this manuscript.

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