

“The provider gender project”

Responding to Requests for Female Health Care Providers at the Royal Women’s Hospital, Melbourne

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The provider gender project: responding to requests for female health care providers at the Royal Women's Hospital

1. Executive Summary and Recommendations

The evolving practice of obstetrics and gynaecology and the increase in the number of female trainees in obstetrics and gynaecology have accompanied changing expectations of women about the service they can expect to receive from women's hospitals. The number of women requesting female health care providers in obstetrics and gynaecology (O&G) appears to have risen, creating increasing demands on female O&G consultants, trainees, nursing staff and support staff.

In 2002 a modest majority of junior medical staff in obstetrics and gynaecology at Royal Women's Hospital (RWH) were female, but only 38% of general O&G consultants and fewer in some areas of practice were women.

The Royal Women's Hospital recognizes that for some women it is important to see a female health care provider. This project was developed in response to difficulties experienced by hospital staff in meeting and consistently responding to requests by women for female doctors.

The literature and consultations confirm that this is a widely recognized issue, but there is little reported practice in terms of organizational responses.

Common themes in the literature were around:

- Discrimination against male health care providers
- Practice differences between male and female practitioners
- Reasons for women's preferences.

Extensive internal consultation was conducted in an effort to gather information, feedback and opinions on this issue. Generally staff felt that:

- Women had a right to request a female health care provider
- The RWH did their best to fulfil requests but the system needed improving and updating.
- Attempts to meet requests for female providers in outpatient care have led to unrealistic and unfulfillable expectations for gender preference to be met in non-elective situations such as delivery suite, emergency department and operating theatres
- Open clear communication about the Hospital's position on provider gender issues should be provided as early as possible in the woman's episode of care to create realistic expectations and avoid disappointments.
- Issues around "discrimination" against male staff were common themes among medical, nursing and allied health staff.
- Efforts to meet provider gender requests have resulted in workload and training imbalances.

2. Recommendations

- 1 That RWH reaffirm the principle that all staff and students are expected to work in a cultural and gender sensitive framework that ensures respect for women's individual rights and needs.
 - 2 That all staff should be encouraged to be respectful and supportive of the role and professionalism of their colleagues regardless of gender and avoid propagating gender stereotypes in their work.
 - 3 "Female doctor preferred" stickers on patient medical records should be removed and/or disregarded, as they are uninformative and have no status.
 - 4 Information about provider gender should be included with other information routinely sent to women on booking .
 - 5 A process should be implemented whereby women requesting female doctors be fully counselled by midwifery staff (see referral pathway attached, appendix 11.7).
 - 6 The discussion referred to in recommendation 5 should be recorded in the medical record with a stamp for future reference (content attached, appendix 11.9).
 - 7 Women requesting female doctors should be provided with a standard information sheet (appendix 11.8).
 - 8 A small number of elective appointments (2-3 per female doctor) should be reserved for women who are prepared to book ahead to see a female doctor.
 - 9 It should be clearly explained to women that choice of provider gender cannot be offered in operating theatres, birthing suites, the Emergency Department or specialized or urgent circumstances.
 - 10 A date should be set for this policy to be implemented and staff education undertaken accordingly.
 - 11 That a means should be established for incorporating education on this issue into ongoing orientation and staff development programs.
 - 12 Evaluation should be undertaken as suggested.
- These recommendations have been accepted by Clinical Directors and implementation is underway. The policy developed is included as appendix 11.6.

3. Introduction

The Royal Women's Hospital is a specialist women's hospital aiming to provide best practice in women's health care. Each year there are approximately 5000 births at the RWH and 20,000 admissions¹. In the year 2000 the RWH treated women from 135 non-English speaking countries, from 37 different religious groups¹. The RWH commitment to listening to the needs of its client base is the driver behind projects such as this. Cultural and gender sensitivities need to be acknowledged and every effort made to ensure that the women attending the RWH are comfortable and in control of their health care. Current best practice in responding to cultural and gender sensitivities has identified the woman's right to request a female health care provider, as noted in the recently released "Public Hospital Patient Charter". *"You have the right to be treated in a way that respects your culture and beliefs; for example this may relate to the gender of the person treating you or dietary requirements. Where possible the hospital will make every effort to meet your needs"*². The Royal Women's Hospital is committed to fulfilling its responsibilities in ensuring that all women have access to women sensitive health care in order for them to feel safe and in control of their health care needs.

