

# Preference for Female Obstetrical Providers

Approaching Muslim patients' desire for female providers during childbirth

Sylvia Kauffman MS4

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## Introduction

The population of Muslims in the U.S. continues to grow, reaching an estimated 3.45 million in 2017 and representing 1.1% of the total U.S. population.<sup>1</sup> Muslim refugees constituted nearly half (46%) of refugee admissions in 2016.<sup>2</sup> As the number of Muslims in the U.S. increases, including individuals who have faced persecution and trauma, so does the number of Muslim patients seen in the U.S. healthcare system. In considering how to best care for this population of patients, certain preferences must be taken into consideration, as with any population. One preference that presents a challenge for healthcare providers and the healthcare system is Muslim women's preference for female providers during childbirth.

Healthcare providers strive to offer patient-centered care. From medical school and residency training to quality improvement initiatives and nationally implemented hospital evaluation systems, patient satisfaction is a fundamental priority. Medical trainees learn to agenda-set with patients, demonstrate appropriate body language, display empathy, and respect patient autonomy. A primer on cultural sensitivity is a universal component of medical school and graduate medical education. Swarms of quality improvement projects revolve around delivering more timely and efficient care to patients, and even Accountable Care Organizations incorporate data from patient satisfaction surveys into their evaluation of healthcare systems and subsequent value-based payment models. At countless levels, health care aims to be patient-centered.

At the same time, non-discrimination is held as a core American value. From the 1964 Civil Rights Act that bans employee discrimination based on race, color, sex, or ethnic origin, to hospital-specific policies, like the University of Virginia's, that protect against discrimination

based on sexual orientation, gender identity, gender expression, national origin, age, or language, we strive for equality. We have progressed to the point where, although it still happens, we are generally shocked when a patient asks for a white instead of a black physician, and such a request is unlikely to be accommodated. However, when a patient asks for a female provider in the context of obstetric or gynecologic care, the conversation becomes murky.

This paper aims to explore the religious basis for Muslim patients preferring female providers, the perspectives of immigrant Muslim women who seek obstetric care with a female provider, the perspectives of obstetrical providers who care for immigrant Muslim women, and potential approaches to dealing with Muslim patients who prefer female obstetrical providers at the University of Virginia.

## Religious Basis for Female Provider Preference

While a detailed analysis of Quranic references to cross-gender medical care is well beyond the scope of this paper, many other scholars, medical ethicists, and physicians have commented on the issue of gender and medical care. Of course, beliefs and behaviors among the dozens of Islamic sects vary. However, for the purposes of understanding immigrant Muslim women's preference for a female obstetrician, the concepts below may inform non-Muslim providers' understanding.

### 1. Modesty and dress code

The Prophet stated that modesty, for both men and women, is one of the innate characteristics of Islam (*Muwatta Imam Malik*). Women are instructed to draw their veils over their bosoms (24:30-31), and to cover parts of their body (called *awrah*) based on the audience in question. By consensus opinion (*ijma*), when women are with children, other Muslim women or when they are with men related by blood, men related by marriage, or men related

by having shared the same wet nurse (together called *mahram* males), they may uncover parts of their body except from the navel to the knees. In front of men who do not fall into the previously mentioned category, in other words non-*mahram* males, women must cover their bodies except for their hands, faces, and feet. The question of what must be covered in front of non-Muslim women is not universally agreed upon.<sup>3</sup>

## 2. Seclusion

Protecting dignity is central to Islamic law and gives rise to the regulations of *khalwah*, which is a 'situation where a man and a woman are both located in a closed space alone and where sexual intercourse between them can occur.'<sup>3</sup> In order to prevent even the accusation or suspicion of illicit relations, this situation is prohibited outside of marriage and family.

## 3. Avoiding physical contact between the sexes

Any physical contact between women and non-*mahram* men (men not related by blood or marriage) is prohibited by Islamic law based on the verse in the Qur'an that states '...nor come nigh to adultery: for it is a shameful (deed) and an evil, opening the road (to other evils)' (17:32).<sup>3</sup> A statement by the Prophet explains that 'it would be better for one of you to have himself stabbed on the head with an iron needle than to touch a woman that is illegal.'<sup>3</sup> This prohibition of contact is specific to the *awrah* parts of the body (everything except the hands, face, and feet).

