Provider Gender: A Barrier for Immigrant Women's Obstetrical Care, from the Patient and Provider Perspectives

by

Christa Lynn Aubrey

A thesis submitted in partial fulfillment of the requirements for the degree of

Master of Science

in
Global Health

School of Public Health
University of Alberta

Abstract

Objectives: To explore the barrier of obstetrical provider gender for immigrant women, to understand the importance, effect, and challenges of having a male provider intrapartum, from the patient and provider perspectives.

Method: A focused ethnography was conducted using purposive and convenience sampling of 38 immigrant women, and 20 obstetrical care providers (10 resident and 10 staff obstetricians) from one hospital in Edmonton, Alberta, Canada. Data collection comprised of semi-structured interviews antenatally (38) and postpartum (21), and observation intrapartum (17) for patient respondents, and a single semi-structured interview for provider respondents. Interviews were audio-recorded and transcribed verbatim. Data was managed using Quirkos software, and analyzed by thematic analysis.

Results: From the patient perspective, although all women preferred a female provider, influenced by a culture of modesty and often interwoven with Islam, they would accept care from a male provider. Nonetheless, all women experienced varying degrees of psychological stress from having a male provider intrapartum, which for a small minority led to significant and potentially serious consequences. From the provider perspective, physicians empathized with women, and respected their autonomy to prefer a female provider. However, they were resistant to accommodating these requests, citing concerns regarding the structure of the health system, difficulties ensuring coercion-free patient decision-making, implications for training and quality of care, and fear of perpetuating and exacerbating gender inequalities in medicine.

Conclusion: A key finding of this study was that despite their preferences, women would accept care from a male provider. However, the implications of accepting this care differed, and for a small minority were significant, manifesting in delayed care seeking, psychological disturbance,

and interpersonal relationship stress. There is a need to identify these women who are at risk of significant negative outcomes, in order to respond appropriately. Viewing this issue in the context of acculturation may help physicians to both conceptualize the preference for a female provider in a balanced perspective, and help to inform subsequent responses to this and other issues that arise in intercultural contact in the healthcare system.

Preface

This thesis is an original work by Christa Aubrey. The research project, of which this thesis is a part, received research ethics approval from the University of Alberta Research Ethics Board, Project Name "Provider Gender: A Barrier to Immigrant Women's Obstetrical Care from the Patient and Provider Perspective", No. Pro00053429, 30/07/2016.

Dedication

To my incredibly supportive and loving husband Chris, and my beautiful daughter Elizabeth.

Acknowledgements

I am deeply grateful to my supervisor, Dr. Zubia Mumtaz, who has been a huge advocate for my success in this program. From my initial meeting with her until the final stages of my degree she has been open and honest with me, challenging me to push my own boundaries. The support and guidance she has shown me will carry me throughout my career as a clinician and researcher. I would not have been able to complete this study also without the support of Dr. Hajra Danial, Dr. Amanda Aiken, and Dr. Gulnaz Jiwa. Despite their extremely busy clinics they provided me both with the space and ability to recruit patients. Thank you to my supervisory committee Dr. Peter Mitchell, Dr. Rhadha Chari, and Dr. Linda Bartlett, for the guidance and advise along the way. Cheryl Lux was an immense logistical support and advocated for my research being a priority in labor and delivery. For all the patients, and resident and staff physicians who took time out of their immensely busy schedules to participate in this study I am so appreciative. Finally, for the support and patience of my family and in-laws, thank you from the bottom of my heart. I owe this degree to the support granted by my husband Chris. Without you I would not be who I am, or where I am, and you are with me every step of the way on my very long (and at times tedious) educational and life journey.

Table of Contents

List of Tables

List of Figures

Chapter 1: Introduction and Literature review, Manuscript #1

Abstract

Having a male obstetrician/gynecologist can be particularly problematic for some immigrant women whose religio-cultural ideals instill a strong preference for female providers. A synthesis of the published literature is presented to explore this preference, and providers' understandings—identifying challenges and potential solutions. Fifty-four articles were identified using five databases, ten where provider gender was a central focus. Preference for female obstetrician/gynecologists was demonstrated. Although many will accept a male provider, psychological stress, delays, or avoidance in seeking care may result. Providers' views were captured in only eight papers, with conflicting perspectives on responding to preferences, and the health system impact.

Introduction

Gender of the provider has been a contentious issue in obstetrics and gynecology since the medicalization of childbirth [1]. Historically, childbirth was a woman's domain [2]. The term '*Midwife*', originating in Old English, literally means 'with woman' [3]. It was only after the 1700's when a more technological approach to childbirth gained momentum in Europe and North America that professional medical men were involved [4]. A male's presence at childbirth, however, remains contested with a majority of women worldwide continually stating a preference for a female obstetrician/gynecologist [3]. For women originating from religio-cultural environments where seclusion and separation of genders is a societal norm, preference for female providers holds even greater importance [5,6].

With increasing movement of populations from the Middle East, Africa, and South Asia to Europe and North America, the issue of the gender of provider is gaining significance. In general, immigrant women in receiving countries have been shown to be at an increased risk of adverse obstetrical outcomes [7-12]. It is therefore imperative to understand and address existing barriers related to gender of the provider and how this may influence receipt of services.

Clinical guidance for providers on how to respond to such requests is contradictory. A patient's refusal of care on the basis of gender could be interpreted as gender discrimination [13]. In the UK, Makam et al. (2010) called for clear clinical guidelines in both medical schools and the Royal College of Obstetricians and Gynaecologists to "prevent discrimination against men"(pg 443) [13]. In Canada, the Canadian Medical Protective Association advises "making reasonable efforts to accommodate a patient's request, based on cultural or religious grounds, to be treated by another physician" [14]. In contrast, the Society of Obstetricians and Gynaecologists of Canada states "provision of services cannot and should not ever be based on gender, race, sexual orientation, age, practice patterns or religious affiliations of either the patient or the provider" [15].

Acknowledging the rights of both patient and provider, especially in the acute obstetrical setting often presents a dilemma. This narrative review aimed to broadly explore and synthesize current evidence surrounding women's preference for female physicians in obstetrics and gynecology, and providers' understandings—specifically identifying reasons for preferences, challenges in negotiation, and potential solutions to providing equitable care. An effort was made to focus on women migrating from conservative religio-cultural environments to Europe and North America.

Methods

From August 2015 to January 2016, a comprehensive search of peer-reviewed literature describing gender preferences for obstetric/gynecological providers held by non-Western women, or women from non-Western countries was done. Five databases (MEDLINE, EMBASE, CINAHL, GLOBAL HEALTH and SCOPUS) were searched using combinations of search terms related to immigrant, refugee, or Muslim women, and obstetrics or gynecological provider gender preference. Bibliographies of relevant papers were also reviewed. The first and second rounds of screening involved reviewing titles and abstracts to identify potentially relevant studies. The third-level of screening consisted of a full review of remaining articles to ascertain relevance in relation to the inclusion criteria (Figure 1).

Since the focus was to look at this issue among women migrating from significantly different religio-cultural environments, eligible articles included peer-reviewed publications (qualitative, quantitative, or review articles) that met the following criteria: 1) discussed either the patient or provider perspective of women's preference for a female obstetrics or gynecological care provider among immigrant women in Western settings, and non-Western settings where seclusion and separation of genders is a societal norm; 2) English literature. No limitations were placed on the date of publication.

Results

572 records were identified, and after duplicates were removed, 407 records were screened in the first round of screening titles and abstracts. A total of 126 articles were assessed for eligibility, of which 54 met the criteria to be included (Figure 1). These included 29 qualitative studies reporting findings from interviews and focus groups, 20 cross-sectional studies reporting results of structured questionnaires, three mixed-methods studies, one systematic review, and one meta-

ethnography. Only ten articles focused specifically on the gender of the provider. Three of these discussed physician gender preference among immigrant women (Table 1), while the other seven explored physician gender preference in non-Western settings (Table 2). All ten were cross-sectional surveys, eight of which explored reasons for women's preference for female physicians. The remaining 44 articles explored women's preferences for female providers as one variable amongst a range of experiences, expectations, and barriers accessing reproductive health services. These studies were divided again into those that discussed patient preference for provider gender specifically in the context of immigrant populations (n=34), and those that explored it in non-Western settings (n=11). While an objective of this review was to describe provider perspectives of patients request for female providers, only eight studies were identified which explored this issue.

Perspectives of female patients

Preference for female providers

A key finding of all studies, both qualitative and quantitative, was a preference for female providers. A systematic review of immigrant and non-immigrant women's experiences of maternity care in Australia, Canada, Sweden, UK and United States, indicated a strong preference female obstetricians among immigrant—particularly Muslim women [5]. A cross-sectional study of perceived barriers to perinatal care reported 77% of South Asian women stating a preference for female obstetricians compared to 27% of Canadian-born women [6]. Similar results were reported from different groups of immigrant populations in Australia, Canada, the US, UK, Switzerland, New Zealand and the Netherlands [16-24]. Additionally, in non-Western settings, cross-sectional studies from Syria, Kuwait, the United Arab Emirates, Iraq and

Israel, indicated that roughly 75-95% of women preferred female obstetrician/gynecologists [25-32]. Notably, the preferences were lower in Egypt (41%) [33], Turkey (32.3%) [34], and Nigeria (36.7%) [35].

In a qualitative study, Saurina et al. (2010) reported that Gambian and Moroccan women in Spain would not accept care from a male gynecologist [36]. Similarly, a qualitative study of African refugee women in Rochester, NY, USA, found that in an emergency only five out of 18 women would accept care from a male physician [20]. With regards to obstetrical care, a qualitative study of migrant Arab women in the UK [37], and another of Muslim immigrant women in Canada [17] demonstrated that male providers were not always accepted. Additionally, in a qualitative study of healthcare providers' perspectives of providing antenatal care to immigrant women in Canada, providers stated that many immigrant, particularly Muslim women, insisted on seeing a female provider, and if one was not available they would at times refuse care altogether [38].

Acceptance of male providers

While maintaining a strong preference for female physicians, a number of studies highlighted that women understood this choice may be limited, and would consequently accept care from male providers. These findings were highlighted in qualitative studies of African refugee women accessing obstetrical care in Australia [39], of Somali women accessing prenatal care in the United States [40], and immigrant Muslim women in accessing healthcare in rural United States [41]. Similarly, for cervical cancer screening, a qualitative study of immigrant women in Canada [42], and a cross-sectional study of Arab Muslim women in the United States [43] demonstrated that in the absence of female providers, males were accepted.

Emergency situations were widely recognized as exceptions to women's insistence on female providers. For example, in a qualitative study of Somali immigrant women's beliefs regarding pregnancy and birth, women were noted to accept male providers if they were in danger, or if it was perceived as an emergency [44]. Similar findings were demonstrated in Muslim immigrant women in Canada [45] and women in Iraq [27]. The desire for a safe delivery was also shown to override the desire for a female provider among rural women in Lebanon [25].

Despite accepting male providers in certain contexts, women wanted their provider to know they preferred a female. This was demonstrated in a mixed methods study of Afghan immigrant women's experiences of maternity care in Australia [46] and in a qualitative study of Muslim immigrant women's experience with maternity care in Canada [17]. Additionally, in a qualitative study exploring the barriers that Muslim and Christian women in Nigeria face in receiving cervical cancer screening, all women were found to be more accepting to have a male provider if a female chaperone was available [47].

Competency of provider more important than gender

Despite significant evidence of preference for female providers, empiric evidence suggests women prioritize provider competence over gender. A cross-sectional study looking at provider and patient perspectives of challenges of providing care to Muslim women in the USA, found that 12% of providers felt restrictions in cross-gender encounters interfered with care provided by male providers. However, this was not identified by any patients. The same study reported that 18 % of providers felt gender concordant encounters contributed to a positive experience, only 9 % of patients held this understanding [48]. Furthermore, a British qualitative study found that while providers assumed the gender of the provider would be very important for immigrant women, women themselves actually valued competency and respect [49]. Similarly, two cross-

sectional studies from Israel looking at gender preference for providers in Muslim Israeli-Arab, and the ethnic minority Druze women, found that despite preferring a female obstetrician/gynecologist, women identified the most important factors in physicians were experience, knowledge, and ability [28,50].

Reasons for preference of female providers

Findings from the literature provided a number of reasons for women's preference for a female provider. These can be broadly divided into 1) Religious reasons; and 2) Comfort with a female provider.

Religious influences

As discussed, delays in seeking healthcare were evident among many immigrant women preferring female providers, but were particularly more common in Muslim women. A number of studies identified religious beliefs to be associated with preference for a female care provider. Chaliha & Stanton (1999) found that among women with urinary incontinence, all Muslim women and approximately half of the Hindu women in the study preferred a female doctor, while Jewish and Christian women had no preference [51]. In Nigeria, Muslim women were 2.1 times more likely to prefer a female obstetrician/gynecologists than non-Muslim women [35]. In another Nigerian study, despite preference for female providers, while Christian women would accept a male provider, Muslim women would not always [47]. In Israel, 90% of Muslim Arab women, compared to 47% of immigrant (from the former USSR), and 29% of Jewish women had a female gynecologist, suggesting gender may be an important religious and cultural factor [52]. Religion (Islam) was also mentioned as a determinant of women's preference for female obstetrician/gynecologists for various groups of immigrant women in Canada [6,17,42,45], Australia

[53], the Netherlands [22], and the United States [20,40,41,43], and for women in the United Arab Emirates [30,54], Iraq [27], and Egypt [33] accessing reproductive health care services. Additionally, obstetric/gynecologic providers attributed cultural and religious reasons to be form the basis for patients preferring female providers [38,48,49,55,56].

Gender-concordant care was found to be frequently requested by American Muslim patients, related to privacy, and concerns about modesty, and influenced health seeking behavior [57]. In Ghana, Muslim women experienced barriers in accessing skilled obstetrical care due to religious obligations to maintain bodily sanctity through modest dressing and avoidance of exposure [58]. Additionally, exposure to male physicians for antenatal care was perceived as psychologically difficult for many women [53], and although permissible in an emergency, often induced stress among expectant mothers [45]. Muslim women in rural United States reported this stress felt with male healthcare providers to be due to religiously defined gender barriers rooted in concepts of *awrah* and *kulwah*, and tried to rationalize their interactions with male providers in order to make it seem acceptable [41].

Comfort with female providers

Obstetrics and gynecology as a practice entails exposure to socially constructed "private areas" of the body. A large number of studies alluded to this phenomena as a reason women preferred female providers. Lebanese women, for example, described their preference for female providers because having a male bothered them *"more psychologically than physically"*(p106) [25]. A cross-sectional study from Turkey showed that 32.2% of women preferred a female provider, because of communication, embarrassment and comfort, while only 5% of them stated religion as a reason for their preference [34]. In Israel, both Arab-Israeli and Druze women explained their

preference for a female gynecologist in terms of comfort, and their perception that female providers were more gentle [28,50]. Among women declining cervical cancer screening in India, 11.6% stated their reluctance was due to shyness with male physicians [59]. Similarly, embarrassment and comfort, were reasons provided by South Asian Muslim women failing to seek care for menorrhagia in Britain [60]. Among Vietnamese patients, female healthcare practitioners were preferred, as birth was considered a woman's event [61], stemming from cultural Confucian teachings of privacy and modesty [62]. Pakistani women in the UK perceived female providers as more able to provide advice on contraception [18], while Hindu women in the UK reported their preference as a personal one [51].

Finally, there is some evidence that male providers may also feel uncomfortable providing reproductive care to certain groups of immigrant women, knowing their preference for a female provider. In a qualitative study of Vietnamese women's participation in breast and cervical cancer screening, general practitioners felt uncomfortable performing gynecological exams on women, due to awareness of the patient's preference for a female provider [62]. Similar findings were also reported in a qualitative study from Britain with general practitioners seeing South Asian women for complaints of menorrhagia [63].

Consequences of denial of request for female providers

For a significant proportion of women a preference for a female provider led to serious consequences. For example, Sange et al. (2008) demonstrated that a number of younger immigrant women with urinary incontinence were unwilling to see a male provider, and would not disclose symptoms for fear of being examined [64]. These findings were echoed in a qualitative study of South Asian women with menorrhagia in Britain [60] and in a recent qualitative study

exploring communication challenges among immigrant women in rural Canada, most prominently among Muslim women [65]. In a mixed methods study, higher rates of Cesarean sections among Syrian refugee women in Lebanon was postulated to have resulted from avoidance in seeking antenatal care due to the lack of female providers [66]. In Ottawa, Canada, results from a focus group of Muslim immigrant women found that many opted for home births with a midwife, to ensure a female provider [45]. Muslim women in Nigeria [47] and Somali women in the United States [20] have been shown to decline cervical cancer screening when no female provider was available. In an attempt to quantify this, Vu et al. (2015) conducted a cross-sectional study of 254 Muslim women in the United States, and found that 53% of women reported delays in seeking healthcare as a result of a lack of female clinicians, greater delays correlating to Muslim women of higher religiosity (OR 5.2) [67].

Provider Perspective

The limited literature on provider perspective indicates wide variation in their reaction to immigrant women's preference for female providers. While some empathized and tried to accommodate, others were less open. In a US study, 15% of providers identified availability of a female obstetrician as a key element of culturally congruent care [48]. Similar findings were echoed in an Irish study where providers were willing to accommodate requests, but highlighted its challenges [56]. In contrast, however, a Finnish study showed that providers, (both male and female, n=10) found such requests to be shocking, insulting, or frustrating[59]. While recognizing the importance of patient autonomy, they felt it inappropriate to impose Somali cultural traditions on the system [55].

Training the next generation of obstetricians

Two studies demonstrated the potential impact requests for female providers could have on the training of future obstetricians/gynecologists. A qualitative study, using focus group discussions with 18 Somali immigrant women in the United States suggested medical students were viewed as extraneous, and male students were especially unwelcome [44]. This issue was also raised in Ng & Newbold (2011)'s study of healthcare providers' experiences providing care to immigrants in Hamilton, Ontario where respondents shared instances of Muslim women opposing the presence of male trainees intrapartum [38].

Discussion

Overall, male obstetrician/gynecologists are clearly a barrier for many immigrant women accessing reproductive healthcare. Some women may accept care from a male provider despite a contradictory preference, because of recognition of the structure of the healthcare system, contextual acceptance due to perceived acuteness of the situation, or by making concessions for social acceptability (chaperones, rationalization). However, for another subset of women great importance appears to be attached to this aspect of care, making it difficult to accept male providers, with resultant delays, psychological stress, or avoidance in seeking care.

The Institute of Medicine has identified provision of both culturally sensitive and patient-centered care as means of providing equitable and quality healthcare [68]. Given that for a significant proportion of woman, preference for a female provider is rooted in culture and religion, accommodating this request can be viewed as the provision of culturally sensitive care. Patient centered care means to respect patients' values, preferences, and expressed needs [69], and

therefore regardless of cultural background, accommodating such requests would also be in line with provision of patient-centered care [56].

