Patient Education and Counseling 86 (2012) 259–263

Contents lists available at ScienceDirect

Patient Education and Counseling

journal homepage: www.elsevier.com/locate/pateducou

Patient Perception, Preference and Participation

Unpredicted gender preference of obstetricians and gynecologists by Muslim Israeli-Arab women

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ARTICLE INFO

Article history:
Received 18 December 2010
Received in revised form 23 March 2011
Accepted 5 May 2011

Keywords:
Gender
Obstetricians/gynecologists
Muslim
Women

ABSTRACT

Objectives: To investigate the gender preference of Muslim Israeli-Arab women regarding obstetricians/gynecologists, and identify other features that affect their choice.
Methods: The study included 167 responders to an anonymous questionnaire.
Results: Around one-half of the responders had no gender preference regarding family physicians, but most (76.6%) preferred a female gynecologist. Likewise, most responders preferred pelvic examinations (85.6%) and pregnancy follow-up (77.8%) by female gynecologists. Additionally, 61.7% preferred consulting female physicians for major obstetrical and gynecological (OB/GYN) problems. The reasons for female preference were embarrassment (67.7%), feeling comfortable with female gynecologists (80.8%) and the notion that female gynecologists are more gentle (68.3%). The three most important factors which affected actual selection, however, were experience (83.8%), knowledge (70.1%) and ability (50.3%), rather than physician gender (29.3%). Multivariate analysis revealed that other qualities and importance of background variables of the gynecologist were independent predictors of gender preference.
Conclusions: Although Muslim Arab-Israeli women express gender bias regarding their preference for gynecologists/obstetricians, personal and professional skills are considered to be more important factors when it comes to actually making a choice.
Practice implication: We suggest that the ideal obstetrician/gynecologist for these women would be female, though skilled, knowledgeable, and experienced male would be appropriate.

1. Introduction

Feminism refers to movements aimed at defining, establishing and defending equal rights for women. In the 1960s, the second-wave feminism has begun, focusing on discrimination and on cultural, social, and political issues [1,2]. During that time women started inquiring about their privileges and became aware for their needs and requirements. Consequently, in 1974, Neubardt discussed women's dissatisfaction with the medical profession and the need for female gynecologists in his commentary entitled "Women's Liberation and the Male Gynecologist" [3].

The mid 70s witnessed a radical shift in the attitude of women towards physician gender [4–6], specifically, in their preference for female gynecologists [7–12]. Many studies have discussed the issue of gynecologist gender, and most of them endorsed the same-sex preference concept [10,11,13–16], although some did not [7,12,17–19]. The more common reasons that were mentioned included religious beliefs and cultural traditions [14,15], but only few articles addressed these preferences among women from extremely traditional and religious cultures [14,15,20,21]. Bashour et al. reported that more than 85% of Syrian preferred their obstetrician to be a female [20]. Lafta et al. found that 74% of Iraqi female patients preferred female gynecologists, 8% preferred male gynecologists and 18% had no gender preference [15]. Both surveys demonstrated an association between gender preference and social tradition and religious beliefs. In 2005, Rizk et al. [14] carried out a survey on gender preference and other factors in gynecologist/obstetrician preference in the United Arab Emirates (UAE) in which the majority of participants (95%) were Moslems. They found that gender was ranked as one of the important factors for selection, regardless of other relevant factors [14]. On the other hand, Amir et al. recently demonstrated that characteristics other than gender were more important than gender among another

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doi:10.1016/j.pec.2011.05.016

extremely religious population the ultra-orthodox Jewish responders [21].

Muslim modesty (hejab) is described as one of the five pillars of the Islamic faith and includes restrictions on: dress (hair, body, arms, and legs must be covered any time a woman may come into contact with men who are not family members), privacy, the mention of anything related to bodily functions, direct eye contact with the opposite gender and opposite gender medical care providers, except in cases of extreme medical necessity [22]. Islam clearly demonstrates any interactions between opposite sexes as illegitimate human relationships. Physical contact between members of the opposite sex is strongly discouraged. Societal laws exist to aid Muslims in abiding by this framework. This framework explains why many prefer to see a same-sex clinician, particularly in consultations necessitating examination of the genitalia [23].

Israel is a multicultural state in which Arabs account for about 20% of the general population. The majority of the Arabs are Muslims and about 20% are Christians. We surveyed the preference of Muslim Israeli-Arab women regarding gynecologist gender preference and investigated which additional characteristics affect their preference when choosing their gynecologist.