This project was developed in response to difficulties experienced by hospital staff in meeting and consistently responding to requests by women for female doctors. The project was designed to develop:

- Policy on availability of choice of provider gender
- A response system for women requesting female or male providers
- Patient information re availability of choice of provider gender
- A system for abandoning "female doctor preferred" stickers
- A staff and patient education plan

4. Methodology

A Steering Group was established to advise and direct the project. Its members (see appendix 11.1) were selected in consultation with clinical directors and professional groups based on the reach they had within the hospital, their capacity to provide a broad range of professional perspectives and their familiarity with process and communication issues around patient care.

The steering group oversaw the project, provided direct input to evolving documentation and guided the consultation and communication around the project.

Information from previous consultations was reviewed and a literature review was conducted specifically seeking information about organisational responses to requests for gender specific health care providers, but also examining information on requests for female doctors and the reasons given for these requests.

Given the information available from previous consultations and the literature, the project was focused on organisational capacity to respond to consumer requests and did not attempt to undertake community consultations, although the Hospital's Community Advisory Committee was advised of progress of the project.

The consultation for the project included:

- Meeting with Nursing staff

- Meeting with Medical Students
- Meeting with Junior Medical Staff
- Meeting with Senior Medical Staff
- Meeting with Community Advisory Committee
- At the time of writing consumer consultation was being conducted about information materials with Community Advisory Committee and through Publications Department.
- External consultation with other providers and key stakeholders in women's health.

Broad staff input was sought by means of a staff survey.

5. Current Status

5.1. RWH History

A community consultation project convened by the Royal Women's Hospital in 1987 identified gender of health care provider as a major barrier to accessing health care as well as a significant issue in terms of acceptability of service provision³.

This issue was again highlighted in the "Community Consultation on Integrated Care" report conducted in 1997⁴. This report identified recruitment and retaining more females in obstetrics and gynaecology would be useful as a response to dealing with women's requests for female health care providers⁴.

A medical memo was traced back to 1993 when a sticker system was introduced (see appendix 11.2) as a means of identifying those who requested female doctors. This system involved placing a sticker on the front of a patient's history noting the preference for a female doctor. Whilst acceptance and understanding by staff of the issue was the impetus behind the development of the sticker system the way the system was used was problematic with no process for placing the sticker on a chart. Problems developed when stickers were placed on charts without requests being made; in some cases staff assumed that because of a patient's past history or cultural background she would prefer a female doctor. There appeared to be no process for assisting a woman to see a female doctor once it had been noted. It worked in an adhoc way so that if there was a female doctor working and available the patient charts were moved to the female doctor's patient list. This often resulted in very long waiting times and female doctors being left with more patients on their list requiring some staff to be working on after other staff had finished for the day⁵. This imbalance in workload resulted in staff frustrations and an unwillingness to fulfil requests for female doctors.

A study conducted by a senior gynaecologist at the RWH examined how medical staff dealt with cultural sensitivities and the barriers to providing culturally sensitive care; all but one highlighted without prompts the issue of provider gender. Some staff mentioned having more experience in certain areas because they were dealing mainly with women requesting female providers and some noted the excessive workload as an issue.

Well Friday night at 5.30 the lights in Outpatients are off, all the consultants have left, all other junior staff have left except me and the 'please can I see a female doctor only' patient and that happens to a lot of female registrars⁵.

A meeting of the Resident Medical Officers Society in February 2000 opposed the development of policy on provider gender on the basis of a belief that it would create unrealistic expectations. Their reasons were similar to the concerns identified in Bayly's study, namely issues of an inability to meet all requests, workload issues for female doctors, the inappropriateness of females accepting the role of technicians in consultations and finally that women from other countries do not normally have this option anyway⁵.