Since religion, specifically Islam, plays a significant role in the request for female providers, it is imperative that providers be aware of the context of these requests. In Islam, modesty is a central concept, encompassing restrictions in dress, and conduct between members of the opposite sex [70]. According to Islam, there are areas of the body required to be covered [26], referred to as *Awrah*[1]. This includes, although is not limited to, the genital area [71]. Generally speaking, unmarried men and women, other than close blood relatives are forbidden to view *awrah* of the opposite sex. *Purdah* refers to the "protection of women", which is achieved through varying degrees of gender segregation [31]. *Kalwah* refers to situations where a chaperone is required to ensure there is no physical touching between men and women who are in close proximity [41]. When seeking obstetrical care, Muslim women may find it difficult to be examined by a male physician due to a combination of complex factors, including *awrah, purdah*, or *kalwah*.

Despite these restrictions, in emergent situations, it is generally permissible in Islam to have cross-gender medical encounters [71]. Islamic principles that can be applied to ethical decision-making in this context include the principle of "necessity" (*Darura*), and the principle of "no hardship" (*La Haradi)*. According to *Darura*, the forbidden (revealing *awarh*) is permitted under circumstances of necessity. According to *La Haradi*, if fulfilling an obligation or duty (modesty), leads to extreme difficulty, then one is exempt from this religious duty [72]. Additionally, a number of historical cases have demonstrated women in Islam being examined by male practitioners [73],

[1] Islam is a religion encompassing many different groups of people; therefore there are numerous words and languages used to describe religious concepts. Arabic is the language of Islam in the Middle East, and the majority of articles reviewed used Arabic words to describe religious concepts, and therefore the terms presented in this discussion are the Arabic words these Islamic concepts. South Asian and Africans use different words to describe the same Islamic values.

supporting the occurrence of this "restriction" in certain contexts. Despite the presence of these apparent flexibilities, however, culture and religion remain closely tied, and social dynamics in communities that heavily value modesty may reinforce these restrictive traditions and beliefs, regardless of the context [26].

Patient-centered, culturally sensitive care is the goal of successful physician-patient interactions. However, providing such care consistently can prove to be difficult in certain settings. A distinction must be made between the ambulatory setting and in-hospital obstetrical care [71], where availability, scheduling and costs limit the access to a female provider at all times [56,74]. From the provider perspective, these system barriers may not be the only source of conflict. Patient's refusal of care on the basis of gender could be interpreted as gender discrimination [13]. This was a central finding from Degni et al. (2012), where physicians felt they should not be treated differently on the basis of gender, with some feeling insulted or even humiliated when patients requested a female provider [55]. Watson and Mahowald (1999) reviewed honoring gender-based requests for obstetricians from a legal and ethical stance, using five reported cases of gender-based discrimination in nursing in the United States [75]. They conclude that legally, although the patient has the right to refuse care from a male provider, the hospital is not responsible for accommodating religiously based modesty requests. However, based on the ethical principle of justice, they argue that hospitals and physicians should strive to accommodate requests unless they are based on gender generalizations [75]. This elucidates the delicate balance required in accommodating patient requests and health system practicalities.

An additional consideration is the implications such preferences may pose on medical education. The decision of medical students to enter obstetrics and gynecology has not been shown to be influenced by the perception of patient desire for female providers [76]. However, interest in obstetrics and gynecology is influenced by clinical experience during rotations. Male medical students in the United States have reported gender discrimination in the form of educational inequalities [77,78]. Indeed, patients have been shown to be more reluctant to have male medical students and residents participate in pelvic examinations [44,79-82], and intrapartum obstetrical care [83]. Educational opportunities should be equal among male and female students, upholding the Canadian Charter of Rights and Freedoms (part 1, section 15) [84], and furthermore, the Universal Declaration of Human Rights [85]. This extends to undergraduate and postgraduate obstetrics and gynecology training. Therefore, honoring gender-based provider requests may further educational discrepancies between male and female learners, which must be guarded against.

Conclusion

Male obstetrician/gynecologists pose a barrier to care for many immigrant women, particularly Muslim women, receiving obstetrical care in Western countries. From the patient perspective, accommodating the preference for a female provider is in line with patient-centered and culturally sensitive care. From the provider perspective, accommodating this preference is in conflict with restraints of the current healthcare system, with underlying questions of gender discrimination and important implications for education. Given the tension between patient and provider perspectives, navigating this issue can pose a significant challenge both practically and ethically. Further research is required to specifically address the perspectives of both patient and provider, in an effort to fully understand motivations, and inform ethical practice.

Figure 1: PRISMA Flow Diagram

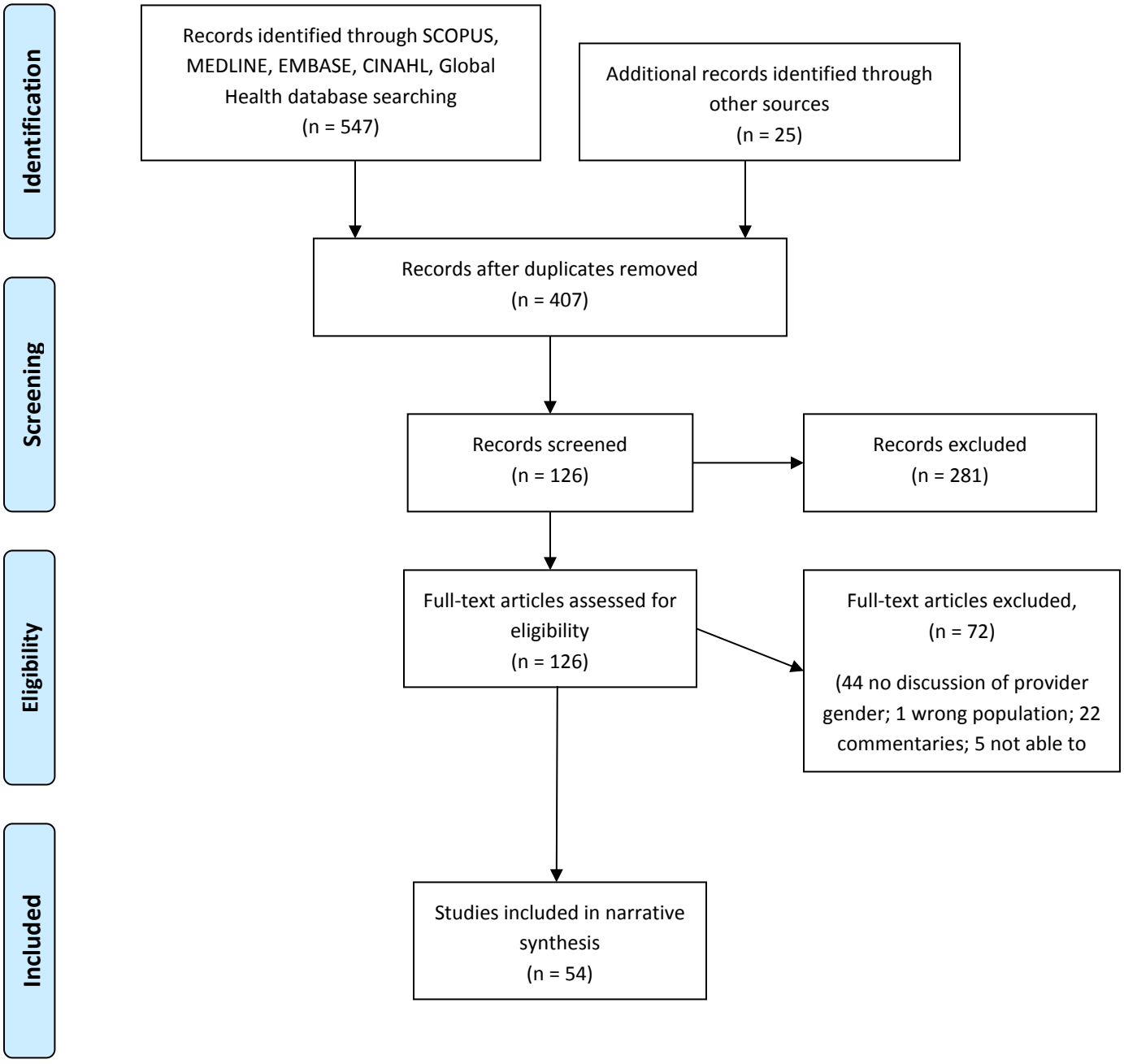


Table 1: *Studies primarily addressing provider gender as a barrier for immigrant women accessing obstetrical or gynecological care (n=3)*

Author, year	*Research Question*	*Method/Population*	*Results: preference for female physician*	*Reason for preference*
Ahmad, F. et al. (2002)	Preferences for family physician gender in Canadian European-descent and Canadian South-Asian immigrant women	Cross-sectional, 50 CED women 44 CSA women	Preference for female family physician: • Gynecologic exam: 72.9% CED vs. 83.7% CSA women • Private body part exposure: 72% CED vs. 81.8% CSA women	Not explored
Vu, M., et al. (2016)	Assess associations between religion-related factors and delayed care seeking due to a perceived lack of female clinicians	Cross-sectional, 254 Muslim women (African American, Arab American, South Asian)	Delay due to perceived lack of female clinicians: 53% • Positively associated with: Religiosity (OR 5.2), Modesty (OR 1.4) • Negatively associated with: Duration in USA >20 years	Religion (Muslim)
Odunukan, O. W. (2015)	To determine gender and racial preferences for providers and interpreters among Somali women in the United States	Cross-sectional, 50 Somali women	Preference for female physicians for physical examinations: • Pelvic (82%), breast (81%), abdominal (71%)	Not explored

Table 2: Studies primarily addressing provider gender as a barrier for women accessing obstetrical or gynecological care in non-Western countries (n=7)

Author, year	*Research Question*	*Country*	*Method/Population*	*Results: preference for female physician*	*Reason for preference*
McLean, M., et al. (2012)	Explore Emirati women's preference for physician gender, religion, age, region/country of certification, marital status, nationality	United Arab Emirates	Cross-sectional, 218 women	Female physician most important for: • Personal scenarios (94.5%); Abdominal & gynecological exams (96.8%) • Facial exposure: 45.9%	Islam, related to *Awarh*
Lafta, R.K. (2006)	Explore gender and other features associated with women's preference for OBGYN	Iraq	Cross-sectional, 500 women	Preference for female OB (79%) and female GYN (73%) • Male physicians accepted in emergencies • Preference decreased as patient age increased	Embarrassment, social tradition, religious beliefs
Amir, H., et al. (2012)	Explore gender and other features associated with Muslim Israeli-Arab women's preference for OBGYN	Israel	Cross-sectional, 167 women	Preference for female OBGYN: 76.6% • Pelvic exams (85.6%), antenatal care (77.8%), obstetrical/gynecological problem consult (61.7%) • *3 most important factors: experience, knowledge, ability (29.3% physician gender)	Embarrassment (67.7%), comfort (80.8%), females more gentle (68.3%)
Zaghloul, A.A., et al (2005)	Determine patient's gender preferences in choosing general practitioners and specialists in Alexandria, Egypt	Egypt	Cross-sectional, 97 male and 205 female	Preference for female physician amongst female patients: 41.0%	Personal reasons, traditions/norms, religious beliefs
Bal, M.D., et al. (2014)	Explore gender and other features associated with Turkish Muslim women's preference for OBGYN	Turkey	Cross-sectional, 710 women in antenatal clinic	Preference for female OBGYN: 32.3% • Positively associated with: higher parity, lower education, lower income, higher unemployment, first gynecological exam	Communication (36%), embarrassment (32%), comfort (27%), religious beliefs (5%)
Amer-Alshiek, J. (2015)	Explore gender and other features associated with Israeli Druze women's preference for OBGYN	Israel	Cross-sectional, 196 Israeli Druze women	Preference for female OGBYN: 63.8% (vs. no gender preference for family physician in 74.5%) • Factors related to preference: age, religious status, gender of regular OBGYN • Most important qualities: experience (91.8%), ability (90.3%), knowledge (84.7%)	Comfort (69.7%), females more gentle (56.6%), embarrassment (45.4%)
Bukar, M. (2012)	Explore gender and other features associated with women's preference for OBGYN	Nigeria	Cross-sectional, 325 women	Preference for female OBGYN: 36.7% • Positively associated with: age (25-34 years), ethnic group (Kanuri/Shuwa); women who were homemakers, married and Islam	Religion (36%), culture/tradition (20%)

References

1. Brodsky PL. The control of childbirth: Women versus medicine through the ages. Jefferson, N.C.: McFarland & Co.; 2008.

2. Tew M. Safer childbirth?: A critical history of maternity care. London; New York: Free Association Books; 1998.

3. Van Teijlingen E. Midwifery and the medicalization of childbirth: Comparative perspectives. Commack, NJ: Nova Science Publishers; 2000.

4. Donnison J. Midwives and medical men: A history of the struggle for the control of childbirth. London: Historical Publications; 1988.

5. Small R, Roth C, Raval M, Shafiei T, Korfker D, Heaman M, et al. Immigrant and non-immigrant women's experiences of maternity care: A systematic and comparative review of studies in five countries. BMC Pregnancy Childbirth. 2014;14:152.

6. Brar S, Tang S, Drummond N, Palacios-Derflingher L, Clark V, John M, et al. Perinatal care for South Asian immigrant women and women born in Canada: Telephone survey of users. J Obstet Gynaecol Can. 2009;31(8):708-16.

7. Drysdale H, Ranasinha S, Kendall A, Knight M, Wallace EM. Ethnicity and the risk of late-pregnancy stillbirth. Med J Aust. 2012;197(5):278-81.

8. Kingston D, Heaman M, Chalmers B, Kaczorowski J, O'Brien B, Lee L, et al. Comparison of maternity experiences of Canadian-born and recent and non-recent immigrant women: Findings from the Canadian maternity experiences survey. J Obstet Gynaecol Can. 2011;33(11):1105-15.

9. Sword W, Watt S, Krueger P. Postpartum health, service needs, and access to care experiences of immigrant and Canadian-born women. J Obstet, Gynecol Neonatal Nurs. 2006;35:717-27.

10. Ganann R, Sword W, Black M, Carpio B. Influence of maternal birthplace on postpartum health and health services use. J Immigr Minor Health. 2012;14(2):223-29

11. Knight M, Kurinczuk JJ, Spark P, Brocklehurst P, UKOSS. Inequalities in maternal health: National cohort study of ethnic variation in severe maternal morbidities. BMJ. 2009;338:b542.

12. Henderson J, Gao H, Redshaw M. Experiencing maternity care: The care received and perceptions of women from different ethnic groups. BMC Pregnancy Childbirth. 2013;13:196.

13. Makam A, Saroja C, Edwards G. Do women seeking care from obstetrician–gynaecologists prefer to see a female or a male doctor? *Arch Gynecol Obstet*. 2010;281:443-7.

14. Canadian Medical Protective Association [Internet]. c2011 [updated Dec 2011; cited 2015 Aug 11]. When a patient asks for another physician on cultural or religious grounds; [about 2 screens]. Available from: https://www.cmpa-acpm.ca/legal-and-regulatory-proceedings/-/asset_publisher/a9unChEc2NP9/content/when-a-patient-asks-for-another-physician-on-cultural-or-religious-grounds;jsessionid=F216C6805B38D6F3D1EA3E27245539C7.

15. The Society of Obstetricians and Gynaecologists of Canada [Internet]. c2013 [updated June 2013; cited 2015 Aug 11]. SOGC position statement: When a patient asks for another physician on cultural or religious grounds [about 1 screen]. Available from: http://sogc.org/media_updates/position-statement-when-a-patient-asks-for-another-physician-on-cultural-or-religious-grounds/.

16. Ahmad F, Gupta H, Rawlins J, Stewart DE. Preferences for gender of family physician among Canadian European-descent and South-Asian immigrant women. Fam Pract. 2002;19(2):146-53.

17. Reitmanova S, Gustafson DL. "They can't understand it": Maternity health and care needs of immigrant Muslim women in St. John's, Newfoundland. Matern Child Health J. 2008;12(1):101-11.

18. Lowe P. Embodied expertise: Women's perceptions of the contraception consultation. Health (London). 2005;9(3):361-78.

19. Odunukan OW, Abdulai RM, Hagi Salaad MF, Lahr BD, Flynn PM, Wieland ML. Provider and interpreter preferences among Somali women in a primary care setting. J Prim Care Community Health. 2015;6(2):105-10.

20. Carroll J, Epstein R, Fiscella K, Gipson T, Volpe E, Jean-Pierre P. Caring for Somali women: Implications for clinician-patient communication. Patient Educ Couns. 2007;66(3):337-45.

21. Qureshi R, Pacquiao DF. Ethnographic study of experiences of Pakistani women immigrants with pregnancy, birthing, and postpartum care in the United States and Pakistan. Journal of Transcult Nurs. 2013;24(4):355-6.

22. van den Muijsenbergh M, Lagro-Janssen T. Urinary incontinence in Moroccan and Turkish women: A qualitative study on impact and preferences for treatment. Br J Gen Pract. 2006;56:945-9.

23. Benza S, Liamputtong P. Pregnancy, childbirth and motherhood: A meta-synthesis of the lived experiences of immigrant women. Midwifery. 2014;30(6):575-84.

24. Markova T, Dean F, Neale AV. Healthcare attitudes and behaviors of immigrant and US-born women in Hamtramck, Michigan: A metronet study. Ethn Dis. 2007;17(4):650-6.

25. Kabakian-Khasholian T, Campbell O, Shediac-Rizkallah M, Ghorayeb F. Women's experiences of maternity care: Satisfaction or passivity? Soc Sci Med. 2000;51(1):103-13.

26. McLean M, Al Yahyaei F, Al Mansoori M, Al Ameri M, Al Ahbabi S, Bernsen R. Muslim women's physician preference: Beyond obstetrics and gynecology. Health Care Women Int. 2012;33:849-76.

27. Lafta RK. Practitioner gender preference among gynecologic patients in Iraq. Health Care Women Int. 2006;27(2):125-30.

28. Amir H, Tibi Y, Groutz A, Amit A, Azem F. Unpredicted gender preference of obstetricians and gynecologists by Muslim Israeli-Arab women. Patient Educ Couns. 2012;86(2):259-63.

29. Bashour H, Abdulsalam A. Syrian women's preferences for birth attendant and birth place. Birth. 2005;21(1):20-6.

30. Rizk DE, El-Zubeir MA, Al-Dhaheri AM, Al-Mansouri FR, Al-Jenaibi HS. Determinants of women's choice of their obstetrician and gynecologist provider in the UAE. Acta Obstet Gynecol Scand. 2005;84:48-53.

31. Currie S, Azfar P, Fowler RC. A bold new beginning for midwifery in Afghanistan. Midwifery. 2007;23:226-34.

32. Al Sairafi M, Mohamed FA. Knowledge, attitudes, and practice related to cervical cancer screening among Kuwaiti women. Med Princ Pract. 2009;18:35-42.

33. Zaghloul AA, Youssef AA, El-Einein NY. Patient preference for providers' gender at a primary health care setting in Alexandria. Egypt. Saudi Med J. 2005;26(1):90-5.