In the setting of medical care, the acceptability of cross-gender interaction is highly variable. In the case of obstetrical care, some studies have documented that up to 23% of women had either no preference or preferred a male provider, although the majority of Muslim women do prefer a female provider.<sup>4,5,6</sup> Islamic bioethics prioritizes gender over religion in the order of preference for providers. For a female patient, a female Muslim provider would be ideal, a female non-Muslim provider would be the next best, a male Muslim would be the next alternative, and a male non-Muslim would be least desirable,<sup>3</sup> assuming that the skill level of the providers is equivalent. The Qur'an emphasizes the sanctity of life, strictly prohibiting suicide (4:29), and allowing exceptions for situations of need. In case of need and emergency, Islamic law permits divergence

from regulations by invoking *aḍ-Darurat tubīḥ al-maḥḍurat*: 'necessity makes for allowing the prohibited,'<sup>3</sup> which many but not all Muslims extend to include medical care from gender non-concordant providers. Similarly, while alcohol and pork are universally prohibited, it is stated that consumption of these is acceptable if the situation is dire (2:173, 6:119).

Awareness of these rulings helps non-Muslim providers understand the deeply rooted value of modesty and think about conversations or arrangements that may need to take place to provide care, with appropriate cultural sensitivity, to female Muslim patients.

## Patient Perspectives

While many providers have encountered patients who prefer female providers for their obstetrical care, there are relatively few studies that systematically present the reasons for such preferences and the perspectives of Muslim women during childbirth. A recent focused ethnography carried out in Alberta, Canada, offers the perspectives of 38 immigrant women antenatally and, of those, 21 women postnatally, the majority of whom were Muslim. All of the women interviewed stated a preference for female providers. However, they also all stated that they were willing to accept care from a male provider if a female were not available. The recurring theme was that the health of the baby was the most important factor, and that trustworthiness and competence of the provider was more important than the provider's gender.<sup>7</sup> When considering the necessity of a male provider in the absence of a female provider, many women's comments were similar to the following: "...he's doing his job in that moment, and then he will leave you in 15 min, or 20 min, right? He won't see you all day long in your private area (laughs). So yeah, so his job, and he will take care of you and your baby, so you should be open mind.' —Age 26, Somalia."<sup>7</sup>

The idea of being uncovered in the presence of or being touched by a man made many women uncomfortable. Religion, however, did not appear to be the sole motivator for preferring a female provider. Strong social norms dictating separation of the sexes meant that many women interviewed felt a need to request a female

provider, even if they were willing to accept care from a male provider. One participant explained that *“Ah, my mom, and his mom would be probably like... ‘what are you doing?’ if I went out and looked for a male doctor.” —Age 26, Somalia.*<sup>7</sup> Religion and the near-universal social norms of segregating sexes contributed to women feeling the need to state their preference for a female provider. However, most women also considered childbirth to be an “emergency” situation in which the necessity of medical care overrode the social norms of modesty. The majority expressed a sentiment similar to this one: *“I know - sometimes in different countries maybe there is more radical opinion, where they are like ok I’d rather die than not see a male doctor - but that’s extreme, that’s not what our religion prescribes, it’s just ah the necessity - the necessity of the person is prioritized, so if there’s need and there’s nothing [no female doctor] available then it’s fine.” —Age 24, Bangladesh.*<sup>7</sup> Women expressed willingness to accept a male provider as long as they had attempted to be seen by a female provider: *“Ah, because I, I did all what I can to do, I will feel comfortable. There’s no problem.” —Age 25, Saudi Arabia.*<sup>7</sup>

For some women, although willing to accept a male provider if no female provider was available, the psychological trauma of having a male provider was profound. The “double pain” of both the physical pain of childbirth as well as the emotional pain of being seen and touched by a man was described in depth.<sup>7</sup> For two of the 38 women interviewed, having a female provider intrapartum was incredibly important. One woman described her husband’s reaction after having a male provider deliver her baby: *“My husband, acted very, unusual. He didn’t talk to me, it was VERY difficult for him to stand, but he couldn’t say anything also... And after doctor [name] left I ask ‘Are you ok?’ He says ‘I feel I want to kill myself.’ —Age 31, Malaysia.*<sup>7</sup> Another woman was so distressed by having had a male provider deliver her first baby that she sought counseling, and then felt worried during her entire second pregnancy that she would have a male provider again. Her husband summarized her concerns to the interviewer: *“She worries, she scared, she everything! You know? And this is - you have yeah, any big responsibility and you can talk with him and with her to explain, because we are in this society -*

*we are Canadian too! We come an immigrant, that’s for sure, but we are now Canadian! Me I have 14 years, she has one year and a half! We have two babies they are Canadian too! They have to listen for us!” —Age 26, Tunisia (Participant’s husband).*<sup>7</sup>

Importantly, adverse health outcomes have been attributed to patients’ fear of being seen by a male provider. Delays in seeking perinatal care, higher rates of midwife-attended home births, and higher caesarian section rates because of failure to seek antenatal care have all been documented as a result of lack of female providers.<sup>8,9,10</sup> While the majority of Muslim women are accepting of a male provider if a female provider is not available, there is a minority of patients for whom a male provider during childbirth may be traumatic.