In response to an issues paper prepared in 2000 by senior RWH staff (see appendix 11.3) the RWH half-day Clinical Practice Review presented "Female Practitioner- A Woman's Right to Choose". The meeting was extremely well attended and the discussion following the presentation highlighted the passion around this issue and the need to develop a consistent response with a possible policy and process for staff and patients. An overview of the history of this issue was given along with some workforce statistics of current trends in gender of obstetric and gynaecology trainees. The distress of attempting to meet the demand for female doctors was discussed and the ramifications of this such as training imbalances and the difficult position in which it placed frontline staff such as clerical staff. The issue of discrimination was raised as a possible conflict for the hospital, as well as workforce constraints such as the number of senior female medical staff available. Different options were discussed, and there was general agreement that this needed to be responded to in a more formal manner⁷.

5.2. Workforce Trends in Obstetric and Gynaecology

In June 2000 the Australian Institute of Health and Welfare released a report looking at the Australian Medical Workforce as it was in December 1998⁸. Of the 16,490 specialists 2,572 were female (15.6%). 1049 of these were obstetricians and gynaecologists and 158 were females (15.1%). Currently, 55% of obstetric and gynaecology trainees are female.

The proportion of females commencing a medical degree in 1998 was 52.7%⁸. The number of female medical practitioners increased by 109.6% between the 1981 and the 1991 censuses compared to an increase of 22% for their male counterparts⁹. Female medical practitioners are more likely to be working part time, in a capital city and as a general practitioner and retire approximately ten years earlier than males⁹. Given the increasing number of females in the medical workforce and the fact that females tend to work part time and are more likely to leave the practice of medicine, there are long term implications that need to be addressed in workforce planning. In 1994 44% of female specialists worked part time⁹. The highest number of females working part time was in the 30-39 year and early 40s age brackets which coincide with an age when a female may be substituting family commitments for workforce commitments⁹.

The new consumer driven market has lead to a perceived need to appoint women to consultant posts particularly in the field of O&G based on gender preferences of patients. An initiative of the NHS in the UK to ensure that 25% of senior consultant appointments are women by the year 2000 has had serious implications for female

specialists. This initiative has set female specialists back in their battle for acknowledgment based on skill and experience; it undermines the issue of equality for female doctors by confusing consumer choice with equality in the workplace¹⁰. Whilst the call for more senior positions to be filled with females is flattering to women and timely there are major flaws in the argument for promotion on the basis of gender. The major argument is that it fails to address the issues of equality of opportunity for women and improvements in training programs for both sexes, in particular the low status that part time work has had over the years. After 10-15 years of postgraduate training a female practitioner does not want or need to feel valued primarily on account of her gender, and would be uncomfortable with allegations of career enhancement because of her gender and an affirmative action policy. This policy in effect has the potential to propagate the issue of gender role stereotypes^{10, 11}.

In 2002 at the RWH:

- 15 of 39 consultants (38%) in the seven general obstetric and gynaecology units at the Royal Women's Hospital were women.
- 3 of the 7 general unit heads were female
- 55.3% of current Australian obstetric and gynaecological trainees were female, the RWH proportion being 65%.

6. Project findings

Much of the available literature concentrated on requests for female doctors and the reasons given for these requests, with very little information examining organisational responses to requests for gender specific health care providers from either provider or community perspectives.

6.2. Women's Preferences

Historically women have had the primary responsibility for childbirth with midwives being displaced by the medical profession in response to a campaign for scientific practice to override lay midwifery. Gender preferences of patients in obstetrics and gynaecology have been widely reported^{3,12,13,14,15}. There are a number of reasons cited, the main one being the intimate nature of examinations required in this field of medicine¹². A survey of patients in an American Family Medical Centre found 57% of women had a gender preference for a doctor for an anal or genital examination, yet only 27% had a gender preference in other medical areas such as flu and arthritis consultations. This suggests that genital examinations are viewed differently to other examinations¹⁵. Other reported reasons for preference for a female doctor in obstetrics and gynaecology include cultural or religious dictates, feelings of vulnerability which make examination by a male doctor frightening or for some women a sexual component to being unclothed regardless of context¹².

Perhaps one of the main reasons gender preference in obstetrics and gynaecology has become such an issue is because of the number of females now training in this field of medicine. In the United States two thirds of obstetrics and gynaecology trainees are now female. Watson and Mahowald postulate that it is because of the increasing number of female trainees that women are acting on their gender preferences¹². Hospitals must juggle the legal and ethical implications of responding to requests for female providers. Watson and Mahowald noted, "*Serious consideration of the unique psychosexual and emotional aspects of obstetrics and*

*gynaecology may lead physicians and hospitals to conclude that it would be unethical to refuse such requests*¹². It is also important to take into account the implications on workforce training requirements for male and female trainees and establish a system that acknowledges and respects a woman's right to request a female health care provider whilst ensuring all trainees have an equal training experience.