34. Bal MD, Yilmaz SD, Beji NK, Uludag S. Muslim women choice for gender of obstetricians and gynecologist in Turkey. IJHS. 2014;11(2):64-73.

35. Bukar M, Takai IU, Audu BM, Isa JB. Women's gender preferences for their obstetrician and gynaecologist at the university of Maiduguri teaching hospital, Maiduguri, Nigeria . Orient J Medicine. 2012;24(1-2):30-6.

36. Saurina C, Vall-Llosera L, Saez M. A qualitative analysis of immigrant population health practices in the Girona healthcare region. BMC Public Health. 2010;10:379.

37. Bawadi H. Migrant Arab Muslim women's experiences of childbirth in the UK. [dissertation]. Leicester (UK): De Montfort University; 2009.

38. Ng C, Newbold KB. Health care providers' perspectives on the provision of prenatal care to immigrants. Cult Health Sex. 2011;13(5):561-74.

39. Murray L, Windsor C, Parker E, Tewfik O. The experiences of African women giving birth in Brisbane, Australia. Health Care Women Int. 2010;31(5):458-72.

40. Beine K, Fullerton J, Palinkas L, Anders B. Conceptions of prenatal care among Somali women in San Diego. J Nurse Midwifery. 1995;40(4):376-81.

41. Simpson JL, Carter K. Muslim women's experiences with health care providers in a rural area of the United States. *J Transcult Nurs.* 2008;19(1):16-23.

42. Redwood-Campbell L, Fowler N, Laryea S, Howard M, Kaczorowski J. 'Before you teach me, I cannot know': Immigrant women's barriers and enablers with regard to cervical cancer screening among different ethnolinguistic groups in Canada. Can J Public Health. 2011;102(3):230-4.

43. Salman KF. Health beliefs and practices related to cancer screening among Arab Muslim women in an urban community. Health Care Women Int. 2012;33:45-74.

44. Hill N, Hunt E, Hyrkas K. Somali immigrant women's health care experiences and beliefs regarding pregnancy and birth in the United States. J Transcult Nurs. 2012;23(1):72-81.

45. George P, Terrion JL, Ahmed R. Reproductive health behaviour of Muslim immigrant women in Canada. Int J Migr Health Soc Care. 2014;10(2):88-101.

46. Shafiei T, Small R, McLachlan H. Women's views and experiences of maternity care: A study of immigrant Afghan women in Melbourne, Australia. Midwifery. 2012;28(2):198-203.

47. Isa Mobibbo F, Dareng E, Bamisaye P, Jedy-Agba E, Adewole A, Oyeneyin L, et al. Qualitative study of barriers to cervical cancer screening among Nigerian women. BMJ Open. 2016;6(1):e008544.

48. Hasnain M, Connell KJ, Menon U, Tranmer PA. Patient-centered care for Muslim women: Provider and patient perspectives. J Womens Health. 2011;20(1):73-83.

49. Binder P, Borné Y, Johnsdotter S, Essén B. Shared language is essential: Communication in a multiethnic obstetric care setting. J Health Commun. 2012;17(10):1171-86.

50. Amer-Alshiek J, Alshiek T, Levy YA, Azem F, Amit A, Amir H. Israeli Druze women's sex preferences when choosing obstetricians and gynecologists. *Isr J Health Policy Res.* 2015;4(13)

51. Chaliha C, Stanton SL. The ethnic cultural and social aspects of incontinence - A pilot study. Int Urogynecol J Pelvic Floor Dysfunct. 1999;10(3):166-70.

52. Benyamini Y, Blumstein T, Boyko V, Lerner-Geva L. Cultural and educational disparities in the use of primary and preventative health care services among midlife women in Israel. Women Health Iss. 2008;18:257-66.

53. Tsianakas V, Liamputtong P. What women from an Islamic background in Australia say about care in pregnancy and prenatal testing. Midwifery. 2002;18(1):25-34.

54. Khan S, Woolhead G. Perspectives on cervical cancer screening among educated Muslim women in Dubai (the UAE): A qualitative study. BMC Womens Health. 2015;15(90).

55. Degni F, Suominen S, Essen B, El Ansari W, Vehvilainen-Julkunen K. Communication and cultural issues in providing reproductive health care to immigrant women: Health care providers' experiences in meeting Somali women living in Finland. J Immigr Minor Health. 2012;14:330-43.

56. Lyons SM, O'Keeffe FM, Clarke AT, Staines A. Cultural diversity in the Dublin maternity services: The experiences of maternity service providers when caring for ethnic minority women. Ethn Health. 2008;13(3):261-76.

57. Padela AI, Gunter K, Killawi A, Heisler M. Religious values and healthcare accommodations: Voices from the American Muslim community. J Gen Intern Med. 2011;27(6):708-15.

58. Ganle JK. Why Muslim women in northern Ghana do not use skilled maternal healthcare services at health facilities: A qualitative study. BMC Int Health Hum Rights. 2015;15(10).

59. Basu P, Sarkar S, Mukherjee S, Ghoshal M, Mittal S, Biswas S, et al. Women's perceptions and social barriers determine compliance to cervical screening: Results from a population based study in India. Cancer Detect Prev. 2006;30(4):369-74.

60. Chapple A. Iron deficiency anaemia in women of South Asian descent: A qualitative study. Ethn Health. 1998;3(3):199-212.

61. Bodo K, Gibson N. Childbirth customs in Vietnamese traditions. Can Fam Phys. 1999;45:690-7.

62. Donnelly TT. Challenges in providing breast and cervical cancer screening services to Vietnamese Canadian women: The healthcare providers' perspective. Nurs Inq. 2008;15(2):158-68.

63. Chapple A, Ling M, May C. General practitioners' perceptions of the illness behaviour and health needs of South Asian women with menorrhagia. Ethn Health. 1998;3(1-2):81-93.

64. Sange C, Thomas L, Lyons C, Hill S. Urinary incontinence in Muslim women. Nurs Times. 2008;104(25):49-52.

65. Higginbottom GM, Safipour J, Yohani S, O'Brien B, Mumtaz Z, Paton P. An ethnographic study of communication challenges in maternity care for immigrant women in rural Alberta. Midwifery. 2015;31(2):297-304.

66. Huster KMJ, Patterson N, Schilperoord M, Spiegel P. Cesarean sections among Syrian refugees in Lebanon from December 2012/January 2013 to June 2013: Probable causes and recommendations. Yale J Biol Med. 2014;87(3):269-88.

67. Vu M, Azmat A, Radejko T, Padela A. Predictors of delayed healthcare seeking among American Muslim women. J Womens Health. 2016;00(00):1-8.

68. Betancourt JR. Cultural competence and medical education: Many names, many perspectives, one goal. Acad Med. 2006;81(6):499-501.

69. Gerteis M, Edgman-Levitan S, Daley J, Delbanco TL, editors. Through the patient's eyes: Understanding and promoting patient-centered care. San Francisco: Jossey-Bass Publishers; 1993.

70. Padela AI, Rodriguez del Pozo P. Muslim patients and cross-gender interactions in medicine: An Islamic bioethical perspective. J Med Ethics. 2011;37:40-4.

71. Aldeen AZ. Commentary: The Muslim ethical tradition and emergent medical care: An uneasy fit. Acad Emerg Med. 2007;14(3):227-8.

72. Larijani B, Anaraki FZ. Islamic principles and decision making in bioethics. Nat Genet. 2008;40(2):123

73. Pormann PE. Female patients and practitioners in medieval Islam. Lancet. 2009;9675(373):1598-9.

74. Vissandjee B, Weinfeld M, Dupere S, Abdool S. Sex, gender, ethnicity, and access to health care services: Research and policy challenges for immigrant women in Canada. J Int Migr Integr. 2001;2(1):55-75.

75. Watson K, Mahowald MB. Honoring gender-based patient requests for obstetricians: Ethical imperative or employment discrimination? J Womens Health Gend Based. 1999;8(8):1031-41.

76. Forgarty CA, Bonebrake RG, Fleming AD, Haynatzki G. Obstetrics and gynecology—To be or not to be? Factors influencing one's decision. Am J Obstet Gynecol. 2003;189(3):652-4.

77. Witte FM, Stratton TD, Nora LM. Stories from the field: Students' descriptions of gender discrimination and sexual harassment during medical school. Acad Med. 2006;81(7):648-54.

78. Emmons SL, Adams KE, Nichols M, Cain J. The impact of perceived gender bias on obstetrics and gynecology skills acquisition by third-year medical students. Acad Med. 2004;79(4):326-32.

79. Mavis B, Vasilenko P, Schnuth R, Marshall J, Jeffs MC. Medical students' involvement in outpatient clinical encounters: A survey of patients and their obstetricians–gynecologists. Acad Med. 2006;81(3):290-6.

80. Ching SL, Gates EA, Robertson PA. Factors influencing obstetric and gynecologic patients' decisions toward medical student involvement in the outpatient setting. Obstet Gynecol. 2000;182(6):1429-32.

81. O'Flynn N, Rymer J. Women's attitudes to the sex of medical students in a gynaecology clinic: Cross sectional survey. BMJ. 2002;325:683-4.

82. Rifkin JI, Sharpiro H, Regensteiner JG. Why do some women refuse to allow male residents to perform pelvic exams? Acad Med. 2002;77(10):1034-8.

83. Grasby D, Quinlivan JA. Attitudes of patients towards the involvement of medical students in their intrapartum obstetric care. Aust N Z J Obstet Gynaecol. 2001;41(1):91-6.

84. Canadian Charter of Rights and Freedoms, Part I of the Constitution Act, 1982, being Schedule to B to the Canada Act 1982 (UK), c 11 (1982).

85. The United Nations. Universal Declaration of Human Rights. 1948

Chapter 2: Methods

Health research has been dominated by a positivist perspective, an epistemological approach that assumes there is one single truth, revealed most validly through the pursuit of quantitative methods to capture or approximate this truth [1]. In contrast, the ontological and epistemological underpinnings of qualitative research maintain that there are both many realities and truths, constructed and influenced by numerous factors; qualitative inquiry "attempting to interpret or make sense of the meaning people attach to their experiences or underlying a particular phenomenon" (pg11) [2]. As such, there is a growing recognition of the role of qualitative inquiry in health research, as not all research objectives lend themselves to quantitative methods [3].

The qualitative methodology used in the present study is a focused ethnography using a feminist lens. Traditional ethnography has its roots in anthropology, and sets about to describe culture broadly. Focused ethnography has evolved from this method, but is focused on a particular research objective and context, to guide decision-making on a particular problem [2], and is therefore particularly suitable for healthcare research [4]. Focused ethnography was felt to be an ideal method to explore the issue of provider gender in obstetrics amongst immigrant women from both the patient and provider perspectives. The context of interest was the acute in-hospital obstetrical care of labor and delivery. Given the objectives of the study: to understand the importance, effect, and challenges associated with obstetrical provider gender for immigrant women, data were collected from two sets of respondents: pregnant women born outside of Canada, and their obstetrical care providers.

Conducting a focused ethnography requires substantial knowledge of the field of interest, to enable appropriate question formation directly applicable and relevant to clinical translation [4]. All data were collected and analyzed by the primary author, a Canadian-born English-speaking

Caucasian female graduate student and resident physician in obstetrics and gynecology. An outsider perspective on the part of the patient respondents was apparent, but with a substantial insider (emic) perspective as a provider with the background knowledge of the clinical importance of provider gender in the acute obstetrical setting. Additionally, as a physician, this enabled access to the provider participants.

Patient Respondents

Patient respondents were recruited using both purposive and convenience sampling. Eligibility criteria included: birth in a country outside of Canada, preference for a female obstetrician during delivery, 36+ weeks gestation, and not having a planned Cesarean section. No restrictions were placed on duration of time in Canada, particular ethnic groups, countries of origin, or religious affiliation. This was deliberately done to explore what factors were important in shaping gender preference of the provider, staying open to all perspectives, and ensuring fair dealing[5]. Restricting participants to 36+ weeks gestation was done for logistical reasons to facilitate the completion of two interviews (antenatal and postpartum) within the study time frame. Additionally, the short interval of time between the first and second interview enabled respondents to reflect and form a relationship of trust with the researcher. Finally, participants were restricted to those not having a planned Cesarean section because we wanted them to be at risk of presenting in labor and having a male provider, and therefore represent a true depiction of their preferences and effect of this variable on them.

In qualitative research, sample size is guided by data saturation. According to Guest et al. (2006), data saturation likely occurs after 12 interviews, but depends on sample heterogeneity [6]. A total of 38 women were recruited and interviewed antenatally, with 21 completing a second

interview postpartum. One woman wished not to be interviewed postpartum, and the remaining 16 women were lost to follow up due to logistical reasons. Of the 21 women who had interviews postpartum, 17 also were observated intrapartum. One participant wished to not be followed intrapartum, and the remaining 3 were not observed due to logistical reasons.

Data collection:

Respondents were recruited from three obstetricians' offices working out of the same hospital, from August 2015 through January 2016. Eligible participants were identified first by their obstetrician during an antenatal appointment. If a patient was interested in participating in the research, she was approached by the first author. At this initial contact, a semi-structured interview, using a piloted tool was conducted. Although a phone translation service was available, all respondents were fluent in English. Questions included: *What has your experience been with healthcare or pregnancy care in Canada? Tell me why you prefer to have a female doctor deliver your baby? How important is this to you? Who is this important to? How would you feel if you had a male doctor? What should we do about this issue?*

When the index respondent presented to the hospital labor, the researcher was alerted. She observed, intrapartum, the interactions between participants, families, and staff, specifically with regards to reactions of participants to the gender of provider that was on duty when they presented in labor. At this time, the prenatal record was also inspected, and using a standardized form, information collected will be presence of a documented discussion between patient and provider about provider gender intrapartum. A total of 17 women were observed for an average of 2 hours each.

The researcher again approached the respondents postpartum and if allowed, a second interview was undertaken, in a private room on the postpartum ward. Questions included: *What was your experience in labor? Did you have a male or female doctor and how did this make you feel? Do you think that this is an issue? How can we address this?*

All interviews were audio-recorded and transcribed verbatim by the first author. Field notes were taken during observations as well as after the antenatal and postpartum interviews.

Provider respondents

Providers, for the purpose of the study, are defined as physicians trained or undergoing training in obstetrics/gynecology. They included obstetricians and resident physicians rotating in the Obstetrics unit during the fieldwork. Provider respondents were recruited through purposive and solicitation sampling. Eligibility criteria included, in addition to provider status, experience providing care to immigrant woman who preferred a female physician intrapartum, and for resident physicians, completion of at least one year of training (to ensure adequate obstetrical experience).

Data collection:

Ten resident and 10 staff obstetricians were interviewed using a piloted guide during off-service hours at a mutually agreed upon location, from August 2015 through January 2016. Questions included: *Does provider gender ever come up as a barrier during labor and delivery? Is this issue discussed with women antenally? What is your response to this request, and how do you personally feel about it? How do you think we can address this issue?*

All interviews were audio-recorded and transcribed verbatim by the first author. Field notes were also taken after the interviews.

Data Analysis

A database of interview transcripts and field notes from interviews and observations was created, stored and handled using Quirkos qualitative computer software (Quirkos 1.3 TA). Data were analyzed using thematic analysis [7]. The first author coded all the data, by reading and rereading, highlighting and identifying recurrent concepts. The codes were then grouped into similar categories and subcategories, and described in detail. This process was fluid and iterative, and occurred concurrent with data collection. Categories were then considered together and common themes were determined.

Rigor

Validity, reliability, and generalizability as described by Morse et al (2002) were used as the framework for ensuring rigor in this study [8]. Achieving validity, reliability, and generalizability requires responsiveness and verification throughout the process of the study. Responsiveness was ensured through the use of a reflexive journal to track process, challenges, thoughts and changes. Regular meetings were held with the first author and her supervisor (Dr. Zubia Mumtaz), discussing emerging concepts, directions, and changes throughout. The minutes of these meetings were kept, in addition to the reflexive journal and field notes, to form an audit trail. Verification was ensured through the iterative process of data collection and analysis. Interviews were transcribed by the first author within 2 weeks of the initial interview, and analysis occurred concurrent with data collection. When new concepts were identified they were followed up in subsequent interviews with participants.

Ethics

Ethics approval was obtained through the University of Alberta Human Research Ethics Board (Panel B), and Alberta Health Services. All participants were annonymized through the use of participant codes. Prior to the initial interview, a copy of information letter and consent form was given to and reviewed with participants, and written consent was obtained. At subsequent interviews participants were verbally consented again, and prior to participant observation, verbal consent was sought from all parties involved. Acknowledging the power differentials between researcher and patient participants, it was made explicitly clear during the consent process that participation, or answers to questions would in no way affect their medical care.

References

1. Denzin NK, Lincoln YS. The discipline and practice of qualitative research. In: Denzin NK, Lincoln YS, eds. *The SAGE handbook of qualitative research.* 4th ed. United States of America: SAGE Publications, Inc; 2011:1-19.

2. Mayan M. *Essentials of qualitative inquiry.* Walnut Creek, California, United States of America: Left Coast Press, Inc; 2009.

3. Morse JM. What is qualitative health research? In: Denzin NK, Lincoln YS, eds. *The SAGE handbook of qualitative research.* 4th ed. United States of America: SAGE Publications, Inc.; 2011:401-414.

4. Higginbottom G, Pillay JJ, Boadu NY. Guidance on performing focused ethnographies with an emphasis on healthcare research. *Qual Rep*. 2013;18(17):1-16.

5. Mays N, Pope C. Qualitative research in health care: Assessing quality in qualitative research. *BMJ*. 2000;320:50-52.

6. Guest G, Bunce A, Johnson L. How many interviews are enough? An experiment with data saturation and variability. *Field Methods*. 2006;18(1):59-82.

7. Green J, Willis K, Hughes E, et al. Generating best evidence from qualitative research: The role of data analysis. *Aust N Z J Public Health*. 2007;31(6):545-550.

8. Morse JM, Barrett M, Mayan M, Olson K, Spiers J. Verification strategies for establishing reliability and validity in qualitative research. *Int J Qual Method*. 2002;1(2):13-22.

Chapter 3: Manuscript #2

The "Double Pain" of Childbirth: Immigrant Women's Preference for Female Providers

Abstract

Objective*:* To gain understanding of the importance and effect of provider gender for immigrant women accessing obstetrical care.

Methods*:* A focused ethnography was conducted using purposive and convenience sampling of 38 immigrant women from one hospital in Edmonton, Alberta, Canada. Data collection was comprised of semi-structured interviews antenatally (38), and postpartum (21), and observation intrapartum (17). Interviews were audio-recorded and transcribed verbatim. Data was managed by a qualitative data analysis software, and analyzed by thematic analysis.

Results: Women came from various educational and ethnic backgrounds, but the majority were Muslim (30) and married (36), with a mean age of 27.7 years. All women stated that although they preferred a female provider, they would accept care from a male provider. Provider competency and desire for a safe birth were deemed most important. A culture of modesty, often interwoven with Islam, underlay the preference for a female provider. Nonetheless, women experienced varying degrees of psychological stress as a consequence of having received care from a male provider intrapartum, which for a small minority led to considerable, potentially serious consequences.

