Curbside Consultation

Gender-Based Requests for Physician Care

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Case Scenario

A female colleague in my clinic recently retired, and her patients were transferred to the care of two other physicians, one of whom is a man. One of my retired colleague's patients is L.P., a woman in her fifties who has been treated in my clinic for nearly a decade. L.P. has requested that her care be assigned to the female physician, with the explanation that she has always had a female physician and that she feels more comfortable discussing her health with a woman. Although the transfer is possible, the remaining female physician in my clinic is already overburdened, whereas the male physician to whom this patient was reassigned has multiple open spaces on his patient panel. Does my clinic have an ethical obligation to honor this patient's request for a female physician?

Commentary

Many patients have personal preferences regarding their choice of physicians. These may include personal factors such as the physician's race, ethnicity, religion, gender, sexual orientation, or age. The literary critic Anatole Broyard, who confessed to harboring his own biases when choosing doctors, famously wrote that "to be sick brings out all our prejudices and primitive feelings."[1] These patient preferences, and requests to accommodate them, occur on a continuum from those that our society views as reasonable to others that are considered pernicious.[2] Some preferences may be grounded in specific personal experience and prove clinically relevant; for example, a patient who is the victim of a race-based hate crime might have trouble engaging with a physician of the same racial background as the perpetrator. Other requests, often shaped by historical context and group identity, reflect subjective levels of patient discomfort. For instance, a Black patient might request for a referral for a Black mental health professional because the patient believes that a White mental health professional cannot meaningfully understand the patient's life experiences. Similarly, a Palestinian patient might raise concerns about seeing an Israeli physician, or a veteran of the Vietnam War might object to being cared for by a Vietnamese-American physician. At the extreme, such requests may reflect outright animosity toward specific groups based on false beliefs about integrity or competence. Barring rare cases of clinical necessity—such as a patient who has psychosis who harbors a delusion that nurses of a certain background are poisoning them—the canons of medical ethics generally forbid accommodating animus-based requests. Under some circumstances, accommodating such requests might violate federal law in light of protections against discrimination laid out in the Civil Rights Act of 1964.[3] Health care professionals may even have a moral duty to educate the patient that such discrimination is ill-founded and will not be tolerated. Unfortunately, higher-income or influential patients are often able to make such choices through access to private physicians. Thus, many ethical and legal limitations restricting the choice of a physician affect only marginalized or low- and middle-income patients.

GENDER

Evidence suggests that overall, both male and female patients prefer physicians of their own gender.[4] The strength of preference varies considerably by patient gender and physician specialty. A strong association exists between female gender and a preference for female primary care physicians.[5] These differences may be related to differences in communication style between male and female physicians.[6] They may also reflect different cultural values regarding what is considered appropriate for gender roles and when physical contact between individuals of different genders is permissible, given that preferences are stronger for certain interventions than others.

Gender-grouping practices are often more broadly accepted than those involving most other demographic-based attributes. Our society tolerates, correctly or incorrectly, a range of social conventions based on gender segregation, such as assigning patients to rooms in hospitals and nursing facilities. Even the Supreme Court has imposed a lower bar for laws that make distinctions based on gender than those that do so by race or religion.[7] Furthermore, requests for female physicians may have a positive societal significance in contradistinction to requests for male

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physicians because women historically have been marginalized in medicine. From a professional and organizational perspective, preference for a female physician may be interpreted as empowering, supporting women with expanded opportunities that may help reverse a legacy of discrimination. Honoring requests for male health care professionals could, in this context, be interpreted as merely reinforcing the status quo. An exception might apply in a female-majority field such as obstetrics, where overwhelming patient preferences for female physicians could potentially deter men from pursuing careers in this specialty.

At the same time, a potential adverse outcome due to high female patient preference for female physicians could be that female physicians are taxed with additional workload to accommodate such requests. For those in academic environments, this could affect the time available for research or other career-advancing endeavors. In addition, gender-based accommodations raise many potentially discriminatory issues for gender-fluid and nonbinary patients and physicians that are often overlooked.

MOTIVATION

Determining whether patients' gender-based requests are reasonable may depend, in part, on the motivation for their preferences.[3] Some religious traditions, for instance, may require concordance between the gender of the health care professional and patient. Preferences may also reflect cultural values, especially among patients not raised in societies in which men and women comingle freely. Where intimate matters such as sexuality or childbirth are concerned, many physicians and ethicists find gender-based requests acceptable.[8] In contrast, nonconcordant requests may be viewed with suspicion. Of particular concern are patients motivated by animus or mistaken notions regarding expertise, such as a male patient who seeks a male surgeon because he wrongly believes that men operate with more skill. To a degree, physicians may find it helpful to explore underlying motives with patients. Unfortunately, patients may choose to falsely report religious or cultural concerns to mask more objectionable motives and to make their requests more acceptable.

MANAGEMENT

In urgent situations, patient safety considerations argue for honoring some gender-based requests because failing to do so might result in the patient refusing essential treatment. A physician does not want to deter a patient from obtaining urgent gynecologic care, for example, by providing the choice of a male physician or no health care professional at all. In contrast, patients who are unhappy with their nonurgent care, including the gender of their physician, are generally able to seek care elsewhere. If a female physician is willing to accept an additional patient, and that patient's motivation is not driven by animus, the clinic could ethically accommodate such a request. At the same time, even though discharging a long-term patient may prove disruptive to their care, a clinic would be well within ethical norms to refuse such an accommodation as long as the patient has opportunities to obtain care elsewhere.

Case Resolution

For L.P.'s situation, the newly assigned male physician should attempt to build rapport and explore the patient's motives for her request, especially to ensure no underlying clinical justification exists. If L.P. insists on seeing a female physician, the male physician should discuss the case with the clinic leadership and the sole female physician to ascertain whether she would be willing to accept the care of this patient and whether other aspects of her workload need to be adjusted accordingly. The final decision about this patient should be made, without pressure or duress, by the female physician; the female physician should be made aware that she will be supported by the clinic and the other physicians regardless of her decision. If the female physician is willing, the patient may be transferred to her care. If she is reluctant, the patient should be encouraged to continue care with the male physician but also afforded the opportunity to seek care elsewhere. Assuming that no insurmountable barriers exist to the patient obtaining medical care elsewhere, the clinic has no obligation to accede to a request that unfairly burdens its sole female physician.

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