A study in Northern California examining women's preferences for the type and sex of the provider in basic gynaecological care found that 55% (n=5014) who remembered the sex of the provider of their last gynaecological visit saw a female for their last examination, and the majority of those (78%) preferred a female¹³. Factors that related to preference for a female provider include being younger and more highly educated and having seen a female for the last pelvic examination. In the multivariate analysis the strongest predictor for preferring a female doctor was having seen a female at the last appointment. It was interesting that familiarity with a particular type of provider (specialist or primary care physician, male or female) was thought to have a strong influence on patient preference in this study. Women who did not see the provider of choice at their last appointment were significantly more likely to have had the examination more than 2 years ago; distaste for gynaecological examinations and dissatisfaction with gynaecological examinations can lead to postponements¹³. Increasing satisfaction by providing doctor of choice may encourage women to attend screening type consultations that in the past have been deferred¹⁴.

One explanation for women's preferences for female obstetricians and gynaecologists is that women doctors may be perceived as more empathic and understanding. On a population basis, women doctors have been found to have better listening skills¹⁶ and perhaps the notion of shared experiences also has a part to play in women requesting female doctors. There is a large body of research into communication styles of male and female doctors; one of the most common findings in the literature has been that in general female doctors conduct longer consultations than male doctors¹⁷. Style of engagement and partnership building have been postulated as possible contributing explanations. Roter, Geller et al conducted a study to determine whether there were any gender differences in style and content of first prenatal visits and whether patient satisfaction with obstetrician care was influenced by obstetrician gender. Unlike other studies, they found that male obstetricians engaged in more dialogue and conducted longer visits¹⁸. Male physicians expressed more concern and partnership than the females, although there was a higher proportionate level of emotionally charged conversation with the female physicians. The measure of global satisfaction was not significantly influenced by physician gender, but female physician gender had a statistically significant positive influence on satisfaction with emotional responsiveness and to a lesser extent informational partnership. The authors considered that the atypical findings of this nevertheless interesting study may have been a result of methodological and sampling issues.

Another study looking at the effect of physician gender on levels of satisfaction amongst men and women visiting an emergency department in California noted that women trusted female doctors more than they trusted male doctors. This is an important point to note in terms of patient adherence to treatment recommendations, satisfaction and improved health status¹⁹. This study also found that the females

had a greater level of satisfaction about the care and concern shown to them by the female doctors¹⁹.

6.3. *Issues of Discrimination*

The issue of employment discrimination against male health care providers has been raised both in the literature and in the course of this project. The *Equal Opportunity Act (Victoria)* prohibits discrimination in relation to employment on the grounds of “impairment”, which, for the purposes of this project includes gender²⁰, but discrimination in the provision of services is not covered in the same way. This means that the Hospital may not discriminate as an employer on the basis of gender, but is not precluded from responding to requests for female health care providers.

The question might arise as to whether discrimination against patients is occurring if care by a female provider is not given on request. If the care offered is considered reasonably necessary to protect the health or safety of the woman, the provision of that care by a male provider is unlikely to be seen as discrimination under the Act, although of course there is a right to refuse treatment.

Another possible case for discrimination could be made by female employees if they are required to do more work than their male counterparts as a result of the institution responding to these requests.

These issues have not been tested in the local equal opportunity jurisdiction, but in an American case reported by Watson and Mahowald, a woman asserted her right not to be seen unclothed by a male; the court found that the hospital is not bound to honor patients’ requests for an all female health care team. However if the hospital agrees to do so then they are bound by the principles of contract and informed consent and must honor that contract¹².