Conclusion: As a whole, women are accepting of care from male providers, yet for some this acculturation come at a price, with a small minority of women perceiving it as profoundly

detrimental. There is a need to identify those women for whom gender of provider is a substantial barrier, so that optimal support can be provided.

Introduction

Gender of provider has shown to be a factor of importance for women seeking gynecologic or obstetrical care [1], and may be of particular importance for immigrant women originating from conservative cultures [2,3]. Given that immigrant women experience a number of barriers when seeking obstetrical care [8-10], it is postulated the gender of the provider may be a critical additional barrier in the receipt of obstetrical care for this population.

Health equity is a fundamental human right, and in health care is defined as equal access and utilization of care for equal need, and equal quality of care for all [11] . For some, the inability to have a female provider may impact health-seeking behavior and practices, resulting in delays or avoidance in seeking care [12] . In contrast to the ambulatory setting, the provision of a female provider at all times in the acute obstetrical setting is often not feasible due to availability, scheduling and costs [13,14] . From the patient perspective, concessions should be made to accommodate preferences for female providers, balancing patient autonomy and beneficence, grounded in principles of cultural sensitivity and patient-centered care [15] . The objective of this study was to use a qualitative approach in order to gain further understanding of the importance and effect of provider gender for immigrant women accessing obstetrical care in Canada.

Materials and Methods

A focused ethnography was conducted. Whereas ethnography sets about to describe culture broadly, focused ethnography is focused on a particular research objective and context, to guide

decision-making on a particular problem, making it particularly suitable for healthcare research [16]

.

Participants were recruited purposively from three obstetrician's offices working out of a large University teaching hospital from August 2015 through January 2016. All three clinics had a high proportion of immigrant clientele. Eligibility criteria included: 1) birth in a county outside of Canada, 2) preference for a female obstetrician during delivery, 3) 36+ weeks gestation, and 4) not having a planned Cesarean section. Eligible participants were identified first by their obstetrician, and if interested in participating in the study, were approached by the first author and informed consent was obtained.

All interviews were semi-structured, using a piloted interview guide. Antenatal questions included: *What has your experience been with healthcare or pregnancy care in Canada? Tell me why you prefer to have a female doctor deliver your baby? How important is this to you? Who is this important to? How would you feel if you had a male doctor? What should we do about this issue?*

The researcher was then alerted when participants presented to labor and delivery, and observed interactions between participants, families, and staff, specifically with regards to reactions to the gender of the provider on duty, when they presented in labor. Observations lasted for two hours, on average.

Postpartum, the researcher again approached participants, and if agreeable, a second interview was undertaken. Follow-up questions included: *What was your experience in labor? Did you have a male or female doctor and how did this make you feel? Do you think that this is an issue? How can we address this?*

All interviews were conducted in English, audio-recorded, and transcribed verbatim by the first author. Although a phone translation service was available, all respondents were fluent in English. A database of interview transcripts and observations was created, stored and handled using Quirkos 1.3 qualitative computer software (Quirkos Ltd., Edinburgh, Scotland). Data were analyzed using thematic analysis [17] . Coding was done by reading and re-reading, highlighting and identifying recurrent concepts. The codes were then grouped into similar categories and subcategories, and described in detail. This process was fluid and iterative, and occurred concurrent with data collection. Categories were then assessed together and common themes were determined.

Validity, reliability, and generalizability as described by Morse et al. were used as the framework for ensuring rigor in this study [18] . This was achieved through purposive sampling, the iterative process of data collection and analysis, following up on emerging concepts and tracking changes. Data collection continued until saturation was achieved. Ethics approval was obtained through the University of Alberta Human Research Ethics Board (Panel B), and operational approval through the Northern Alberta Clinical Trials and Research Centre.

Results

A total of 38 women were recruited and interviewed antenatally, with 21 having follow-up postpartum interviews, and 17 being observed intrapartum. Of the 21 women interviewed postpartum, 10 had a male obstetrician intrapartum while 11 had a female. Participant demographics are indicated in Table 1. The mean age of women was 27.7 years, representing a wide range of countries of origin, most commonly Somalia (n=7) and Ethiopia (n=6). Educational status of women ranged from no formal (n=1) to PhD/MD level (n=2), with the most

common being completion of secondary school (n=11). All but two women were married, the majority were Muslim (n=30), did not work outside the home (n=26), and were in their first pregnancy (n=17).

Our study revealed three main themes with regards to immigrant women preferring female providers intrapartum:

1) *Accepting care from male providers:* All women, although they preferred a female provider, would accept care from a male. Safety of both the mother and baby, and quality of care were the most important factors expressed by respondents.
2) *Culture of modesty, tied to religion, were the key drivers of the preference for a female provider:* A culture of modesty, often interwoven with Islam, underlay preferences for a female provider. Women tried to align behavior with normative religious and societal expectations, however, these influences were also flexible, allowing women to accept care from male providers in the event a female was not available.
3) *Difficulty in adaptation:* Regardless of this flexibility, women experienced varying degrees of psychological stress after adapting to male providers intrapartum, and for a small minority of women, having a male provider led to considerable and potentially serious mental health consequences.

1) Accepting care from male providers:

A key finding of this study was that, while our respondents stated a preference for a female provider intrapartum, they were flexible. All women accepted a male provider when a female was not available, and framed their preference for female providers within a context of larger priorities. Women recognized the health of their baby as paramount, and continually stated that

they were willing to compromise their preferences when they felt this was in the best interest of the safe delivery of their child.

> *"For the safety of my baby I wouldn't. I wouldn't let that impede that ever"- Age 27, Kenya*

The importance placed upon this preference did differ between women, and in some cases changed after childbirth. For many women (n=17) this was their first experience of childbirth, and particularly after delivery they reflected on their experience and rearranged their values in a different way. It was at this time when women were most thankful for and focused on the health and safety of themselves and their baby.

As a result of the priority placed upon the health of their child, women identified competency and trust as characteristics of their physician that transcended gender. Since labor and delivery was such a difficult time, they called upon the support, expertise and guidance of competent physicians and nurses. Women stated that a doctor was a doctor, and viewing physicians in such a gender neutral way seemed to give women solace that they were not really compromising their beliefs.

> *"…if you see him as a doctor you see he's just doing his job."-Age 27, Eretria*

Although having a female obstetrician was important for our respondents, keeping the big picture in mind, women recognized the value of being open-minded. By viewing a male provider's presence in the larger context translated into making it easier to accept.

> *"If you being like open-mind, he's doing his job in that moment, and then he will leave you in 15 min, or 20 min and he will go, 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

2) Culture of modesty, tied to religion

An overall culture of modesty, in many cases tied to religion, was the key driver of preference for female providers. All women, irrespective of country of origin, stated they were more comfortable with a female provider, given the intimate nature of obstetrics. Women articulated greater ease resulting from a culturally derived concept of modesty, and in many cases referred to a "female connection" in gender-concordant patient-provider interactions. Women implied that gender solidarity enabled female providers to be better equipped to understand what they were doing.

"Because you can experience with woman anything you are going through with pain, or with pregnancy or with delivery. Women will be more understanding of what you are going through. So yeah, the male also will understand, but not everything. So that's why" –Age 26, Somalia

Muslim women merged their culture of modesty with religious requirements of modesty. These women explained that modesty was central to Islam, and that compromising this modesty made them uncomfortable. Both exposure of private areas and touch by men outside of their husband/immediate family were seen to compromise their religiously defined concepts of modesty.

"First of all, the big part is a religious perspective, so because in our religion women are supposed to .. ahh, keep their modesty, cover up, and protect their privates, and you know, adornments, that's why we dress up differently. And we consider only some family

members- male family members to see without the hijab- the head scarf, so it's that, so the possibility that I can get a female- a doctor to examine me- because doctors we have to show whatever is necessary right, so we cannot so no you cannot see me. That's why we prefer a female"-Age 24, Bangladesh

These cultural and religious influences did not stop at the individual. Women were also aligning behavior with their normative societal expectations. Our data suggested that an important aspect of women's stated preference for a female provider was reflective of their desire to align behaviors with the expectations of their social group.

"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

In some cases, families drove their preferences for female providers. These women insisted upon female providers because "*that's what my husband wants".* The influence of the family, often husbands, was so powerful that some women delayed or avoided care. One woman did not present to the hospital when she felt she needed to because her husband worried that a female provider might not be available.

"And I was still bleeding, and I started to have contractions- regular contractions, so I told my husband, ok I think we should go to hospital. And my husband said, do you think maybe it's better to go in morning? Because at night, ahh.. Dr. X ah, once told us that normally male doctor will be in charge at night."- Age 31, Malaysia

Interestingly, these social group expectations, although powerful, were not exceptionally rigid. The fact that women were allowed to accept care from male providers if necessary correlated to a flexibility within the social group. Most Muslim women acknowledged that flexibility within Islam hinged on the context of the situation. A male doctor was acceptable, but only if there was no female available. In addition, many women identified childbirth as an "emergency" situation, where the necessity of medical care overrode all barriers of modesty and Islamic prohibitions of cross-gender contact.

What constituted an emergency differed between women. For some women, the definition of emergency was likened to life or death situations. However, for most respondents this was loosely defined, and if a female was not available and there was a need, it was acceptable.

> *"I know- sometimes in different countries maybe there are 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 available then it's fine." –Age 24, Bangladesh*

Finally, regardless of the context of the situation, women deemed the acceptability of having a male physician on the basis of having already tried for a female. There was a perception that it was acceptable both personally and outwardly, only if they had done all they could to try and have a female physician.

> *"Ahh… because I, I did all what I can to do, I will feel comfortable. There's no problem" –Age 25, Saudi Arabia*

3) Difficulty in adaptation

Despite viewing gender preference of provider on a continuum of priorities, and regardless of the flexibility, many women experienced psychological distress when they had to see a male provider. Although our respondents recognized that in the context of childbirth, cross-gender interactions were permissible, some women had difficulty adjusting their mindset. The internal conflict arose from their deeply rooted religious and cultural values, and obligations of modesty:

> *"Um… How do you say it.. 31 years of your life you didn't get exposed to any male except your husband. Then, and so you just believe that it's totally something you shouldn't do- except emergency. Yeah, those are emergency too right… so to realize in your mind that this is ok, yeah it takes time. It's not easy.-Age 31, Malaysia*

This additional stress to adapt was eloquently referred to by one respondent as the "double pain" of childbirth:

> *"It would be double pain! Double pain, like I'm struggling with the pain, the natural pain, and I'm again struggling with the male pain, like I'm like I have to cover here, and here, and he just have to open this side and that side." –Age 31, Somalia*

Childbirth was regarded as a stressful and difficult event, in which having a male provider compounded the discomfort. Although having a female provider was only one amongst many priorities, women still wished that accommodations could be made for their preference, in an attempt to not further compound their discomfort. Additionally, although the vast majority of women were quite adaptive, for a small minority (two women in the study), having a female provider intrapartum was extremely important, and the consequences of having a male provider were significant. One woman, while reflecting on her experience intrapartum with a male physician shared the reaction of her husband:

"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 XY left I ask "Are you ok?" He says "I feel I want to kill myself".-Age 31, Malaysia

Another woman's delivery with a male provider in her first pregnancy resulted in significant difficulty postpartum, ultimately needing mental health counseling to help her overcome the trauma. Subsequently, she was preoccupied for the entirety of her second pregnancy with worry about having a male physician again deliver her baby. This participant's husband spoke of being a member of society, and as such desiring their preferences to be heard and accommodated because their voices too were important:

"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 have 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)

These women's experiences exemplify how difficult having a male provider can be for some. Although these women also regarded having a female obstetrician as one of many priorities, their ability to adapt differed from other respondents and had further reaching consequences.

Discussion

This study exemplifies that for immigrant women, having a male provider intrapartum can be problematic, influenced by a culture of modesty, often tied to religion (Islam). Additionally, although all women in the study would accept care from a male provider, the implications varied.

Therefore, we argue that acceptance of care is not the primary concern, but rather the potential psychological sequelae.

Thirty of the 38 women recruited were Muslim, reinforcing that the preference for a female provider is more pronounced in Muslim women [3] . Modesty is central to Islam, manifesting in restrictions in dress, gender segregation, and forbidding physical contact between the sexes [19] , defined as *awrah, purdah, or kalwah*. In this study, many women referred to a culture of modesty restricting cross-gender encounters, one specifically explaining this in relation to *awrah*, or areas of the body required by Islam to be covered [20] . None of the women spoke of *purdah* (gender segregation for "protection of women" [21]), or of *kalwah* (instances where a chaperone is required because of the close proximity between opposite sexes [22]), although demonstrated elsewhere [23] .

Despite the importance of modesty in Islam, it is generally believed that cross-gender medical encounters are permissible, particularly in emergent situations [19] . However, what exactly constitutes an emergency was loosely defined in our study, anywhere from presenting to a hospital for assessment, to a life or death situation. These differing interpretations could contribute to a woman's level of flexibility allowing a male provider intrapartum.

Muslim women in our study commonly stated they "had to prefer", or "had to try" to have a female physician. In a phenomenology exploring Muslim women's encounters with healthcare providers in rural United States, it was identified that when women had limited options, they would rationalize their interaction with male providers, in an attempt to make it seem acceptable [22] . Therefore, enquiring and insisting on a female provider intrapartum may, at one level, simply

represent a mechanism by which women and their family/community have the solace knowing they have done all they can.

A central finding of the study was that despite knowing that physical exposure and cross-gender encounters were permissible in specific medical contexts such as childbirth, women found it difficult to adapt. Acculturation refers to "the general processes and outcomes (both cultural and psychological) of intercultural contact" [24] . For the vast majority of women in the study, having a female provider was of low priority relative to other variables, and for these women, acculturation was relatively easy, requiring only some "cultural shedding" [24] . However, for a minority this aspect of acculturation caused a great deal of conflict and stress, which manifested in delays in seeking care, psychological disturbance, and interpersonal relationship stress, referred to as *acculturative stress* [24] .

Delays or avoidance in health seeking behavior amongst Muslim women because of the uncertainty of having a female provider has been demonstrated in a variety of settings. A recent study of American Muslim women reported that over half of the women in the study delayed seeking care due to a perceived lack of female clinicians [12] . Although this was in an ambulatory setting, our study demonstrated that delays are also seen in the urgent obstetrical setting, which is of concern. Finally, the role that partners and families had in shaping perceptions and reactions to having a male provider intrapartum was also clearly demonstrated in our study. The influence that family has on acculturation stress has been widely demonstrated, as one validated measurement tool of acculturation stress in immigrants includes the family factor [25] .

However, having a male provider intrapartum had considerable implications for a minority of women in our study, which could be characterized as acculturative stress. High levels of

acculturative stress have been shown to be predictive of adverse psychological outcomes [26] . Therefore, identification of these women is imperative, to address potentially substantial psychological sequelae and enable providers to ensure appropriate support.

Potential limitations of this study were that a broad inclusion criteria with no restrictions on ethnic or religious groups, or duration of time spent in Canada, was adopted. This method was adopted to avert assumptions and enhance rigor, but in order to fully explore the impact of these factors, a stricter inclusion criteria may be necessary. Additionally, although interviews were conducted both antenatal and postpartum, some women may have changed their perspective had they had a male provider intrapartum.

Table 1: Respondent Demographics

Demographic Variable	Respondents (n=38)
Age, mean (years)	27.7
Birth Country	Somali (7)* Ethiopia (6) India, Bangladesh (3 each) Kenya, Pakistan, Lebanon (2 each) Saudi Arabia, Philippines, Sri Lanka, Malaysia, Zimbabwe, Tunisia, Congo, Italy, Yemen, Gambia, Iraq, Eritrea, Syria (1 each)
Marital Status	Married (36) Unmarried (2)
Education	No formal (1), Primary (4), Secondary (15) Post-secondary (4), Bachelors (7) Masters (4), PhD (1), MD (1)
Religion	Muslim (30) Christian (5) Hindu, Sikh, Buddhist (1 each)
Parity	P0 (17), P1 (11), P2 (9), P3 (1)
Employment status	Home-maker (26) Employed outside the home (12)

* (number) refers to the number of participants this referred to References

References

1. Janssen SM, Lagro-Janssen ALM. Physician's gender, communication style, patient preferences and patient satisfaction in gynecology and obstetrics: A systematic review. *Patient Educ Couns*. 2012;89(2):221-26.

2. Brar S, Tang S, Drummond N, Palacios-Derflingher L, Clark V, John M, et al. Perinatal care for South Asian immigrant women and women born in Canada: Telephone survey of users. *J Obstet Gynaecol Can*. 2009;31(8):708-16.

3. Small R, Roth C, Raval M, Shafiei T, Korfker D, Heaman M, et al. Immigrant and non-immigrant women's experiences of maternity care: A systematic and comparative review of studies in five countries. *BMC Pregnancy Childbirth*. 2014;14:152.

4. Henderson J, Gao H, Redshaw M. Experiencing maternity care: The care received and perceptions of women from different ethnic groups. *BMC Pregnancy Childbirth*. 2013;13:196.

5. Drysdale H, Ranasinha S, Kendall A, Knight M, Wallace EM. Ethnicity and the risk of late-pregnancy stillbirth. *Med J Aust*. 2012;197(5):278-81.

6. Ganann R, Sword W, Black M, Carpio B. Influence of maternal birthplace on postpartum health and health services use. *J Immigr Minor Health*. 2012;14(2):223-29.

7. Knight M, Kurinczuk JJ, Spark P, Brocklehurst P, UKOSS. Inequalities in maternal health: National cohort study of ethnic variation in severe maternal morbidities. *BMJ*. 2009;338:b542.

8. Higginbottom GM, Hadziabdic E, Yohani S, Paton P. Immigrant women's experience of maternity services in Canada: A meta-ethnography. *Midwifery*. 2014;30(5):544-59.

9. Small R, Yelland J, Lumley J, Brown S, Liamputtong P. Immigrant women's views about care during labor and birth: An Australian study of Vietnamese, Turkish, and Filipino women. *Birth*. 2002;39(4):266-77.

10. Benza S, Liamputtong P. Pregnancy, childbirth and motherhood: A meta-synthesis of the lived experiences of immigrant women. *Midwifery*. 2014;30(6):575-84.

11. Whitehead M. The concepts and princiles of equity in health. *Health Promot Int*. 1991;6(3):217-28.

12. Vu M, Azmat A, Radejko T, Padela A. Predictors of delayed healthcare seeking among American Muslim women. *J Womens Health*. 2016;25(6):586-93.

13. Vissandjee B, Weinfeld M, Dupere S, Abdool S. Sex, gender, ethnicity, and access to health care services: Research and policy challenges for immigrant women in Canada. *J Int Migr Integr*. 2001;2(1):55-75.

14. Lyons SM, O'Keeffe FM, Clarke AT, Staines A. Cultural diversity in the Dublin maternity services: The experiences of maternity service providers when caring for ethnic minority women. *Ethn Health*. 2008;13(3):261-76.

