Perspectives of Immigrant Women on the Gender of Provider During Childbirth

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Abstract

Objective: This study sought to gain an understanding of the importance and effect of provider gender for immigrant women accessing obstetrical care.

Methods: A focused ethnography was conducted using purposive sampling of 38 immigrant women from one hospital in Edmonton, Alberta. Data collection consisted of semistructured interviews conducted antenatally (n = 38); an attempt was made to conduct interviews postpartum (n = 21), and intrapartum observations were made (n = 17). Interviews were audio-recorded and transcribed verbatim. Data were managed using qualitative data analysis software and analyzed through thematic analysis.

Results: Study participants came from varied educational and ethnic backgrounds (predominately North/East African, Middle Eastern, and South Asian), but most were Muslim (n = 30) and married (n = 36), with a mean age of 27.7. All of the women stated that they preferred a female provider, which they explained in terms of the high value they placed on modesty, often as part of the Muslim faith. The women deemed provider competency and having safe childbirth more important, however, and said that they would accept intrapartum care from a male provider. A small minority of the women reported experiencing psychological stress as a consequence of having received care from a male provider.

Conclusion: As a whole, our study population accepted care from male providers, yet for some women this compromise came at a price, and a small minority of women perceived 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.

Résumé

Objectif : Cette étude avait pour but de nous aider à comprendre l'importance et les conséquences du sexe du fournisseur de soins obstétricaux pour les femmes immigrantes.

Méthodologie : Nous avons mené une ethnographie focalisée par l'échantillonnage raisonné de 38 immigrantes dans un hôpital d'Edmonton (Alberta). La collecte de données a été faite au moyen d'entrevues semi-structurées anténatales (n = 38); des entrevues postpartum ont été tentées (n = 21), et des observations intrapartum ont été effectuées (n = 17). Les entrevues ont été enregistrées et transcrites mot à mot. Les données ont été gérées au moyen d'un logiciel d'analyse de données qualitatives et analysées par thèmes.

Résultats : Les participantes possédaient divers niveaux d'éducation et avaient des origines ethniques variées (elles venaient principalement du nord et de l'est de l'Afrique, du Moyen-Orient et du sud de l'Asie); la plupart étaient musulmanes (n = 30) et mariées (n = 36). L'âge moyen était de 27,7 ans. Toutes les femmes ont dit avoir une préférence pour les fournisseurs de soins de sexe féminin en raison de la grande importance qu'elles accordent à la modestie, souvent attribuable à leur religion. Elles ont toutefois indiqué que la compétence du fournisseur et le fait de vivre un accouchement sécuritaire étaient encore plus importants à leurs yeux, et qu'elles accepteraient de recevoir des soins intrapartum d'un homme. Une faible minorité de femmes a déclaré avoir vécu un stress psychologique après avoir été soignée par un homme.

Conclusion : Dans l'ensemble, la population étudiée a accepté d'être soignée par des hommes; ce compromis a toutefois eu des conséquences sur certaines femmes, et une faible minorité a perçu cela comme étant profondément nuisible. Il faut reconnaître les femmes pour qui le sexe du fournisseur de soins constitue une barrière importante afin de les accompagner de façon optimale.

Key Words: Emigrants, immigrants,patient preference, physicians, women

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INTRODUCTION

For many women seeking gynaecologic or obstetrical care, gender of provider is an important factor determining the experience of medical services.[1,2] A preference for a female provider is particularly important for women from religious-cultural backgrounds where gender separation is a societal norm.[3,4] With greater immigration to Western nations of people from such backgrounds, gender of

provider is becoming a more contentious issue in obstetrics. Immigrant women experience numerous barriers to obstetrical care including language, culture, discrimination, socioeconomic factors, lack of social support, and difficulties navigating the system.[5–7] For some women, the inability to have a female provider may constitute an additional barrier, affecting health-seeking behaviors and practices and resulting in delays or avoidance in seeking care.[8]

Requests for female providers are easier to meet in ambulatory settings than in acute obstetrical settings. Challenges of meeting such requests in the latter revolve around costs and inability to schedule female providers to be available at all times.[9,10] Requests made on the basis of a preference for a specific gender of provider could also be interpreted as gender discrimination.[11,12] Additionally, such requests limit the clinical practice of male medical students and physicians and potentially affect the quality of training received.[12] Although the decision of medical students to enter obstetrics and gynaecology has not been shown to be influenced by the perception of patients' desire for female providers,[13] interest is influenced by clinical experience during rotations. Male medical students in the United States have reported gender discrimination in the form of educational inequalities during their obstetrics and gynaecology clerkship rotations,[14] and they have believed that their gender adversely affected their skills acquisition.[12]

Clinical guidance in Canada on responses to gender of provider requests is contradictory. The Canadian Medical Protective Association favours accommodating requests that are made on the basis of religious or cultural grounds.[15] This position has its basis in human rights legislation that recognizes that all individuals have the right to receive equal treatment with respect to goods, services, and facilities without discrimination.[15] In contrast, the SOGC states that gender-based requests may inhibit provision of the best care for all women and therefore should not be accommodated.[16] However, it could also be argued that accommodating preferences for female providers is congruent with patient autonomy and beneficence, grounded in principles of cultural sensitivity and patient-centred care.[17] The objective of this qualitative focused ethnographic study was to gain greater understanding of immigrant women's perspectives on the importance of provider gender. Insight from this study will help obstetrical care providers and decision makers understand the importance this population places on the gender of the provider.

MATERIALS AND METHODS

Focused ethnography is a qualitative research approach in which researchers use a combination of data-gathering methods, typically interviewing and observation, to examine decision-making rationales and behavior related to a particular problem in a specific context.[18] It captures the perspectives of people involved with the issue being studied, thus making it particularly suitable for health care research.[18] From August 2015 through January 2016, we conducted a focused ethnography at a large university teaching hospital in Alberta to study perspectives on gender of provider requests during labour and delivery. Ethics approval was obtained through the University of Alberta Human Research Ethics Board (Panel B), and operational approval was obtained through the Northern Alberta Clinical Trials and Research Centre.

At the hospital we studied, obstetricians have a sign-out system, whereby after hours on weekdays and on weekends there is single physician covering for the group. The group of obstetricians consists of both male and female providers, covering calls in approximately a 1:2 ratio; thus patients to not have a choice regarding gender of their provider intrapartum. Participants were recruited purposively at three female obstetricians' clinics, which had a high proportion of immigrant clientele. Eligibility criteria included the following: (1) birthplace outside of Canada; (2) preference for a female obstetrician during delivery; (3) 36 + weeks gestation, to facilitate completion of the study; and (4) not having a planned CS, because these patients would have their regular, female obstetrician for delivery. Eligible individuals were first identified by their obstetrician, and if they expressed interest they were approached by the first author, who obtained informed consent.

All interviews were semistructured and followed a piloted interview guide. Antenatal questions included the following: *What has your experience been with health care 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 participants presented to labour and delivery, the researcher was alerted and observed interactions among participants, families, and staff. These naturalistic observations[19] captured participants' reactions to the gender of the provider on duty and responses by the hospital staff to any gender of provider requests. Observations lasted for 2 hours, on average.

In the immediate postpartum period, the researcher conducted a second interview with participants while they remained inpatients, if they agreed. Follow-up questions included the following: *What was your experience in labour? Did*