6.4. *How do other services respond to these requests?*

In the early phases of the project all women’s hospitals around Australia were contacted and asked if they had developed a process to deal with requests by patients for female doctors. All hospitals contacted acknowledged that trying to fulfil these requests had been problematic but mostly the requests were dealt with on an individual basis. Only one Australian hospital had developed a formal response: this hospital conducted a similar consultation to our own and developed patient information that acknowledged the patient’s requests but had decided that these requests could not be fulfilled. Patients were given the option of seeking private care (see appendix 11.4). In the process of this project we became aware of another Victorian hospital which had prioritised an evaluation of women’s needs, with the aim to develop a model of maternity care for women requesting female health care providers. The hospital concerned has found the project more difficult than anticipated.

6.5. *Staff Survey*

Apart from the study conducted by Bayly⁵ there were little data available to assist us in understanding the breadth of the issue. Largely we were relying on anecdotal evidence that requests for female doctors cause anxiety and distress amongst consumers and hospital staff when the requests cannot be met. A brief survey was

designed with the purpose of obtaining an understanding of the views held by hospital staff about provider gender and seeking suggestions on how to respond to requests for female health care practitioners. The survey also provided staff with a response mechanism for input into policy development.

The survey was distributed via members of the steering group, advertised in the staff bulletin and sent specifically to department heads and medical staff members. The project team conducted in-service education and consultation sessions for nursing and medical staff on wards and distributed the survey at these meetings. 230 questionnaires were distributed and 161 were completed and returned. This response rate (70%) is high, although some questionnaires may have been photocopied and further circulated: we believe this to have been infrequent.

The survey results (see appendix 11.5) showed a range of opinions; the majority of staff felt that women had the right to request female care providers. Some staff felt that all women should be asked if they wish to see a female and all requests must be fulfilled. Most staff were aware of the hospital's inability to support every request due to problems of rostering, inadequate numbers of female specialists and the volume of requests made.

The majority of staff felt that women who have a history of sexual assault/abuse have more of a need for female health care providers than other women do. Staff also felt that certain religious and cultural beliefs meant that some women had more of a need. A Muslim background was often cited by staff in this context. Many respondents stated that any request for a female doctor is reasonable, which was supported by the large number of staff who answered that there are no unreasonable requests.

74% of doctors had, at least once, been unable to fulfil a request for a female doctor, which resulted in a variety of outcomes. Staff suggested many ways to meet the requests of women, or their partners, including clearer communication, education of the public about the services that the hospital can realistically provide, thorough explanations of the situation, adjusting staff rosters and providing midwife led care. However staff also noted that many issues could arise if the hospital adopted these approaches including female doctors becoming overworked, male doctors not exposed to certain areas of training and problems with funding.

When comparing the responses from medical, nursing/midwifery and allied health staff, there was not a significant difference in opinion. Gender of respondents was not consistently recorded and numbers were too small to identify any significant differences. More detailed study would be required to identify differences between professions, genders, age groups and areas of work, but this was beyond the scope of this study.

6.6. Internal Audit

Due to the lack of data available to assist with understanding the number of requests made an audit was undertaken in medical records and the outpatients department. For one week in July 2002 all patients attending the hospital for an appointment or admission had their patient histories checked for a sticker requesting a female provider. Of the 1321 histories checked 80 (6%) had a sticker on their history requesting a female provider. In the same week there were 30 telephone requests

for a female provider. It is important to note that this exercise was a scoping exercise and it is difficult to draw substantive conclusions as we do not know why the sticker was on the patient chart and whose request it was. These figures do not include women who were already booked to see a female doctor and do not differentiate between clinics with different staffing ratios and service profiles. However although the issues around provider gender provoke much interest and discourse the actual number of women making these requests may be fewer than anticipated.

6.7. Other findings from internal consultations

The individual and focus group consultations reinforced issues raised in the literature and previous RWH consultations. The following points were frequently and strongly made.

- The more requests for female providers are fulfilled, the greater are the expectations that all future requests will be met. Therefore it is critical that women have realistic expectations of our capacity to meet their requests.
- There are particular difficulties in meeting these requests in delivery suites, emergency department and operating theatres
- There is a tendency to respond to the most persistent requesters, who staff believe may not be those with the greatest need.
- Requests often come from male partners rather than women themselves; the woman's views are seen as more important but sometimes difficult to establish.
- Our current responses are seen by staff as inconsistent.
- Current responses result in imbalances in workload and training experience for male and female medical staff.
- Both male and female medical staff and students have experienced discrimination around this issue.
- Consultations following these requests are often long because of involvement of interpreters and sometimes associated complex psychosocial issues.
- It is not appropriate to call staff away from their other responsibilities to meet these requests.
- The separation of history taking and examination in relation to a particular problem is not good medical care.
- Women should not be encouraged in preference for women doctors; all staff should be supportive of the professionalism of colleagues regardless of gender and be mindful of avoiding the propagation of gender stereotypes.