15. Shahawy S, Deshpande NA, Nour NM. Cross-cultural obstetric and gynecologic care of Muslim patients. *Obstet Gynecol*. 2015;126(5):969-73.

16. Higginbottom G, Pillay JJ, Boadu NY. Guidance on performing focused ethnographies with an emphasis on healthcare research. *Qual Rep*. 2013;18(17):1-16.

17. Green J, Willis K, Hughes E, Small R, Welch N, Gibbs L, et al. Generating best evidence from qualitative research: The role of data analysis. *Aust NZ J Publ Heal*. 2007;31(6):545-50.

18. Morse JM, Barrett M, Mayan M, Olson K, Spiers J. Verification strategies for establishing reliability and validity in qualitative research. *Int J Qual Methods*. 2002;1(2):13-22.

19. Padela AI, Rodriguez del Pozo P. Muslim patients and cross-gender interactions in medicine: An Islamic bioethical perspective. *J Med Ethics*. 2011;37:40-4.

20. Aldeen AZ. Commentary: The Muslim ethical tradition and emergent medical care: An uneasy fit. *Acad Emerg Med*. 2007;14(3):227-8.

21. Currie S, Azfar P, Fowler RC. A bold new beginning for midwifery in Afghanistan. *Midwifery*. 2007;23:226-34.

22. Simpson JL, Carter K. Muslim women's experiences with health care providers in a rural area of the United States. *J Transcult Nurs*. 2008;19(1):16-23.

23. Isa Mobibbo F, Dareng E, Bamisaye P, Jedy-Agba E, Adewole A, Oyeneyin L, et al. Qualitative study of barriers to cervical cancer screening among Nigerian women. *BMJ Open*. 2016;6(1):e008544.

24. Berry JW. Immigration, acculturation, and adaptation. *Appl Psychol*. 1997;46(1):5-38.

25. Fuertes JN, Westbrook FD. Using the social, attitudinal, familial, and environmental (SAFE) acculturation stress scale to assess the adjustment needs of Hispanic college students. *Meas Eval Couns Dev*. 1996;29(2):67-76.

26. Goforth AN, Oka ER, Leong F, Denis DJ. Acculturation, acculturative stress, religiosity and psychological adjustment among Muslim Arab American adolescents. *J Muslim Ment Health*. 2014;8(2):3-19.

Chapter 4: Manuscript #3

Empathetic Yet Resistant: Accommodating Immigrant Women's Preferences for Female Providers

Abstract:

Objective*:* To gain obstetricians' understanding of the importance, effect, and challenges to providing care when immigrant women prefer a female obstetrician.

Methods*:* A focused ethnography was conducted using purposive sampling of 20 obstetrical providers (10 resident and 10 staff obstetricians) in Edmonton, Alberta, Canada. Data collection comprised of a single semi-structured interview with participants. Interviews were audio-recorded and transcribed verbatim. Data was managed by a qualitative data analysis software, and analyzed using thematic analysis.

Results: A total of 13 female and seven male physicians were interviewed. In line with patient-centered care, physicians recognized the validity, and empathized with immigrant women's preference for female providers. However, they were resistant to accommodating these requests, stemming from concerns about the extent to which the host communities should accommodate immigrant cultural requests, based on the ability of the health system to respond, discerning coercion-free patient decision-making, implications for training and quality of care, and fear of perpetuating and exacerbating gender inequalities in medicine.

Conclusion: Physicians faced a dilemma trying to balance patient preferences with their own autonomy as a physician and a person. Identifying physician's values and perspective will enhance understanding of the patient-physician relationship, ultimately progressing towards addressing this issue both philosophically and practically.

Introduction:

Since time immemorial, childbirth has been the domain of women. Only after obstetrics entered the male-dominated medical profession in the ninetieth century did provision of care shift exclusively to male providers [1] . However, the feminization of medicine [2] has reinstated choice with regards to gender of provider, which for immigrant women may be particularly important [3,4] .

Accommodating requests for a female obstetrical provider respects patient's values, preferences, and expressed needs, representing patient-centered care [5] . However, not only is the feasibility of this a challenge [6,7] , but a patient's refusal of care on the basis of gender can be interpreted as gender discrimination [8,9] . Although physicians and hospitals are not legally bound to comply with patient's requests for a specific gender of provider, it is an ethical matter of balancing the interests of both the provider and patients [10] . Honoring gender-based patient requests may also have educational implications. Male medical students in the United States have reported gender-based educational inequalities during their obstetrics and gynecology clerkship rotations [11] , and have felt their gender adversely affected skills acquisition [12] .

Despite these concerns, there is a paucity of literature on the provider perspective of this issue, which is imperative to fully comprehending and addressing ethnic disparities in healthcare [9,13] . The objective of this study was to use a qualitative approach to gain understanding of importance, effect, and challenges to providing care when immigrant women prefer a female obstetrician.

Materials and Methods:

A focused ethnography was conducted. Whereas ethnography sets about to describe culture

broadly, focused ethnography is focused on a particular research objective and context, to guide decision-making on a particular problem [14] , and is therefore particularly suitable for healthcare research [15] .

Participants were recruited purposively from resident and consultant obstetricians that had ample experience working with immigrant women. In addition to provider status, eligibility criteria included: 1) experience providing care to immigrant woman who preferred a female physician intrapartum, and 2) for resident physicians, completion of at least one year of training. Eligible participants were invited to participate through email and in-person invitation by the first author.

A total of 10 resident and 10 consultant obstetricians were interviewed after informed consent was obtained, in a semi-structured format using a piloted guide during off-service hours at a mutual location, from August 2015 through January 2016. Questions included: *How has/does provider gender come up as a barrier during labor and delivery? Is this issue discussed with women antenatally? What is your response to this request, and how do you personally feel about it? How do you think we can address this issue?*

All interviews were audio-recorded and transcribed verbatim by the first author. A database of interview transcripts and observations was created, stored and handled using Quirkos 1.3 qualitative computer software (Quirkos Ltd., Edinburgh, Scotland). Data were analyzed using thematic analysis [16] . Coding was done by reading and rereading, highlighting and identifying recurrent concepts. The codes were then grouped into similar categories and subcategories, and described in detail. This process was fluid and iterative, and occurred concurrent with data collection. Categories were then considered together and common themes were determined.

Validity, reliability, and generalizability as described by Morse et al. were used as the framework for ensuring rigor of the study [17] . This was achieved through purposive sampling, the iterative process of data collection and analysis, following up on emerging concepts and tracking changes. Data collection continued until saturation was achieved.

Ethics approval was obtained through the University of Alberta Human Research Ethics Board (Panel B), and operational approval through the Northern Alberta Clinical Trials and Research Centre.

Results:

Respondent demographics are shown in Table 1. The mean age of the 10 resident physicians was 29.2 years, and seven were female. The mean age of the 10 consultant obstetricians was 46.3 years, with a mean of 15.1 years in practice, and six were female.

Our study revealed two main themes with regards to providers' response to immigrant women requesting a female provider intrapartum:

1) *Physicians recognize the validity, and empathize with women's preference for female providers*

   Physicians wanted to respect patient autonomy, recognizing that this preference and request was often tied to cultural and religious norms. While acknowledging they did not fully understand these women's perspective or necessity, they were empathic of patients' request for female providers.

2) *Resistance to accommodating patient requests for female providers*

   Regardless of the desire to respect patient preference, physicians were resistant to accommodating requests for a female provider intrapartum. This stemmed from concerns

about the extent to which host community should accommodate immigrant cultural requests, the ability of the health system to respond, discerning coercion-free patient decision-making, implications for training of future obstetricians and quality of care, and fear of perpetuating and exacerbating gender inequalities in medicine.

1) Physicians recognize the validity, and empathize with women's preference for female providers

Our data showed that all respondents viewed patient-centered care as the epitome of best practice. They recognized the importance of honoring patient requests, even if they differed from recommendations. Physicians alluded to many examples of requests that are accommodated in obstetrics, likening the request for a female provider to a whole host of other patient preferences.

> *"like we respect a patients 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"-Pro06*

However, the preference particular patients had for a female provider was also viewed somewhat differently. Given that the rationale for this was influenced, at least in part, by the patient's cultural, religious, and social context, physicians were found to empathize with patients requesting a female provider. They acknowledged the values entrenched within these contexts, and recognized the influence of multiple factors, from the patient to her surrounding community. Physicians also highlighted that it was not possible to know every factor influencing a particular patient's request for a female provider, and recognized that many women may have come from war-torn countries where sexual violence was a systematic form of abuse. One physician even

talked about her experience with a patient who had been a victim of sexual abuse from a healthcare provider, sensitive to the fact that care from a male provider would replicate the trauma of these past experiences. Therefore the priority shifted to respect and provision of the best care for an individual, keeping in mind that one may never know how important or why this is important to many patients.

> *"like I think in general I am kind of pro- patient request, because like you never know where someone is coming from and why they have a certain preference one way or the other"-Pro08*

2) Resistance to accommodating patient requests for female providers

Despite being sensitive to patient's requests for female obstetrical providers, physicians were aware that such requests were not being met. Furthermore, our data indicated that physicians did not believe patient requests for female providers should be met.

2.1 System challenges:

All respondents were part of a health care system in which after-hours and weekend care was provided by an on-call obstetrician. This meant that patients presenting to the hospital were not guaranteed care by their regular obstetrician, but by any one of many consulting obstetricians (both male and female) who have privileges at that hospital. This system is common in Canada's publicly funded system, and physicians recognized that the structure of the system enabled provision of safe, immediate care for patients presenting to the hospital. They also recognized that this system was in the best interest of providers. By having a sign-out system, physicians were able to have a more sustainable practice, protecting their time outside of working hours. If

the system allowed for women to request female physicians intrapartum, female physicians expected that they would have larger workloads, particularly infringing upon work/life balance.

Physicians faced a dilemma when the patient-centered care model came into conflict with the structure of the healthcare system. Although physicians wanted to respect patient preferences, given the current system, there were obvious immediate patient safety concerns to doing this, as a female obstetrician was not always available.

> *"... it's very worrisome actually, because you just fear that- that they're not allowing themselves the best care, based on gender- like their fear of males, and their refusal of males, their care is definitely, impacted."-Pro12*

One physician also shared two examples of adverse neonatal outcomes when a woman refused care from a male obstetrician. Although they recognized that failure to respond to patient requests might jeopardize patient care, they were resistant to making changes to the health system that would allow for requests for female obstetricians. They argued that the massive restructuring that would be required to ensure this occur safely was not justifiable. Physicians felt that the healthcare system was facing many challenges in providing high quality care to all, and especially immigrant populations. Of all the issues requiring attention, accommodating requests for female providers was deemed to be of lesser importance, and not a judicious use of limited healthcare resources in a publically funded system.

> *"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."-Pro18*

2.2: The challenge of discerning coercion-free patient decision-making

Our respondents identified informed consent as a central pillar of patient-centered care. This became imperative when patient requests differed from provider recommendations and had potentially negative implications. More importantly, physicians wanted to ensure such requests and consent for the potential implications were patient-driven and not coerced. They had noted that often the decision-makers were not the women themselves, but their male partners, or other family members. Not only did this make physicians uneasy, they perceived it as a denial of a women's right to make decisions, and a form of oppression. Respondents ubiquitously, both male and female, became personally upset when they recalled or pictured such scenarios.

> *"Yeah, I've been in that situation, where you walk in and the husband, or like the father or grandfather, you know it's a very male- unfortunately- and that's pretty sad. I don't care for that at all. If it's the woman's choice than so be it, but the husband, or the boyfriend…"-Pro03*

> *"…the mother doesn't have any rights! I just- IT JUST PUTS THE BACK OF MY HAIR ON MY NECK UP."-Pro18*

2.3: Quality of care and training implications

Current attempts to accommodate patient requests for a female obstetrician intrapartum meant only female residents provided the care. Both resident and staff physicians felt this was problematic. Firstly, for an optimal training and educational environment, direct supervision is imperative, particularly for junior learners. Additionally, when a resident was providing care unsupervised, it potentially compromised the quality of care, and also opened the door to unintended legal consequences. Finally, for female residents this lead to an increased burden of

care that could be potentially overwhelming, consequently diminishing the ability to provide safe care; whereas for male residents and medical students this meant exclusion from particular patient encounters and therefore lost learning opportunities.

> *"I think that's a huge barrier to not only care, but also from- when you're coming to a learning hospital, I think it's a huge barrier to our trainees, and them getting the experience and the exposure that they deserve too.."-Pro19*

> *"…from an education point of view, we have to be supervising people, and then to be deliberately not supervising people because of their choice of the sex I don't think should be done and I think is wrong."- Pro10*

2.4: The fear of further perpetuating and exacerbating gender inequalities

On a personal level, physicians at times took offense to women preferring to have a female physician. When a patient cited comfort as the reason for their request it was more acceptable, but physicians were guarded in accepting this, because they did not want to be a victim of gender generalizations. Physicians, both male and female, were extremely sensitive to gender inequities. They felt that although respecting patient requests was important, the desire to protect principles of gender equity within society and medicine was stronger. Many physicians interpreted a patient's request for a female obstetrician as a form of gender discrimination, and for these physicians, felt requests for female obstetricians should not be condoned, regardless of the motivation behind the request. This was viewed as something that would not be tolerated in other areas of society, yet in labor and delivery was tolerated and at times encouraged within the setting of cultural differences.

"I think it's pretty ridiculous that this preference for a male healthcare 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, ah 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. And um… 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."-Pro04

This was particularly important to physicians given the historical picture of gender inequalities within the field of Medicine in particular. In the not-so-recent past, obstetrics, and medicine in general was closed to females, a memory that influenced positions against allowing gender concessions.

… (sighs)… "I suppose I defend either gender equally. It's not my issue… I've defended both, and I just- I don't see that marginalizing our male residents or male medical students.. ahh, demanding that they not see them is necessarily in society's or our best interests. That's how I see it. I mean I've lived through where women weren't allowed in medicine, so I'm not going to go there. It's not my- I don't think it's right, I've never thought it's right, so I'm not going to be part and parcel of it."- Pro18

Additionally, the culture of gender discrimination was still felt to be present within the medical profession. Some female physicians shared experiences of being discriminated against because they were females, either from patients or allied health professionals. Although undeniable progress in medicine has occurred, it was feared that by accommodating requests it would further propagate gender inequalities, an undesirable consequence, regardless if it was in the reverse form. Furthermore, it was feared that this could lead to a slippery slope of permitting a host of preferences that could threaten the very values of society.

> *"So .. 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."-Pro16*

As a result of this fear for unintended consequences of accommodating requests that included patient safety, legal, and educational implications, physicians felt it was imperative that a policy be made. It was felt this would protect patients by providing more guidance and support for physicians on the issue, and help to separate patients who this impacted more substantially. However, a policy was desired mostly to guard against the ambiguity and potential slippery slope of accommodating requests, providing solidarity amongst physicians:

> *"[It] 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."-Pro07*

Discussion:

Results from this study suggest that, despite empathy for immigrant women who prefer a female

provider intrapartum, physicians are resistant to accommodating requests. Physicians found it particularly difficult to understand the value ascribed to having a female provider, as they perceived it to be based on religious or cultural preference, heavily influenced by other (male familial) decision makers. Our data suggests that physicians approached patient decision-making from a Western feminist perspective, a secular movement that emphasizes agency and autonomy [18] . Rooted in rational individualism, this approach can be problematic when applied to other cultures and religions. In many Eastern societies, the concept of self is more group-orientated, and therefore the autonomous person as understood in a Western context might not be universally applicable [19] .

The resistance to accommodating requests for female providers was not only the result of differing value perspectives. Pellegrino (1994) identified three broad categories of physician autonomy that can interfere with respecting patient preferences, coinciding with the areas of resistance physicians felt in our study: autonomy as a physician, autonomy as a member of a professional and moral community, and autonomy as a person [20] .

Firstly, autonomy as a physician to uphold the ethical principle of beneficence felt threatened when women opposed care from a male obstetrician. Beneficence refers to "the moral obligation to act for the benefit of others" [21] , and historically was the unchallenged first principle of medical ethics. However, since the 1970s, beneficence has been equated with medical paternalism, and autonomy has been emphasized [21] . Although both approaches have been critiqued, and alternative models proposed [22,23] , determining the "best" solution requires identifying the limits of autonomy and the moral conflict behind this limit, a task fraught with difficulty.

Secondly, physicians belong to a professional and moral community [20] , entrusted by society to ensure judicial use of healthcare resources. As providers in a public system, physicians were trying to balance both the fiduciary responsibility of the physician to the patient, and the greater societal well-being [24] . As such, respondents did not view provision of a female care provider intrapartum as a priority. The allocation, rationing and prioritization of finite healthcare resources inherently involves value judgments, and are primarily based on an economic analysis of both direct and indirect costs of illness. A third group, referred to as *intangible costs*, involve "pain and suffering", and although they cannot be objectively measured, are vital in accounting for gender and diversity, and ensuring social justice and equity [25] . For certain women, not being able to have a female provider intrapartum might invoke an intangible cost. Since physicians have a pivotal role in resource allocation, they must not only balance societal and individual interests based on direct and indirect costs, but also consider intangible costs.

Finally, physicians felt their autonomy as a person was threatened, as they had both practical and personal objections to the provision of a care provider intrapartum based on gendered requests. Situating this within the history of women in medicine allows for a contextual understanding of the sensitivity to gender-related requests, given the relatively recent inclusion of women in the medical profession. Furthermore, as Boulis states, "medicine feminized incompletely and unevenly", with unequal gender distribution across medical specialties, female physicians still facing discrimination, earning less, and being underrepresented in research and leadership [2,26] . It is from this perspective that physicians in our study reacted to the gendered requests of patients, feeling that it both threatened progress, and risked further propagating gender inequalities. Additionally, from a resident education point of view, respondents cited apprehension regarding appropriate supervision of learners, loss of learning opportunities for male learners, and an

increased workload for female learners. Respondents included both resident and staff obstetricians, and although this provided insight into educational aspects of this issue, in order to further address this issue a study design limited to trainees may be of interest.

Understanding the provider perspective is imperative. It grounds the strong reactions to requests for female providers within a larger narrative of the history and current affairs of women in Medicine, influenced by Western perceptions of feminism. Careful evaluation of patient values can provide the foundation of culturally appropriate and patient-centered care. However, failure to recognize the physician within the patient-physician interaction has led to a neglect of the nuances of physician autonomy in this context, contributing to difficulties in addressing this issue.

Table 1: Respondent Demographics

Demographic Variable	Resident Physician (n=10)	Staff Physician (n=10)
Mean age (years)	29.2	46.3
Mean number of years in practice	3.2	15.1
Sex ratio (F:M)	7:3	6:4

References

1. Drife J. The start of life: A history of obstetrics. *Postgrad Med J*. 2002;78:311-315.

2. Boulis AK, Jacobs JA. The changing face of medicine: Women doctors and the evolution of health care in America. Ithaca (NY): Cornell University Press; 2008.