### Provider Perspectives

The perspectives of healthcare providers on the issue of gender preference vary, and are not systematically documented in published literature. The same principal investigator who studied patient perspectives in Alberta, Canada, also conducted a focused ethnographic study of providers, interviewing 10 residents and 10 staff obstetricians. Findings of this study included two predominant themes: 1) providers understood and respected immigrant women’s desire for a female provider, and 2) providers still resisted the idea of accommodating requests for female providers.<sup>11</sup>

The physicians surveyed emphasized the importance of patient-centered care and cited other examples of providers honoring patient requests. For example, *“We respect a patient’s desires to use or not use pain medication, and we respect patient desires to use natural-you know-oh I don’t know, natural birthing, versus whatever. And so I think that this is just another patient preference that is important for us to consider.” —Obstetrics resident, female.*<sup>11</sup> Providers tended to acknowledge the cultural, religious, and social context that contributed to the preference for a female provider. They also acknowledged that, as providers, they could never be fully aware of a patient’s reasons for requesting a female provider. They recognized that “many women may have come from war-torn countries where sexual violence was a systematic form of abuse,”<sup>11</sup> and that care from a male provider could in some

instances replicate the trauma of prior experiences. Providers expressed clearly their sympathy for patient's preferences and their desire to provide patient-centered care.

Despite this understanding, however, none of the 20 providers interviewed felt that the healthcare system should guarantee a female provider. The two predominant reasons for this reluctance were a) issues of gender discrimination against caregivers and b) issues of logistics and health system cost.<sup>11</sup> The topic of discrimination against male physicians and medical students led to clear opinions among some providers. One resident stated: *"I think it's pretty ridiculous that this preference for a female health care provider is condoned at our institution. I think that it's been couched as an issue of cultural sensitivity, but I also think that in Canada—we—in general—and this doesn't always happen in practice certainly—but in general, [I] feel that discrimination by sex or gender is not acceptable, but in this case, we are allowing blatant discrimination by sex. And, or I guess I should say by gender—whatever. I don't really know if I agree that it's an issue of cultural sensitivity. I think these people are now interacting with the healthcare system in Canada, and that may or may not be by choice, depending on their circumstance, but um I think like their ability and their freedom to express their cultural norms, or their cultural milieu within Canada should not kind of supersede our policy of non-discrimination."* —Obstetrics resident, female.<sup>11</sup> Other providers, particularly ones who had lived through an era of gender discrimination against females in medicine, felt strongly that discriminating against males was equally unacceptable. Some felt that honoring preferences for gender could lead to the acceptance of other forms of discrimination: *"I think it's a fine line, but I think the other thing is that once you start to make exceptions then you set a precedent."* —Staff obstetrician, female.<sup>11</sup>

In addition to the issue of gender discrimination, providers felt that accommodating gender requests would unduly burden the health care system and providers. Scheduling on-call providers allows the judicious use of resources and the protection of a work-life balance by giving providers designated time off. Calling in female providers when a male provider is present was

unacceptable to most providers because *"it's a huge drain on the system, it's a huge use of resources, and I'm not sure that it has anything to do with quality of care, and these people aren't denied care. They have choices, but I think they have to understand... that we may be able to accommodate their requests, but we're not going to guarantee that."* —Staff obstetrician, female.<sup>11</sup>

Furthermore, providers expressed a desire to have a well-defined policy on how to respond to a patient's request for provider gender. Physicians wanted to avoid ambiguity and inconsistency, and felt that an institutional policy would *'make people more empowered to say that we aren't sexist here, and we have support not to be sexist, because we're all having the same opinion about that. And so I think if we work together as a group about that, it would be a lot easier for everybody, and you would never feel like you are discriminating, or not providing patient-centered care.'* —Obstetrics resident, female.<sup>11</sup>

Anecdotally, a convenience sample of faculty, residents, and medical students at UVA expressed a diversity of opinions. Some providers (and soon-to-be providers) felt that, in an ideal world, all obstetrical care would be provided by females, and gender preferences would be honored. Some felt that honoring gender preferences was tantamount to gender discrimination and that gender preferences should not be honored. Others felt uncertain and did not voice a strong stance on when or how to honor gender preferences.