Interestingly, provider gender issues appeared to be less prominent in some of the subspecialty areas, perhaps suggesting that the complexity and prominence of the clinical problem and the perceived need for care might outweigh the importance of the characteristics of the provider in these situations.

7. Process Development

Throughout the project it became clear that it was important to provide women with information about provider gender as early as possible in the provision of care so that they will have realistic expectations about the possibility of seeing female doctors at various stages in their care. It was felt that providing women with information about what it meant to make a request for a female doctor at the Royal

Women's Hospital would assist them in the decision about how important it was for them to see a female doctor. If women knew that there were not enough senior female doctors to cater to all requests and this often translated to very long waiting times and disappointment when a female was not available, those with a preference rather than a perceived "need" would be more likely to accept seeing a male doctor rather than wait.

There was much discussion about prioritising requests, however in the end this seemed inappropriate and unfair. Firstly it sets the midwife up as the person that has to decide why one woman's request is more just and reasonable than another's which is likely to cause distress and anxiety to all involved. Secondly we questioned the necessity of asking why a woman had made the request. Some women may find it very difficult to articulate why they would prefer a female doctor, particularly in cases of undisclosed sexual assault; it really was not in anyone's interest to force women into explaining their requests. It was felt that if women had all the information about waiting times, skills match and the fact that a female doctor could never be guaranteed, those to whom it was important would pursue the option offered at the initial contact with the hospital.

The provider gender booking process fitted with the new model of antenatal care introduced in May 2002. It is proposed that all new patients attending the hospital will be sent patient information flagging the issues around requesting female doctors; this information will be incorporated with general information about transport and childcare and will also include information about student involvement in care. All maternity patients attend the Pregnancy Booking Clinic at the commencement of their care at the hospital, providing an opportunity to address this issue in a consistent way. If a request is made at the Pregnancy Booking Clinic for a female doctor the midwife will discuss the implications of this request and explain that reasonable efforts will be made to fulfil the request for routine care. Requests in areas such as delivery suite, emergency department and operating suites will only be fulfilled if a female doctor is rostered in that area and not already committed with other duties; usually it will only be possible to see the doctor who is rostered to provide care.

If a request for a female doctor is received after the Pregnancy Booking Clinic appointment it will be necessary for the patient to have a discussion in a separate appointment about this. On the day the request is made the patient should be offered a time with midwifery triage, pregnancy booking clinic or the consumer advocate before a female doctor appointment can be made. If they have an appointment that day they may continue with the appointment as booked or re-book after they have been through the provider gender booking process (see appendix 11.6).

Gynaecology patients do not as yet attend a central booking clinic as the maternity patients do, so most first gynaecology appointments will not be with a female doctor unless the request was made prior to receiving the patient information sent out with their appointment time. Gynaecology patients must also go through the provider gender booking process prior to being booked electively with a female doctor. This can be provided for with the development of the Women's Health Assessment Clinic "WHAC", which offers comprehensive health assessment with a nurse practitioner followed by referral as appropriate to RWH or other services.

It is proposed that there will be a number of appointments with female doctors, say 2-3 each doctor, reserved for those who have been through the booking process and are willing to wait a few weeks to see a female doctor. These appointments will be early in the session and may need to be double appointments if there are complex issues. As always, the clinic staff will evaluate how smoothly the session is running and redistribute some patients to other lists if the female doctor is running behind because she is seeing women with complex issues. Once a woman has been allocated to a female doctor list it should also be noted on the electronic appointment schedule so that if staff move patients they should check this sheet prior to moving the patient in case she has been booked to that doctor for a particular reason.