3. Brar S, Tang S, Drummond N, Palacios-Derflingher L, Clark V, John M, et al. Perinatal care for South Asian immigrant women and women born in Canada: Telephone survey of users. *J Obstet Gynaecol Can*. 2009;31(8):708-16.

4. Small R, Roth C, Raval M, Shafiei T, Korfker D, Heaman M, et al. Immigrant and non-immigrant women's experiences of maternity care: A systematic and comparative review of studies in five countries. *BMC Pregnancy Childbirth*. 2014;14:152.

5. McLean M, Al Yahyaei F, Al Mansoori M, Al Ameri M, Al Ahbabi S, Bernsen R. Muslim women's physician preference: Beyond obstetrics and gynecology. *Health Care Women Int*. 2012;33:849-876.

6. Vissandjee B, Weinfeld M, Dupere S, Abdool S. Sex, gender, ethnicity, and access to health care services: Research and policy challenges for immigrant women in Canada. *J Int Migr Integr*. 2001;2(1):55-75.

7. Lyons SM, O'Keeffe FM, Clarke AT, Staines A. Cultural diversity in the Dublin maternity services: The experiences of maternity service providers when caring for ethnic minority women. *Ethn Health*. 2008;13(3):261-76.

8. Makam A, Saroja C, Edwards G. Do women seeking care from obstetrician–gynaecologists prefer to see a female or a male doctor? *Arch Gynecol Obstet*. 2010;281:443-447.

9. Degni F, Suominen S, Essén B, El Ansari W, Vehviläinen-Julkunen K. Communication and cultural issues in providing reproductive health care to immigrant women: Health care providers' experiences in meeting Somali women living in Finland. *J Immigr Minor Health*. 2012;14(2):330-343.

10. Watson K, Mahowald MB. Honoring gender-based patient requests for obstetricians: Ethical imperative or employment discrimination? *J Womens Health Gend Based*. 1999;8(8):1031-1041.

11. Witte FM, Stratton TD, Nora LM. Stories from the field: Students' descriptions of gender discrimination and sexual harassment during medical school. *Acad Med*. 2006;81(7):648-654.

12. Emmons SL, Adams KE, Nichols M, Cain J. The impact of perceived gender bias on obstetrics and gynecology skills acquisition by third-year medical students. *Acad Med*. 2004;79(4):326-332.

13. Ng C, Newbold KB. Health care providers' perspectives on the provision of prenatal care to immigrants. *Cult Health Sex*. 2011;13(5):561-574.

14. Mayan M. Essentials of qualitative inquiry. Walnut Creek (CA): Left Coast Press, Inc; 2009.

15. Higginbottom G, Pillay JJ, Boadu NY. Guidance on performing focused ethnographies with an emphasis on healthcare research. *Qual Rep*. 2013;18(17):1-16.

16. Green J, Willis K, Hughes E, et al. Generating best evidence from qualitative research: The role of data analysis. *Aust NZ J Publ Heal*. 2007;31(6):545-550.

17. Morse JM, Barrett M, Mayan M, Olson K, Spiers J. Verification strategies for establishing reliability and validity in qualitative research. *Int J Qual Methods*. 2002;1(2):13-22.

18. Salem S. Feminist critique and Islamic feminism: The question of intersectionality. *The Postcolonialist*. 2013;1(1).

19. Bulbeck C. Re-orienting western feminisms: Women's diversity in a postcolonial world. Cambridge (UK): Cambridge University Press; 1998.

20. Pellegrino ED. Patient and physician autonomy: Conflicting rights and obligations in the physician-patient relationship. *J Contemp Health Law Policy*. 1994;10:47-68.

21. Beauchamp TL, Childress JF. Principles of biomedical ethics. Sixth ed. New York (NY): Oxford University Press, Inc.; 2009.

22. Pellegrino ED, Thomasma DC. The conflict between autonomy and beneficence in medical ethics: Proposal for a resolution. *J Contemp Health Law Policy*. 1987;23:23-46.

23. Savulescu J. Rational non-interventional paternalism: Why doctors ought to make judgments of what is best for their patients. *J Med Ethics*. 1995;21:327-331.

24. Kluge EW. Resource allocation in healthcare: Implications of models of medicine as a profession. *MedGenMed*. 2007;9(1):57.

25. Hankivsky O, Friesen J, Varcoe C, MacPhail F, Greaves L, Spenser C. Expanding economic costing in health care: Values, gender and diversity. *Can Public Policy*. 2004;30(3):257-282.

26. Heru AM. Pink-collar medicine: Women and the future of medicine. *Gender Issues*. 2005:20-34.

Chapter 5: Conclusion

The objective of this study was to explore the barrier created by the gender of the obstetrical care provider gender for immigrant women. Specifically the study aimed to understand the importance, effect, and challenges of having a male provider intrapartum, both from patient and provider perspectives. Despite having a preference for female providers, women would accept care from male obstetricians. However, the implications of accepting this care differed from individual to individual, and for some resulted in considerable, potentially serious consequences. From the physician perspective, although empathetic and sensitive to this request from patients, physicians resisted accommodating these requests. They feared that by opening the door to discussion of this issue it could lead to a slippery slope of what is acceptable and accommodated.

Acculturation refers to the processes and outcomes of intercultural contact, the outcome of which is variable between different individuals [1]. In the traditional view of intercultural contact, the outcome expected was that the non-dominant culture would assimilate, resulting in a homogenous society reflecting the dominant culture [2]. Although this simplistic view of intercultural contact has long-since been contested, our data suggests that to an extent, this is still functioning.

In Berry's model, the strategy for responding to acculturation is based on attitudes and behaviors of both the non-dominant and dominant culture [1]. Assimilation is one strategy used by those in non-dominant cultures to respond to intercultural contact. Indeed, women in our study were assimilating to the dominant culture, as all women would accept care from male providers, despite their alternate preference. However, a key finding was that while women would accept care from male providers, the implications of accepting this care differed. This can be conceptualized in the outcomes of acculturation. For some, it resulted in minimal difficulty,

requiring only a *behavioral shift*, but for others it caused greater conflict and stress response, manifested in delays in seeking care, psychological disturbance, and interpersonal relationship stress, referred to as *acculturative stress* [1].

Additionally, although assimilation is a strategy for responding to acculturation for the non-dominant culture, when assimilation is mandated by the dominant culture, the result, is not a 'melting pot', but a 'pressure cooker' [1]. Physicians desired assimilation of immigrant women to the current system, wanting them to accept the fact that the system will not guarantee a female physician intrapartum. Additionally, they desired to have a policy to support assimilation in this regard, in line with the current system.

Instigating a policy to confront women refusing care from a male provider was the response of physicians to intercultural contact, and this sought to impose assimilation from the dominant culture on the non-dominant culture, the implications of which could be further damaging for both parties.

This unilateral understanding of acculturation among physicians was influenced by a reaction to the both the past and present gender inequalities that still exist within medicine. Despite considerable progress to the feminization of the medical profession in the recent decades, there is still a long way to go. Gender distribution is not even across medical specialties, female physicians still face discrimination, earn less, and are underrepresented particularly in research and leadership [3-5]. As such, physicians, both male and female, were particularly sensitive to upholding values of gender equality and saw this issue as directly compromising these values.

The Canadian Medical Protective Association (CMPA) [6] and the Society of Obstetricians and Gynaecologists (SOGC) [7] have policies providing guidance to physicians in dealing with patient requests for gender of obstetrical provider. However, as introduced previously, these policies are in conflict with each other, thereby contributing to the difficulty interpreting these guidelines in the acute obstetrical setting. Individual institutions may have policies or procedures in place providing more concrete guidance in dealing with these types of patient requests, as demonstrated at the institution level of Catholic hospitals in Alberta, Canada [8]. This policy echoes the SOGC stance of not accommodating gender-related patient requests, regardless of the motivation behind the request. It would be of interest to survey obstetrical providers in Canada to enquire of similar policies or strategies for dealing with dealing with gender-related patient requests, to inform subsequent policy on this and similar matters.

However, as introduced above, our findings suggest that despite having a preference for female providers, all women actually would accept care from a male obstetrician. Therefore, physicians desire assimilation from women, but indeed this has already occurred. The actual issue at hand is the small minority of women who suffer significant consequences as a result of this aspect of acculturation.

Although this study suggests that the prevalence of significant negative outcomes deemed as acculturative stress occurs in a small minority of women, given the objectives and methods of the study this is speculative. Therefore, there is a need to quantify this occurrence. In doing so, the goal should not be to identify the number of immigrant women who prefer a female provider, but rather the proportion who this will have a significant psychological impact upon. Numerous tools have been developed to measure acculturation stress in individuals, as it has been demonstrated that high levels of acculturation stress are predictive of adverse psychological outcomes [9]. It

might follow that women who have higher levels of acculturation stress may be those at increased risk of suffering adverse psychological effects of having a male provider intratpartum. Therefore, being able to predict women who this may impact greatly will enable providers to respond, and ensure women are appropriately supported through a difficult cultural transition.

From the study, the preference for a female provider was tied to a culture of modesty, in many instances merged with religious obligation in Islam. While traditionally the focus of acculturation has been on intercultural contacts, the impact that religious identity has on the process is only now becoming apparent [10]. In line with our findings, Amer & Hovey (2007) demonstrated different acculturation patterns amongst Christian and Muslim immigrant Arab Americans, indicating the role of religion in acculturation [11]. Religious identity may play a significant role in women experiencing acculturation stress. Therefore, in trying to identify women for whom this might significantly impact, it would make sense to focus not only on the cultural aspect (i.e. immigrant women), but also on the religious perspective (i.e. immigrant Muslim women).

One validated tool for measuring acculturation stress is the Social, Attitudinal, Familial and Environmental (SAFE) Scale. Initially a 60-item questionnaire developed to identify acculturation stress in immigrant university students [12], it has subsequently been shorted to a 24-item, validated questionnaire [13,14]. As the name implies, the scale is a series of questions on a 5-point Likert scale, based on four domains of social, attitudinal, familial and environmental factors; the higher the score, the more acculturative stress apparent (See Appendix 5). The domains represented in the SAFE scale also reflect domains women cited in the study as driving their preference for a female provider intrapartum. If acculturation stress can be shown to predict women for whom having a male provider intrapartum results in significant negative implications,

this issue can be further explored in this subset of women, identifying ways to support them in a feasible way, based on their needs.

Beyond addressing the barrier that a male obstetrical provider poses to some immigrant women, the role that acculturative stress has in health seeking behaviors, adherence, and overall experience of health care in the immigrant population has not been demonstrated. There are numerous challenges and barriers that have been identified to providing care to the immigrant population [15-17], and individuals process acculturation changes in different ways. Therefore, if acculturative stress is found to be predictive of those women who suffer more negative implications from having a male provider intrapartum, it might also be able to predict those who experience particular difficulty adapting, impacting uptake, usage, and experience of healthcare services. Identifying this subset of women may help to inform how best they are supported, and potentially contribute to addressing other barriers immigrant women face.

Limitations:

There were some limitations of the study. Firstly, the inclusion criteria of the study was broad, with no restrictions on ethnic or religious groups, or duration of time spent in Canada. This was to avert assumptions by suspending knowledge, thereby enhancing rigor. However, in order to explore more fully the impact of these factors, a stricter inclusion criteria may have to be adopted. Additionally, perceptions of having a male provider may have changed if women had a male provider intrapartum. By interviewing women both antenatal and postpartum we hoped capture this, but to further explore the impact of a male provider intrapartum it might be necessary to limit the postpartum interviews to only those who experienced a male provider.

Although most of our respondents accepted care from a male provider, it is possible those adamant at not accepting male care may not have been captured in our sampling strategy. Our respondents were recruited in third trimester, at 36+ weeks gestation. The issue of provider gender at the time of delivery is addressed, in most cases, by obstetricians in the first prenatal visit. Therefore, women who had a significant issue with male providers may not have returned to this group of providers but rather may have opted for a female-only group, one of which exists as a group of family physicians. In provider interviews, it was apparent that some providers did refer patients to this group of family physicians occasionally, for this reason, although it was quite rare. In order to capture this subset of women it would be necessary to either recruit additionally from these providers, or have the initial interview at the time of first prenatal appointment.

References

1. Berry JW. Acculturative stress. In: Wong PTP, Wong LCJ, eds. *Handbook of multicultural perspectives on stress and coping.* United States of America: Springer Science + Business Media, Inc.; 2006:287-298.

2. Berry JW. Globalisation and acculturation. *Int J Intercult Rela*. 2008;32:328-336.

1999;45:690-7.

2. Boulis AK, Jacobs JA. *The changing face of medicine: Women doctors and the evolution of health care in America.* Ithaca (NY): Cornell University Press; 2008.

26. Heru AM. Pink-collar medicine: Women and the future of medicine. *Gender Issues*. 2005:20-34.

5. Jena AB, Olenski AR, Blumenthal DM. Sex differences in physician salary in US public medical schools. *JAMA Int Med*. 2016.

6. Canadian Medical Protective Association [Internet]. c2011 [updated Dec 2011; cited 2015 Aug 11]. When a patient asks for another physician on cultural or religious grounds; [about 2 screens]. Available from: https://www.cmpa-acpm.ca/legal-and-regulatory-proceedings/-/asset_publisher/a9unChEc2NP9/content/when-a-patient-asks-for-another-physician-on-cultural-or-religious-grounds;jsessionid=F216C6805B38D6F3D1EA3E27245539C7.

7. The Society of Obstetricians and Gynaecologists of Canada [Internet]. c2013 [updated June 2013; cited 2015 Aug 11]. SOGC position statement: When a patient asks for another physician on cultural or religious grounds [about 1 screen]. Available from: http://sogc.org/media_updates/position-statement-when-a-patient-asks-for-another-physician-on-cultural-or-religious-grounds/.

8. Covenant Health. Patient request for specific health care provider: Corporate policy & ProceduresManual. . 2012;VII-B-30.

9. Goforth AN, Oka ER, Leong F, Denis DJ. Acculturation, acculturative stress, religiosity and psychological adjustment among Muslim Arab American adolescents. *J Muslim Ment Health*. 2014;8(2):3-19.

10. Olds GR. *Religio-cultural integration among Muslim-Americans.* [Doctor of Philosophy]. Texas A&M University; 2009.

11. Amer MM, Hovey JD. Socio-demographic differences in acculturation and mental health for a sample of 2nd generation/early immigrant Arab Americans. *J Immigr Minor Health*. 2007;9:335-347.

12. Padilla AM, Alvarez M, Lindholm KJ. Generational status and personality factors as predictors of stress in students. *Hisp J Behav Sci*. 1986;8(3):275-288.

13. Mena FJ, Padilla AM, Maldonado M. Acculturative stress and specific coping strategies among immigrant and later generation college students. *His J Behav Sci*. 1987;9(2):207-225.

14. Fuertes JN, Westbrook FD. Using the social, attitudinal, familial, and environmental (SAFE) acculturation stress scale to assess the adjustment needs of Hispanic college students. *Meas Eval Couns Dev*. 1996;29(2):67-76.

15. Higginbottom GM, Hadziabdic E, Yohani S, Paton P. Immigrant women's experience of maternity services in Canada: A meta-ethnography. *Midwifery*. 2014;30(5):544-59.

16. Small R, Roth C, Raval M, Shafiei T, Korfker D, Heaman M, et al. Immigrant and non-immigrant women's experiences of maternity care: A systematic and comparative review of studies in five countries. *BMC Pregnancy Childbirth*. 2014;14:152.

17. Benza S, Liamputtong P. Pregnancy, childbirth and motherhood: A meta-synthesis of the lived experiences of immigrant women. *Midwifery*. 2014;30(6):575-84.

Bibliography

Ahmad F, Gupta H, Rawlins J, Stewart DE. Preferences for gender of family physician among Canadian European-descent and South-Asian immigrant women. *Fam Pract.* 2002;19(2):146-53.

Al Sairafi M, Mohamed FA. Knowledge, attitudes, and practice related to cervical cancer screening among Kuwaiti women. *Med Princ Pract*. 2009;18:35-42.

Aldeen AZ. Commentary: The Muslim ethical tradition and emergent medical care: An uneasy fit. *Acad Emerg Med*. 2007;14(3):227-8.

Amer-Alshiek J, Alshiek T, Levy YA, Azem F, Amit A, Amir H. Israeli Druze women's sex preferences when choosing obstetricians and gynecologists. *Isr J Health Policy Res.* 2015;4(13)

Amer MM, Hovey JD. Socio-demographic differences in acculturation and mental health for a sample of 2nd generation/early immigrant Arab Americans. *J Immigr Minor Health*. 2007;9:335-347.

Amir H, Tibi Y, Groutz A, Amit A, Azem F. Unpredicted gender preference of obstetricians and gynecologists by Muslim Israeli-Arab women. *Patient Educ Couns*. 2012;86(2):259-63.

Bal MD, Yilmaz SD, Beji NK, Uludag S. Muslim women choice for gender of obstetricians and gynecologist in Turkey. *IJHS*. 2014;11(2):64-73.

Bashour H, Abdulsalam A. Syrian women's preferences for birth attendant and birth place. *Birth*. 2005;21(1):20-6.

Basu P, Sarkar S, Mukherjee S, Ghoshal M, Mittal S, Biswas S, et al. Women's perceptions and social barriers determine compliance to cervical screening: Results from a population based study in India. *Cancer Detect Prev*. 2006;30(4):369-74.

Bawadi H. *Migrant Arab Muslim women's experiences of childbirth in the UK*. [dissertation]. Leicester (UK): De Montfort University; 2009.

Beauchamp TL, Childress JF. *Principles of biomedical ethics. Sixth ed*. New York (NY): Oxford University Press, Inc.; 2009.

Beine K, Fullerton J, Palinkas L, Anders B. Conceptions of prenatal care among Somali women in San Diego. *J Nurse Midwifery*. 1995;40(4):376-81.

Benyamini Y, Blumstein T, Boyko V, Lerner-Geva L. Cultural and educational disparities in the use of primary and preventative health care services among midlife women in Israel. *Women Health Iss*. 2008;18:257-66.

Benza S, Liamputtong P. Pregnancy, childbirth and motherhood: A meta-synthesis of the lived experiences of immigrant women. *Midwifery*. 2014;30(6):575-84.

Berry JW. Globalisation and acculturation. *Int J Intercult Rela*. 2008;32:328-336.

Berry JW. Immigration, acculturation, and adaptation. *Appl Psychol*. 1997;46(1):5-38.

Berry JW. Acculturative stress. In: Wong PTP, Wong LCJ, eds. *Handbook of multicultural perspectives on stress and coping.* United States of America: Springer Science + Business Media, Inc.; 2006:287-298.

Betancourt JR. Cultural competence and medical education: Many names, many perspectives, one goal. *Acad Med*. 2006;81(6):499-501.

Binder P, Borné Y, Johnsdotter S, Essén B. Shared language is essential: Communication in a multiethnic obstetric care setting. *J Health Commun*. 2012;17(10):1171-86.