### **Ideas for the University of Virginia Family Medicine Department**

The challenge of accommodating Muslim patient's requests for a female provider has led to ethically challenging and potentially dangerous situations on more than one occasion at UVA. In conversations with residents and faculty, it is apparent that these situations have caused distress to providers and, likely, to a small number of patients. While there is no clear hospital policy on precisely how to respond to a patient's request for a female provider, the UVA Health System cannot, at this time, guarantee a particular gender of provider for intrapartum care. Based on thoughts from physicians and staff who work with the

refugee community in Charlottesville, there are several potential avenues for responding to the obstetrical needs of Muslim patients. These ideas can be grouped into two categories: 1) information gathering, and 2) managing expectations.

- 1) Information gathering: while most providers at UVA understand, at least in part, the request for a female provider, physicians have expressed the desire for more information. It would be helpful to understand why some patients have refused male providers even in emergency situations, and why some patients have refused male non-obstetrical providers (e.g. anesthesiologists) when female providers were not available. Table 1 lists ideas for how to deepen providers' understanding of patients' perspectives in Charlottesville.
- 2) Managing expectations: in addition to seeking a better understanding of why certain patients express such strong gender preferences for their obstetrical care, it is critical to communicate clearly to patients that UVA is unable to guarantee the gender

of any portion of the care team. Table 1 also lists ideas for how to guide and document essential discussions with patients prenatally.

### Conclusion

Providing optimal, patient-centered obstetrical care for Muslim patients requires an understanding of religious beliefs, societal norms, and individual preferences. Respectfully responding to a patient's request for a female provider entails a conversation about the patient's values and preferences, and necessitates a careful explanation that, at the current time, a female provider cannot be guaranteed. While most Muslim patients are willing to accept a male provider if no female provider is available or in case of emergency, there are some women whose preference for a female provider is strong enough that they refuse care from a male provider. As the University of Virginia continues to provide obstetrical care for Muslim women, it is vital that we better understand these strong preferences and develop a policy for how to avoid precarious or even dangerous situations for patients and providers alike.

**Table 1. Potential next steps for developing a policy to approach requests for female obstetrical provider**

<i>Information Gathering</i>
<ul style="list-style-type: none"> <li>• Meeting with imams, respected Muslim women, and Muslim physicians</li> <li>• Meeting with Family Medicine OB providers and IRC case managers who have worked with Muslim women with provider gender preferences</li> <li>• Meeting with pregnant Muslim women, Muslim women who have given birth in Charlottesville (both with male and female providers), and Muslim women who have given birth in all-female health care settings (perhaps in Afghanistan)</li> <li>• Determine how other hospitals or family medicine residency programs handle patient requests for provider gender</li> </ul>
<i>Managing Expectations</i>
<ul style="list-style-type: none"> <li>• Utilize a Smart Phrase to document discussions with patients on the following points: <ul style="list-style-type: none"> <li>[ x ] Patient understands that UVA cannot guarantee the gender of the provider, but will try within reason to offer a female provider if available. The patient must understand that her obstetrical provider could be a male.</li> <li>[ x ] Patient understands that although we will try within reason to have only females present, there could be males in the room if necessary, even if the obstetrical provider is female, including but not limited to: OB, family medicine, anesthesiology or pediatrics residents,</li> </ul> </li> </ul>

anesthesiology or pediatrics attending physicians, nurses, and medical assistants.

[ x ] Patient understands that great care will be taken to prevent a situation in which she and a male are alone in a room.

[ x ] Patient understands that she is free to transfer her care elsewhere if she chooses not to accept the possibility of having any males in the room. However, she also understands that we are not aware of anywhere in the Charlottesville area where 100% female-provided care can be guaranteed.

- Have patients sign a form stating an understanding that UVA cannot guarantee a female provider at delivery, and remind patient that she is free to transfer care
- Provide a list of places where a female midwife or OB could be guaranteed, but with the knowledge that a female anesthesiologist or an all-female team cannot be guaranteed.
- Offer a list of people with whom the patient can speak prior to delivery about her concerns and questions, possibly including:
  - a. UVA chaplain service
  - b. Muslim women who have delivered babies at UVA
  - c. Local Imam
  - d. Female Muslim physicians
  - e. Ethics consultation service

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