7.2. Tools to support the process

The following tools have been developed to assist with implementation of the findings and recommendations of the project:

- Policy statement to be available as a clinical practice guideline on the RWH website (see appendix 11.6)
- A revised information sheet sent to all women on booking appointments: includes information about transport and parking, childcare, involvement of students in care and provider gender issues (In development)
- A referral pathway which summarizes the process to be offered to women requesting female providers (see appendix 11.7)
- Information sheet for women about provider gender issues, provided to those who make requests (see appendix 11.8)
- Stamp to record discussion and preference in medical record after discussion with designated midwife (see appendix 11.9)

7.3. Internal Responses to Proposed Process

All staff had an opportunity to respond to the proposed process and make suggestions or recommendations. Whilst most responded favourably some responses expressed concern that the project was driven from the organisation's capacity to respond rather than by a woman's "right". The Community Advisory Committee was also critical of the lack of community consultation around the project. As previously stated, this was considered, but the project was based on an organizational imperative to improve the response to what was experienced by staff as unmeetable demand.

8. Implementation

8.1. Immediate steps

More detailed training and discussion of the process is being undertaken during early 2003 with staff who will be directly involved in discussion around requests for female providers.

The consumer information sheet has been piloted and revised with consumers and Community Advisory Committee over the same period and the policy will be publicized to relevant clinical staff.

The process for reserving forward booked “female doctor only” appointments will be finalized, together with a means for flagging this in the booking system if appointment times are changed.

8.2. *Ongoing Education*

A process needs to be established to ensure that new staff are trained around this topic as part of their orientation and that updates are included in ongoing staff development programs.

8.3. *Evaluation*

It is proposed that the practice as described be evaluated within the first year of implementation. Evaluation will include:

- assessment of the number of requests for female providers
- assessment of the number of medical records with “female doctor preferred” stickers
- assessment of the number of complaints received about availability of preferred gender of provider
- anecdotal and systematic feedback from staff about the effects of the introduction of the policy on clinical practice
- Community Advisory Committee will be consulted about consumer and/or community consultation on the acceptability of and satisfaction with the process as implemented.

9. Conclusion

This project has generated a high level of interest both within and outside RWH and has been challenging to undertake. The proposed process is summarized in the form of recommendations (page 2, with the Executive Summary) and supporting tools (presented as appendices). The recommendations have been approved by the Clinical Directors.

The Royal Women’s Hospital aims to respond to women’s needs and understands that it is important to some women to see a female doctor for sexual and reproductive health care in particular. However, it should also be noted that offering to fulfil all requests for female doctors potentially propagates gender stereotypes that female doctors are better for women in obstetrics and gynaecology. These stereotypes need to be challenged in the same way that all stereotypes need challenging.

The issue of demand for female practitioners and the RWH organizational response can be further examined and reviewed after implementation of the project’s recommendations, which can be expected to improve the matching of expectations with service delivery.

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11 Appendices

Appendix 11.1 Steering Committee Members

Chris Bayly: Chair, Associate Director Women's Services
Geraldine McDonald: Project Coordinator
Kerrith McGrath: Project Officer
Jeremy Oats: Clinical Director Women's Services
Marg Darcy: Manager Centre Against Sexual Assault (CASA)
Hilary Russell: Research and Education
Jenny Ryan: Unit Manager Delivery Suite
Les Reti: Senior Medical Staff
Samia Moussa: Coordinator Outpatients Clerks
Angela Guzys: Unit Manager Outpatients
James Friebe: Junior Medical Staff
Suse Hiscock: Junior Medical Staff
Zeinab Mohamud: Family and Reproductive Rights Education Program Worker

THE ROYAL WOMEN'S HOSPITAL

Med 029/1993

13th July, 1993

PATIENT REQUESTS FOR ATTENDANCE BY A FEMALE DOCTOR

It is Hospital policy to make every reasonable attempt to fulfil the wish of a patient requesting attendance by a female doctor.

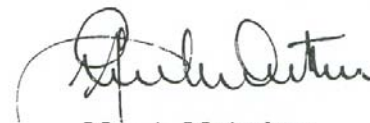
Where a patient wishes to be attended by a female doctor and that is known at the Outpatient Clinic during the antenatal review period, a stamp which is used to record her wish on the cover of the patient's medical record.

Notwithstanding the above, I must emphasise that, because we only have a small proportion of female Medical Officers at the Hospital, we cannot guarantee that a patient requesting attendance by a female Medical Officer will have that wish fulfilled on each and every occasion.