Bodo K, Gibson N. Childbirth customs in Vietnamese traditions. *Can Fam Phys*. 1999;45:690-7.

Boulis AK, Jacobs JA. *The changing face of medicine: Women doctors and the evolution of health care in America.* Ithaca (NY): Cornell University Press; 2008.

Brar S, Tang S, Drummond N, Palacios-Derflingher L, Clark V, John M, et al. Perinatal care for South Asian immigrant women and women born in Canada: Telephone survey of users. *J Obstet Gynaecol Can*. 2009;31(8):708-16.

Brodsky PL. *The control of childbirth: Women versus medicine through the ages*. Jefferson, N.C.: McFarland & Co.; 2008.

Bukar M, Takai IU, Audu BM, Isa JB. Women's gender preferences for their obstetrician and gynaecologist at the university of Maiduguri teaching hospital, Maiduguri, Nigeria. *Orient J Medicine*. 2012;24(1-2):30-6.

Bulbeck C. *Re-orienting western feminisms: Women's diversity in a postcolonial world*. Cambridge (UK): Cambridge University Press; 1998.

Canadian Charter of Rights and Freedoms, Part I of the Constitution Act, 1982, being Schedule to B to the Canada Act 1982 (UK), c 11 (1982).

Canadian Medical Protective Association [Internet]. c2011 [updated Dec 2011; cited 2015 Aug 11]. When a patient asks for another physician on cultural or religious grounds; [about 2 screens]. Available from: https://www.cmpa-acpm.ca/legal-and-regulatory-proceedings/-/asset_publisher/a9unChEc2NP9/content/when-a-patient-asks-for-another-physician-on-cultural-or-religious-grounds;jsessionid=F216C6805B38D6F3D1EA3E27245539C7.

Carroll J, Epstein R, Fiscella K, Gipson T, Volpe E, Jean-Pierre P. Caring for Somali women: Implications for clinician-patient communication. *Patient Educ Couns*. 2007;66(3):337-45.

Chaliha C, Stanton SL. The ethnic cultural and social aspects of incontinence - A pilot study. *Int Urogynecol J Pelvic Floor Dysfunct*. 1999;10(3):166-70.

Chapple A. Iron deficiency anaemia in women of South Asian descent: A qualitative study. *Ethn Health*. 1998;3(3):199-212.

Chapple A, Ling M, May C. General practitioners' perceptions of the illness behaviour and health needs of South Asian women with menorrhagia. *Ethn Health*. 1998;3(1-2):81-93.

Ching SL, Gates EA, Robertson PA. Factors influencing obstetric and gynecologic patients' decisions toward medical student involvement in the outpatient setting. *Obstet Gynecol*. 2000;182(6):1429-32.

Covenant Health. Patient request for specific health care provider: Corporate policy & Procedures Manual. 2012;VII-B-30.

Currie S, Azfar P, Fowler RC. A bold new beginning for midwifery in Afghanistan. *Midwifery*. 2007;23:226-34.

Degni F, Suominen S, Essen B, El Ansari W, Vehvilainen-Julkunen K. Communication and cultural issues in providing reproductive health care to immigrant women: Health care providers' experiences in meeting Somali women living in Finland. *J Immigr Minor Health*. 2012;14:330-43.

Denzin NK, Lincoln YS. The discipline and practice of qualitative research. In: Denzin NK, Lincoln YS, eds. *The SAGE handbook of qualitative research. 4th ed*. United States of America: SAGE Publications, Inc; 2011:1-19.

Donnelly TT. Challenges in providing breast and cervical cancer screening services to Vietnamese Canadian women: The healthcare providers' perspective. *Nurs Inq*. 2008;15(2):158-68.

Donnison J. *Midwives and medical men: A history of the struggle for the control of childbirth*. London: Historical Publications; 1988.

Drife J. The start of life: A history of obstetrics. *Postgrad Med J*. 2002;78:311-315.

Drysdale H, Ranasinha S, Kendall A, Knight M, Wallace EM. Ethnicity and the risk of late-pregnancy stillbirth. *Med J Aust*. 2012;197(5):278-81.

Emmons SL, Adams KE, Nichols M, Cain J. The impact of perceived gender bias on obstetrics and gynecology skills acquisition by third-year medical students. *Acad Med*. 2004;79(4):326-32.

Forgarty CA, Bonebrake RG, Fleming AD, Haynatzki G. Obstetrics and gynecology—To be or not to be? Factors influencing one's decision. *Am J Obstet Gynecol*. 2003;189(3):652-4.

Fuertes JN, Westbrook FD. Using the social, attitudinal, familial, and environmental (SAFE) acculturation stress scale to assess the adjustment needs of Hispanic college students. *Meas Eval Couns Dev*. 1996;29(2):67-76.

Ganann R, Sword W, Black M, Carpio B. Influence of maternal birthplace on postpartum health and health services use. *J Immigr Minor Health*. 2012;14(2):223-29.

Ganle JK. Why Muslim women in northern Ghana do not use skilled maternal healthcare services at health facilities: A qualitative study. *BMC Int Health Hum Rights*. 2015;15(10).

George P, Terrion JL, Ahmed R. Reproductive health behaviour of Muslim immigrant women in Canada. *Int J Migr Health Soc Care*. 2014;10(2):88-101.

Gerteis M, Edgman-Levitan S, Daley J, Delbanco TL, editors. *Through the patient's eyes: Understanding and promoting patient-centered care.* San Francisco: Jossey-Bass Publishers; 1993.

Goforth AN, Oka ER, Leong F, Denis DJ. Acculturation, acculturative stress, religiosity and psychological adjustment among Muslim Arab American adolescents. *J Muslim Ment Health*. 2014;8(2):3-19.

Grasby D, Quinlivan JA. Attitudes of patients towards the involvement of medical students in their intrapartum obstetric care. *Aust N Z J Obstet Gynaecol*. 2001;41(1):91-6.

Green J, Willis K, Hughes E, Small R, Welch N, Gibbs L, et al. Generating best evidence from qualitative research: The role of data analysis. *Aust NZ J Publ Heal*. 2007;31(6):545-50.

Guest G, Bunce A, Johnson L. How many interviews are enough? An experiment with data saturation and variability. *Field Methods.* 2006;18(1):59-82.

Hankivsky O, Friesen J, Varcoe C, MacPhail F, Greaves L, Spenser C. Expanding economic costing in health care: Values, gender and diversity. *Can Public Policy*. 2004;30(3):257-282.

Hasnain M, Connell KJ, Menon U, Tranmer PA. Patient-centered care for Muslim women: Provider and patient perspectives. *J Womens Health*. 2011;20(1):73-83.

Henderson J, Gao H, Redshaw M. Experiencing maternity care: The care received and perceptions of women from different ethnic groups. *BMC Pregnancy Childbirth*. 2013;13:196.

Heru AM. Pink-collar medicine: Women and the future of medicine. *Gender Issues*. 2005:20-34.

Higginbottom GM, Hadziabdic E, Yohani S, Paton P. Immigrant women's experience of maternity services in Canada: A meta-ethnography. *Midwifery*. 2014;30(5):544-59.

Higginbottom G, Pillay JJ, Boadu NY. Guidance on performing focused ethnographies with an emphasis on healthcare research. *Qual Rep*. 2013;18(17):1-16.

Higginbottom GM, Safipour J, Yohani S, O'Brien B, Mumtaz Z, Paton P. An ethnographic study of communication challenges in maternity care for immigrant women in rural Alberta. *Midwifery*. 2015;31(2):297-304.

Hill N, Hunt E, Hyrkas K. Somali immigrant women's health care experiences and beliefs regarding pregnancy and birth in the United States. *J Transcult Nurs.* 2012;23(1):72-81.

Huster KMJ, Patterson N, Schilperoord M, Spiegel P. Cesarean sections among Syrian refugees in Lebanon from December 2012/January 2013 to June 2013: Probable causes and recommendations. *Yale J Biol Med*. 2014;87(3):269-88.

Isa Mobibbo F, Dareng E, Bamisaye P, Jedy-Agba E, Adewole A, Oyeneyin L, et al. Qualitative study of barriers to cervical cancer screening among Nigerian women. *BMJ Open*. 2016;6(1):e008544.

Janssen SM, Lagro-Janssen ALM. Physician's gender, communication style, patient preferences and patient satisfaction in gynecology and obstetrics: A systematic review. *Patient Educ Couns*. 2012;89(2):221-26.

Jena AB, Olenski AR, Blumenthal DM. Sex differences in physician salary in US public medical schools. *JAMA Int Med*. 2016.

Kabakian-Khasholian T, Campbell O, Shediac-Rizkallah M, Ghorayeb F. Women's experiences of maternity care: Satisfaction or passivity? *Soc Sci Med*. 2000;51(1):103-13.

Khan S, Woolhead G. Perspectives on cervical cancer screening among educated Muslim women in Dubai (the UAE): A qualitative study. *BMC Womens Health.* 2015;15(90).

Kingston D, Heaman M, Chalmers B, Kaczorowski J, O'Brien B, Lee L, et al. Comparison of maternity experiences of Canadian-born and recent and non-recent immigrant women: Findings from the Canadian maternity experiences survey. *J Obstet Gynaecol Can*. 2011;33(11):1105-15.

Kluge EW. Resource allocation in healthcare: Implications of models of medicine as a profession. *MedGenMed*. 2007;9(1):57.

Knight M, Kurinczuk JJ, Spark P, Brocklehurst P, UKOSS. Inequalities in maternal health: National cohort study of ethnic variation in severe maternal morbidities. *BMJ*. 2009;338:b542.

Lafta RK. Practitioner gender preference among gynecologic patients in Iraq. *Health Care Women Int*. 2006;27(2):125-30.

Larijani B, Anaraki FZ. Islamic principles and decision making in bioethics. *Nat Genet.* 2008;40(2):123

Lowe P. *Embodied expertise: Women's perceptions of the contraception consultation*. Health (London). 2005;9(3):361-78.

Lyons SM, O'Keeffe FM, Clarke AT, Staines A. Cultural diversity in the Dublin maternity services: The experiences of maternity service providers when caring for ethnic minority women. *Ethn Health*. 2008;13(3):261-76.

Makam A, Saroja C, Edwards G. Do women seeking care from obstetrician–gynaecologists prefer to see a female or a male doctor? *Arch Gynecol Obstet*. 2010;281:443-7.

Mavis B, Vasilenko P, Schnuth R, Marshall J, Jeffs MC. Medical students' involvement in outpatient clinical encounters: A survey of patients and their obstetricians–gynecologists. *Acad Med.* 2006;81(3):290-6.

Markova T, Dean F, Neale AV. Healthcare attitudes and behaviors of immigrant and US- born women in Hamtramck, Michigan: A metronet study. *Ethn Dis.* 2007;17(4):650-6.

Mayan M. *Essentials of qualitative inquiry*. Walnut Creek, California, United States of America: Left Coast Press, Inc; 2009.

Mays N, Pope C. Qualitative research in health care: Assessing quality in qualitative research. *BMJ*. 2000;320:50-52.

McLean M, Al Yahyaei F, Al Mansoori M, Al Ameri M, Al Ahbabi S, Bernsen R. Muslim women's physician preference: Beyond obstetrics and gynecology. *Health Care Women Int*. 2012;33:849-76.

Mena FJ, Padilla AM, Maldonado M. Acculturative stress and specific coping strategies among immigrant and later generation college students. *His J Behav Sci*. 1987;9(2):207-225.

Morse JM. What is qualitative health research? In: Denzin NK, Lincoln YS, eds. *The SAGE handbook of qualitative research. 4th ed*. United States of America: SAGE Publications, Inc.; 2011:401-414.

Morse JM, Barrett M, Mayan M, Olson K, Spiers J. Verification strategies for establishing reliability and validity in qualitative research. *Int J Qual Methods*. 2002;1(2):13-22.

Murray L, Windsor C, Parker E, Tewfik O. The experiences of African women giving birth in Brisbane, Australia. *Health Care Women Int*. 2010;31(5):458-72.

Ng C, Newbold KB. Health care providers' perspectives on the provision of prenatal care to immigrants. *Cult Health Sex*. 2011;13(5):561-74.

Odunukan OW, Abdulai RM, Hagi Salaad MF, Lahr BD, Flynn PM, Wieland ML. Provider and interpreter preferences among Somali women in a primary care setting. *J Prim Care Community Health*. 2015;6(2):105-10.

O'Flynn N, Rymer J. Women's attitudes to the sex of medical students in a gynaecology clinic: Cross sectional survey. *BMJ*. 2002;325:683-4.

Olds GR. *Religio-cultural integration among Mulsim-Americans.* [Doctor of Philosophy]. Texas A&M University; 2009.

Padela AI, Gunter K, Killawi A, Heisler M. Religious values and healthcare accommodations: Voices from the American Muslim community. *J Gen Intern Med.* 2011;27(6):708-15.

Padela AI, Rodriguez del Pozo P. Muslim patients and cross-gender interactions in medicine: An Islamic bioethical perspective. *J Med Ethics*. 2011;37:40-4.

Padilla AM, Alvarez M, Lindholm KJ. Generational status and personality factors as predictors of stress in students. *Hisp J Behav Sci*. 1986;8(3):275-288.

Pellegrino ED. Patient and physician autonomy: Conflicting rights and obligations in the physician-patient relationship. *J Contemp Health Law Policy*. 1994;10:47-68.

Pellegrino ED, Thomasma DC. The conflict between autonomy and beneficence in medical ethics: Proposal for a resolution. *J Contemp Health Law Policy*. 1987;23:23-46.

Pormann PE. Female patients and practitioners in medieval Islam. *Lancet*. 2009;9675(373):1598-9.

Qureshi R, Pacquiao DF. Ethnographic study of experiences of Pakistani women immigrants with pregnancy, birthing, and postpartum care in the United States and Pakistan. *Journal of Transcult Nurs*. 2013;24(4):355-6.

Redwood-Campbell L, Fowler N, Laryea S, Howard M, Kaczorowski J. 'Before you teach me, I cannot know': Immigrant women's barriers and enablers with regard to cervical cancer screening among different ethnolinguistic groups in Canada. *Can J Public Health*. 2011;102(3):230-4.

Reitmanova S, Gustafson DL. "They can't understand it": Maternity health and care needs of immigrant Muslim women in St. John's, Newfoundland. *Matern Child Health J*. 2008;12(1):101-11.

Rifkin JI, Sharpiro H, Regensteiner JG. Why do some women refuse to allow male residents to perform pelvic exams? *Acad Med*. 2002;77(10):1034-8.

Rizk DE, El-Zubeir MA, Al-Dhaheri AM, Al-Mansouri FR, Al-Jenaibi HS. Determinants of women's choice of their obstetrician and gynecologist provider in the UAE. *Acta Obstet Gynecol Scand*. 2005;84:48-53.

Salem S. Feminist critique and Islamic feminism: The question of intersectionality. *The Postcolonialist*. 2013;1(1).

Salman KF. Health beliefs and practices related to cancer screening among Arab Muslim women in an urban community. *Health Care Women Int*. 2012;33:45-74.

Sange C, Thomas L, Lyons C, Hill S. Urinary incontinence in Muslim women. *Nurs Times*. 2008;104(25):49-52.

Saurina C, Vall-Llosera L, Saez M. A qualitative analysis of immigrant population health practices in the Girona healthcare region. *BMC Public Health*. 2010;10:379.

Savulescu J. Rational non-interventional paternalism: Why doctors ought to make judgments of what is best for their patients. *J Med Ethics*. 1995;21:327-331.

Shafiei T, Small R, McLachlan H. Women's views and experiences of maternity care: A study of immigrant Afghan women in Melbourne, Australia. *Midwifery*. 2012;28(2):198-203.

Shahawy S, Deshpande NA, Nour NM. Cross-cultural obstetric and gynecologic care of Muslim patients. *Obstet Gynecol*. 2015;126(5):969-73.

Simpson JL, Carter K. Muslim women's experiences with health care providers in a rural area of the United States. *J Transcult Nurs*. 2008;19(1):16-23.

Small R, Roth C, Raval M, Shafiei T, Korfker D, Heaman M, et al. Immigrant and non-immigrant women's experiences of maternity care: A systematic and comparative review of studies in five countries. *BMC Pregnancy Childbirth*. 2014;14:152.

Small R, Yelland J, Lumley J, Brown S, Liamputtong P. Immigrant women's views about care during labor and birth: An Australian study of Vietnamese, Turkish, and Filipino women. *Birth*. 2002;39(4):266-77.

The Society of Obstetricians and Gynaecologists of Canada [Internet]. c2013 [updated June 2013; cited 2015 Aug 11]. SOGC position statement: When a patient asks for another physician on cultural or religious grounds [about 1 screen]. Available from: http://sogc.org/media_updates/position-statement-when-a-patient-asks-for-another-physician-on-cultural-or-religious-grounds/.

Sword W, Watt S, Krueger P. Postpartum health, service needs, and access to care experiences of immigrant and Canadian-born women. *J Obstet, Gynecol Neonatal Nurs.* 2006;35:717-27.

Tew M. *Safer childbirth?: A critical history of maternity care.* London; New York: Free Association Books; 1998.

Tsianakas V, Liamputtong P. What women from an Islamic background in Australia say about care in pregnancy and prenatal testing. *Midwifery*. 2002;18(1):25-34.

The United Nations. Universal Declaration of Human Rights. 1948

van den Muijsenbergh M, Lagro-Janssen T. Urinary incontinence in Moroccan and Turkish women: A qualitative study on impact and preferences for treatment. *Br J Gen Pract.* 2006;56:945-9.

Van Teijlingen E. *Midwifery and the medicalization of childbirth: Comparative perspectives*. Commack, NJ: Nova Science Publishers; 2000.

Vissandjee B, Weinfeld M, Dupere S, Abdool S. Sex, gender, ethnicity, and access to health care services: Research and policy challenges for immigrant women in Canada. *J Int Migr Integr*. 2001;2(1):55-75.

Vu M, Azmat A, Radejko T, Padela A. Predictors of delayed healthcare seeking among American Muslim women. *J Womens Health*. 2016;25(6):586-93.

Watson K, Mahowald MB. Honoring gender-based patient requests for obstetricians: Ethical imperative or employment discrimination? *J Womens Health Gend Based*. 1999;8(8):1031-41.

Whitehead M. The concepts and princiles of equity in health. *Health Promot Int*. 1991;6(3):217-28.

Witte FM, Stratton TD, Nora LM. Stories from the field: Students' descriptions of gender discrimination and sexual harassment during medical school. *Acad Med*. 2006;81(7):648-54.

Zaghloul AA, Youssef AA, El-Einein NY. Patient preference for providers' gender at a primary health care setting in Alexandria. Egypt. *Saudi Med J*. 2005;26(1):90-5.