2. Methods

The study was performed at a women health center located in Taibeh, Israel, over a 4-month period in 2010 after receiving approval by the local Helsinki Committee 0588-09-TLV#. The health center provides every type of ambulatory gynecological/obstetrical care for women and includes primary as well as secondary care services. The staff consists of board certified obstetricians and gynecologists, registered nurses and licensed ultrasound technicians. The population of the city is composed almost entirely of Muslim Arabs. Residents who belong to the "Clalit" health-care organization (HMO) are entitled to the services of the center.

Of the eligible women, 11 refused enrollment and the remaining 167 gave their oral consent to participate in the study. They were at least 18 years of age. They were recruited after they had been seen by their gynecologist and gave their oral consent to fill out an anonymous, self-reported 38-item questionnaire. The first part of the questionnaire gathered basic socio-demographic data (age, country of origin, family status, religious status, education and employment). The religious status of the responders was classified into one of three subgroups; secular, religious and extremely religious. The classification was measured according to their self-definition and estimation (the self-estimation has evaluated their intensity of belief and accordingly life habits). In the second part, the women were asked about their gender preferences for gynecologist/obstetrician, and in the last part they were asked about diverse characteristics they sought in their preferred gynecologist.

Descriptive statistics are given as median, mean and standard deviation (SD) for continuous variables and frequency distribution for categorical variables. The McNemar test for symmetry was used to compare preference for physician's gender between gynecologist and family physician; to compare gynecologist gender preference for intrusive procedures vs. non-intrusive procedures; and to compare association between three desirable characteristics (embracement, sympathy and doctor quality) and physician's gender. A multiple logistic regression was applied in order to assess which variables were independently associated with preference for a female gynecologist. Preference for gynecologist's gender was coded as 0 for female, 1 for indifference/male preference. Each responder was asked to rank how important sixteen different variables are in relation to her preference of phsyician's gender. Variables were coded on a scale of 0–3, with 0 being no preference, 3 for highest preference. Variables were then combined to four categories: background, professional, academic and other, by summing all of the variables in each category. The regression models that were constructed by using backward elimination and forward selection yielded the same level of the C parameter (area under the ROC curve of the model), $C = 0.764$. The model building methods were forced entry, forward selection and backward elimination. All statistical analyses were performed using SAS for Windows 9.1.3.

3. Results

The study sample was comprised of 167 suitable women the demographic and clinical characteristics are presented in Table 1. Table 2 displays their gender preferences for gynecologists and for family physicians: the preference for female gynecologists was most conspicuous. There is a significant higher preference for female gynecologist than female family physician (McNemar test $\chi^2_{(3)} = 52.3$, $p < 0.0001$).

The majority of the surveyed women (85.6%) preferred to undergo a pelvic examination by a female gynecologist, and 77.8% preferred pregnancy follow-up by a female gynecologist. In contrast, the majority (52%) had no gender preference when it came to non-intrusive procedures. On the other hand, 62% preferred a female gynecologist when it came to receiving advice for major obstetrical or gynecological (OB/GYN) problems (Table 3). There is a significant preference to undergo a pelvic examination by a female gynecologist than cesarean section (McNemar test $\chi^2_{(3)} = 80$, $p < 0.0001$), gynecologic surgery ($\chi^2_{(3)} = 82$, $p < 0.0001$) and advice for major OB/GYN problem ($\chi^2_{(3)} = 38.4$, $p < 0.0001$). In addition there is significant preference to undergo pregnancy follow-up by a female gynecologist than cesarean section ($\chi^2_{(3)} = 66.6$, $p < 0.0001$), gynecologic surgery ($\chi^2_{(3)} = 66.6$, $p < 0.0001$), advice for major OB/GYN problem ($\chi^2_{(3)} = 16.3$, $p < 0.001$).

The reasons for preferring a female gynecologist/obstetrician are presented in Table 4. Most of the patients answered that both male and female gynecologists were similar with respect to their

Table 1
Demographic characteristics of the 167 women who participated in the study.

Characteristic	Number	Percentage
Age, mean	28.0	6.83
Origin		
Israel	166	99.4
Not Israel	1	0.6
Religious status		
Secular	11	6.6
Religious	68	40.7
Extremely religious	88	52.7
Marital status		
Single	6	3.6
Married	161	96.4
Separated	0	0
Divorced	0	0
Widowed	0	0
Children		
Yes	111	66.5
No	56	33.5
No. of children, median	1	
Education		
Primary school	11	6.6
High school	47	28.15
Seminar	35	20.95
University	74	44.3
Employment		
Yes	100	59.9
No	67	40.1