Appendix 1: Information Letter and Consent Form: Patient Participants

Information Letter: Patient Participants
University of Alberta

Study Title: Provider Gender: A Barrier to Immigrant Women's Obstetrical Care from the Patient and Provider Perspective

Research Investigator:
Dr. Christa Aubrey
MD, BSc, PGY3 Obstetrics and Gynecology
Clinical Investigator Program- MSc Global Health
3-300 Edmonton Clinic Health Academy
University of Alberta, Edmonton AB T6G 1C9
preuss@ualberta.ca, (780) 721-1908

Supervisor:
Dr. Zubia Mumtaz
Associate Professor
School of Public Health
3-300 Edmonton Clinic Health Academy
University of Alberta, Edmonton AB, T6G 1C9
zubia.mumtaz@ualberta.ca, (780) 492-7709

Background

You are being asked to participate in this study because I am wishing to study pregnant immigrant women who prefer to have a female doctor deliver their baby.

- This research is being done as part of my graduate studies at the School of Public Health. Your doctor has indicated that you may be willing to participate in the study. If you agree, I will be asking you to share your beliefs and views on why having a female doctor is important to you.

Purpose

- As an immigrant woman, some of your healthcare needs are different. One issue that can come up when delivering your baby in Canada is that there is not always a female doctor in the hospital to help with delivery. I want to understand this issue, from your side and from the doctor's side, so that we can try to address this problem.

Study Procedures

- I am asking if I can interview you once before your baby is born, and once after your baby is born. I also would like to come to the hospital when you think you are in labor so that I can observe a short period of time when you are in the hospital.
    - Interview before your baby is born: This will be done after your regular doctor appointment, in the clinic for approximately 30 minutes to one hour. I will be asking questions about pregnancy and why you want to have a female doctor.
    - Interview after your baby is born: This will be done in hospital the day after you deliver your baby, for approximately 30 minutes to one hour. I will be asking similar questions about why you want to have a female doctor and what your birth was like.

- Both interviews will be voice recorded, and then written down so I can look at the interviews in writing afterwards.
- Observations: When you come to the hospital in labor, I will get called to come in and I will be observing how things are going and also asking short questions to you and people in the room with you, before go to the delivery room. I will be observing you for less than one hour.
- I would like to look at your prenatal record, to see what your doctor told you about who would be at your delivery. This will be the only information taken from the prenatal record.

- If after the interview there is something that I think needs clarification I would like permission to follow up with a phone call. Your contact information will be destroyed after data has been analyzed.

Benefits

- You will not benefit personally from being in this study, and it will not affect the care that you get in hospital or from your doctor.
- The information from this study will help us to better understand why some women want to have a female doctor deliver their baby and what can be done to make women feel comfortable with the care they get in their pregnancy and delivery.
- There are no personal costs and you will not be compensated for participation in the study.

Risk

- The risks to being involved in this study are very minimal. However, some questions could be sensitive because they are tied to your culture and religious beliefs. If you feel distressed after any part of the process, the nearest hours, location and contact information for Alberta Counseling Services will be provided. Additionally, if at any time you require medical attention, a doctor will be notified.
- It will require about 1-2 hours in total of your time, before your baby is born and after your baby is born, and I will observe when you come to the hospital in labor, for less than one hour before you go to the delivery room. I will not be interfering in any way with the care you get.

Voluntary Participation

- You do not need to participate in this study. Your involvement is voluntary, and even if you are participating and do not want to answer certain questions you do not need to.
- If you agree to be part of the study but then change your mind for any reason and either do not want to continue to be part of the study or you wish to withdraw your information that you have already provided you can without penalty. This can be done anytime until the final parts of the study when I am looking all the data. I order to withdraw please contact Christa Aubrey either by phone or email at the contact information provided above.

Confidentiality & Anonymity

- This research is part of my thesis and will also be submitted to research journals to be published, presented at conferences and may be included in helping to draft hospital policy when women want to have a female doctor.
- Everything collected will be kept confidential and only my supervisor and myself will have access to it.

- You will not be identified and all information will be kept anonymous, but direct quotes from interviews may appear in publications or presentations.
- Data will be kept in a secure place for a minimum of 5 years after the study, and electronic data will be password protected. When data is destroyed it will be done in a way that ensures privacy and confidentiality.
- By signing this consent form you are saying it is okay for the study team to collect, use and disclose information about you from your personal health records as described above.

Further Information

- If you have any further questions regarding this study, please do not hesitate to contact Christa Aubrey via email at preuss@ualberta.ca
- The plan for this study has been reviewed for its adherence to ethical guidelines by a Research Ethics Board at the University of Alberta. For questions regarding participant rights and ethical conduct of research, contact the Research Ethics Office at (780) 492-2615.

Consent Form: Patient Participants
University of Alberta

UNIVERSITY OF ALBERTA

Title of Study: Provider Gender: A Barrier to Immigrant Women's Obstetrical Care from the Patient and Provider Perspective

Principal Investigator: Dr. Christa Aubrey **Phone Number: (780) 721-1908**

	Yes	No
Do you understand that you have been asked to be in a research study?	☐	☐
Have you read and received a copy of the attached Information Sheet?	☐	☐
Do you understand the benefits and risks involved in taking part in this research study?	☐	☐
Have you had an opportunity to ask questions and discuss this study?	☐	☐
Do you understand that you are free to leave the study at any time, without having to give a reason and without affecting your medical care?	☐	☐
Has the issue of confidentiality been explained to you?	☐	☐
Do you understand who will have access to your study records and prenatal records, including personally identifiable health information?	☐	☐

Who explained this study to you? _____

I agree to take part in this study: YES ☐ NO ☐

Signature of Research Participant

_____

(Printed Name) _____

Date:_____

I believe that the person signing this form understands what is involved in the study and voluntarily agrees to participate.

Signature of Investigator or Designee_____ Date _____

THE INFORMATION SHEET MUST BE ATTACHED TO THIS CONSENT FORM AND A COPY GIVEN TO THE RESEARCH PARTICIPANT

Appendix 2: Information Letter and Consent Form: Provider Participants

Information Letter: Provider Participants
University of Alberta

UNIVERSITY OF ALBERTA

Study Title: Provider Gender: A Barrier to Immigrant Women's Obstetrical Care from the Patient and Provider Perspective

Research Investigator:
Dr. Christa Aubrey
MD, BSc, PGY3 Obstetrics and Gynecology
Clinical Investigator Program- MSc Global Health
3-300 Edmonton Clinic Health Academy
University of Alberta
Edmonton, AB, T6G 1C9
Email: preuss@ualberta.ca
Phone: (780) 721-1908

Supervisor:
Dr. Zubia Mumtaz
Associate Professor
School of Public Health
3-300 Edmonton Clinic Health Academy
University of Alberta
Edmonton, AB, T6G 1C9
Email: zubia.mumtaz@ualberta.ca
Office Phone: 780-492-7709

Background

- You are being asked to participate in this study because I am studying Obstetrical care providers who have experience with immigrant women requesting a female care provider in hospital.
- The results of this study will be used in support of my thesis in Global Health. The research is funded by the Clinical Investigator Program, which facilitates resident physicians to do a Masters degree in their clinical training.

Purpose

- Immigrant woman have specific barriers to receiving Obstetrical care in comparison to Canadian-born women. One such barrier that has been identified is gender of care provider. This presents an issue because of the systems barriers that prevent women from being able to choose the gender of their Obstetrical care provider when they present in labor. Additionally, it may be perceived as gender discrimination when a woman refuses to have a male provide her Obstetrical care. There is a tension between the patient and the provider perspective on this issue and this research aims to further understand the differing perspectives, hopefully allowing us to address this barrier.

Study Procedures

- I am asking to understand your perspective on this issue by way of an interview.
- Detail of all information to be collected:
    - The interview will take approximately 30-60 minutes and will occur in off-service times in a private room at the Royal Alexandra Hospital. I will be asking questions about personal experiences and views on this issue. These interviews will be audio recorded and transcribed.

- If when analysis of the data is being done there is something that needs clarification on the basis of the interview I would like permission to follow up with a phone call. Your telephone number will be destroyed as soon as data collection has been completed.

Benefits

- You will not benefit personally from being in this study.
- The information generated from this study will hopefully help us to better understand why some immigrant women wish to have a female Obstetrician and what the physician perspective on this issue is.
- There are no personal costs to being involved in the study.
- There will be no compensation for those participating in the study.

Risk

- The risks to being involved in this study are very minimal. It will require approximately 30-60 minutes in total of your time for the interview.

Voluntary Participation

- You are under no obligation to participate in this study. The participation is completely voluntary, and if you are participating and do not wish to answer specific questions you are not obligated to do so.
- If you agree to be part of the study but change your mind for any reason and either do not want to continue to be part of the study or wish to withdraw your information you can do so. If you choose to withdraw your data from the study you can do so anytime until the final data analysis stages, and any specific quotations or contents of the data will be discarded. If you wish to withdraw from the study please contact Christa Aubrey at the contact information provided above.

Confidentiality & Anonymity

- This research is part of my thesis and will also be submitted for publication, presented at conferences and may help inform hospital policy surrounding this issue.
- All data collected will be kept confidential and only my supervisor and myself will have access to it.
- Participants will not be identified when research is disseminated, all data collected will be anonymous, but direct quotes from interviews may appear in publications or presentations.
- Data will be kept in a secure place for a minimum of 5 years following completion of research project, and electronic data will be password protected. When data is destroyed it will be done in a way that ensures privacy and confidentiality.

Further Information

- If you have any further questions regarding this study, please do not hesitate to contact Christa Aubrey via email at preuss@ualberta.ca
- The plan for this study has been reviewed for its adherence to ethical guidelines by a Research Ethics Board at the University of Alberta. For questions regarding participant rights and ethical conduct of research, contact the Research Ethics Office at (780) 492-2615.

Consent Form: Provider Participants
University of Alberta

UNIVERSITY OF ALBERTA

Title of Study: Provider Gender: A Barrier to Immigrant Women's Obstetrical Care from the Patient and Provider Perspective

Principal Investigator: Dr. Christa Aubrey **Pager Number: (780) 721-1908**

	Yes	No
Do you understand that you have been asked to be in a research study?	☐	☐
Have you read and received a copy of the attached Information Sheet?	☐	☐
Do you understand the benefits and risks involved in taking part in this research study?	☐	☐
Have you had an opportunity to ask questions and discuss this study?	☐	☐
Do you understand that you are free to leave the study at any time, without having to give a reason and without affecting your medical care?	☐	☐
Has the issue of confidentiality been explained to you?	☐	☐
Do you understand who will have access to your study records?	☐	☐

Who explained this study to you? _____

I agree to take part in this study: YES ☐ NO ☐

Signature of Research Participant

_____

(Printed Name) _____

Date:_____

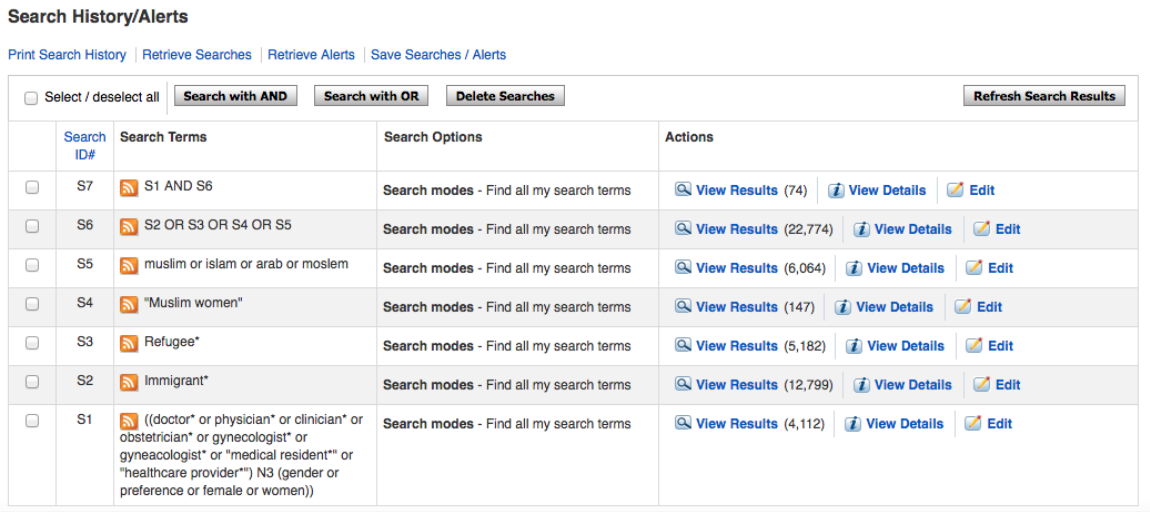
I believe that the person signing this form understands what is involved in the study and voluntarily agrees to participate.

Signature of Investigator or Designee_____ Date _____

THE INFORMATION SHEET MUST BE ATTACHED TO THIS CONSENT FORM AND A COPY GIVEN TO THE RESEARCH PARTICIPANT

Appendix 3: Literature Review Search Strategies

CINAHL Database



Search History/Alerts

Print Search History | Retrieve Searches | Retrieve Alerts | Save Searches / Alerts

Select / deselect all | Search with AND | Search with OR | Delete Searches | Refresh Search Results

	Search ID#	Search Terms	Search Options	Actions
☐	S7	S1 AND S6	Search modes - Find all my search terms	View Results (74) | View Details | Edit
☐	S6	S2 OR S3 OR S4 OR S5	Search modes - Find all my search terms	View Results (22,774) | View Details | Edit
☐	S5	muslim or islam or arab or moslem	Search modes - Find all my search terms	View Results (6,064) | View Details | Edit
☐	S4	"Muslim women"	Search modes - Find all my search terms	View Results (147) | View Details | Edit
☐	S3	Refugee*	Search modes - Find all my search terms	View Results (5,182) | View Details | Edit
☐	S2	Immigrant*	Search modes - Find all my search terms	View Results (12,799) | View Details | Edit
☐	S1	((doctor* or physician* or clinician* or obstetrician* or gynecologist* or gyneacologist* or "medical resident*" or "healthcare provider*") N3 (gender or preference or female or women))	Search modes - Find all my search terms	View Results (4,112) | View Details | Edit

MEDLINE database

Database: Epub Ahead of Print, In-Process & Other Non-Indexed Citations, Ovid MEDLINE(R) Daily and Ovid MEDLINE(R) <1946 to Present>

Search Strategy:

---

1 ((doctor* or physician* or clinician* or obstetrician* or gynecologist* or gynaecologist* or "medical resident*" or "healthcare provider") adj2 (gender or female or women or preference*)).mp. [mp=title, abstract, original title, name of substance word, subject heading word, keyword heading word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier] (9893)

2 exp Refugees/ or Refugee*.mp. (9916)

3 exp Islam/ or "Muslim women".mp. (4525)

4 exp "Emigration and Immigration"/ or exp "Emigrants and Immigrants"/ or Immigrant*.mp. (40195)

5 2 or 3 or 4 (51786)

6 1 and 5 (119)

7 limit 6 to english language (105)

EMBASE database

Database: Embase <1974 to 2016 June 17>

Search Strategy:

---

1 ((doctor* or physician* or clinician* or obstetrician* or gynecologist* or gynaecologist* or medical resident*) adj2 (gender or female)).mp. [mp=title, abstract, heading word, drug trade name, original title, device manufacturer, drug manufacturer, device trade name, keyword] (6647)

2 exp immigrant/ or Immigrant*.mp. (24898)

3 exp refugee/ or Refugee*.mp. (10592)

4 exp Islam/ or Islam.mp. (1626)

5 exp Moslem/ or "Muslim women".mp. (730)

6 2 or 3 or 4 or 5 (36229)

7 1 and 6 (45)

8 limit 7 to english language (40)

GLOBAL HEALTH database

Database: Global Health <1910 to 2016 Week 12>

Search Strategy:

---

1 Immigrant*.mp. [mp=abstract, title, original title, broad terms, heading words, identifiers, cabicodes] (9686)

2 Refugee*.mp. [mp=abstract, title, original title, broad terms, heading words, identifiers, cabicodes] (3544)

3 "Muslim women".mp. [mp=abstract, title, original title, broad terms, heading words, identifiers, cabicodes] (101)

4 (Muslim or Islam).mp. [mp=abstract, title, original title, broad terms, heading words, identifiers, cabicodes] (1337)

5 1 or 2 or 3 or 4 (14018)

6 ((doctor* or physician* or clinician* or obstetrician* or gynecologist* or gynaecologist* or medical resident* or "healthcare provider*") adj2 (gender or female)).mp. [mp=abstract, title, original title, broad terms, heading words, identifiers, cabicodes] (339)

7 5 and 6 (10)

SCOPUS database

(TITLE-ABS-KEY (((**doctor*** OR **physician*** OR **obstetrician*** OR **gynecologist*** OR **gynaecologist*** OR **clinician*** OR **"medical resident"** OR **"healthcare provider"**) W/3 (**gender** OR **female** OR **women** OR **preference***)))) AND ((TITLE-ABS-KEY (**immigrant***) OR TITLE-ABS-KEY (**refugee***) OR TITLE-ABS-KEY (**mulsim**) OR TITLE-ABS-KEY (**islam**) OR TITLE-ABS-KEY (**"Muslim women"**)))

Appendix 4: Literature Review Data Extraction and Analysis

Refworks was used to manage retrieved items. A Microsoft Excel database was developed to organize and chart study characteristics (authors, year, country, design, population, sample size), key relevant findings, if the study addressed the patient or provider perspective, and the following data, where applicable: reasons cited for the preference for female provider. We began by grouping the studies by those looking at immigrant women and those in a non-Western setting. We then looked at the findings of the quantitative studies according to common topics such as numerical outcomes of patients preferring female providers, and reasons for this request, comparing them across studies. We then focused on qualitative studies, and elicited common themes, compared these across settings.

Appendix 5:

24 item short SAFE Scale:
Total of 120 potential score, the higher the score, the more likely acculturation stress is apparent.

5-point Likert scale:
1 = not stressful; 2 = somewhat stressful; 3 =stressful; 4 = very stressful; 5 = extremely stressful

Factor 1: Environmental

1. Because I am different, I do not get enough credit for the work I do
2. I often feel ignored by people who are supposed to assist me
3. I often feel that people actively try to stop me from advancing
4. Many people have stereotypes about my culture or ethnic group and treat me as if they are true
5. In looking for a job, I sometimes feel that my ethnicity is a limitation
6. I feel uncomfortable when others make jokes about or put down people of my ethnic background
7. Because of my ethnic background, I feel that others often exclude me from participating in their activities
8. It bothers me when people pressure me to assimilate
9. People look down upon me if I practice the customs of my culture

Factor 2: Attitudinal

10. Loosening the ties with my country is difficult
11. It bothers me that I cannot be with my family
12. I often think about my cultural background
13. It is hard to express to my friends how I really feel
14. I often think about my cultural background

Factor 3: Social

15. I have trouble understanding others when they speak
16. I don't have any close friends
17. People think I am unsociable when in fact I have trouble communicating in English
18. I don't feel at home

Factor 4: Familial

19. It bothers me that family members I am close to do not understand my new values
20. Close family members and I have conflicting expectations about my future
21. My family does not want me to move away but I would like to
22. It bothers me to think that so many people use drugs
23. It bothers me that I have an accent
24. It is difficult for me to "show off" my family.