It is wrong to establish a false expectation that we can guarantee availability of a female doctor. We cannot offer such a guarantee. Accordingly, medical and nursing staff must make it perfectly clear at the outset that, while we will do our best to accommodate patient requests, the number of female medical staff is very limited. To do otherwise is cruel and potentially dangerous because when a promise is not kept, the patient may become disillusioned and so emotionally distraught that an inappropriate response (eg. refusal to accept any assistance or care from an available competent male Medical Officer) may seriously jeopardise the outcome for mother and/or baby.

In summary, the key to handling this sensitive and important issue is careful explanation from the outset, that while every reasonable effort will be made, we cannot guarantee attendance by a female Medical Officer.


Clive Wellington
Director of Medical Services


Mrs. A. McArthur
Director of Nursing

PROBLEM

Is it the right of a woman to have a female practitioner?

Is it our commitment wherever possible to provide a female practitioner where that is requested?

AIMS

To produce policy for consideration by the RWH directors meeting.

To develop communication strategy so policy is understood, standardised across publications and promulgated to women and staff in education programs.

BACKGROUND

O&G workforce

- 15.1% of the specialist obstetric and gynaecological workforce in Australia is female, slightly higher in Victoria.
- 14 of 38 consultants (36.8%) in the nine general obstetric and gynaecology units at the Royal Women's Hospital are women.
- 2 of the 9 general unit heads are female (22%).
- 55.3% of current obstetric and gynaecological trainees are female, RWH figures being 62%.

Gender is an issue for providers:

16 of 18 RWH medical staff (7 male, 9 female) interviewed about providing care to women from different cultural backgrounds spontaneously identified provider gender as being an important issue in their work, being a charged issue with a variety of negative responses among providers. Both men and women advocated the appointment of more women in senior positions.

State wide statistics

Male: 241 Fellows 3 Senior registrars (5/6 year trainees) 15 Registrars (1-4 year trainees)

Female: 80 Fellows 8 Senior registrars (5/6 year trainees) 48 Registrars (1-4 year trainees)

MINC study

- Preference for female care givers:
 - 78% Vietnamese
 - 69% Turkish
 - 58% Filipino
- Percentage of those to whom it was important who actually saw a female doctor:
 - 29% Vietnamese
 - 54% Turkish
 - 41% Filipino

Reasons women may request female practitioners:

- Religious conviction
- Comfort/Shyness
- Previous bad experience attributed to male gender of provider
- History of sexual abuse
- Preference
- Partner's belief/wishes

These preferences are prominently expressed among some cultural groups.

Reasons women may request male practitioners:

- Lack of trust (cultural?) in female practitioners
- Preference
- Previous bad experience attributed to female gender of provider

Medical memo 029/1993 (see attached)

"It is Hospital policy to make every reasonable attempt to fulfil the wish of a patient requesting attendance by a female doctor..... Notwithstanding the above..... we cannot guarantee..... It is wrong to establish a false expectation....."

ISSUES FOR PROVIDERS

All

- Distress, anger and humiliation if rejected.

Female practitioners

- "Excess" experience with women from different cultural backgrounds, including working with interpreters and counselling work

- Unequal work load (last left in clinic)
- Consequently less experience in other areas

Male practitioners

- Less experience of this work including technical issues for example female genital mutilation and counselling issues such as in cases of sexual abuse

Issues in care

- Female staff not always available
- Female junior staff usually present in Hospital, but sometimes busy
- Examination by male may be refused, can be important in situation where senior opinion is warranted
- Female providers not available in some sub specialist areas

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Information for

Female Patients Requesting

Female Doctors

We are a public hospital where treatment is free for you if you are a public patient.

All the patients who come here are women but not all doctors and nurses are women.

We teach doctors and nurses. Part of their training requires them to examine patients.

Because we teach, train and help all staff in training, they see an equal number of patients.

It is natural as a woman for you to want to have a woman doctor and woman nurse to examine you and treat you. This feeling is the same for women all over the world including Australian women.

All our staff respect women, their natural modesty and need for privacy.

We understand your modesty, but patients are seen solely on the basis of their medical condition and are prioritised accordingly.

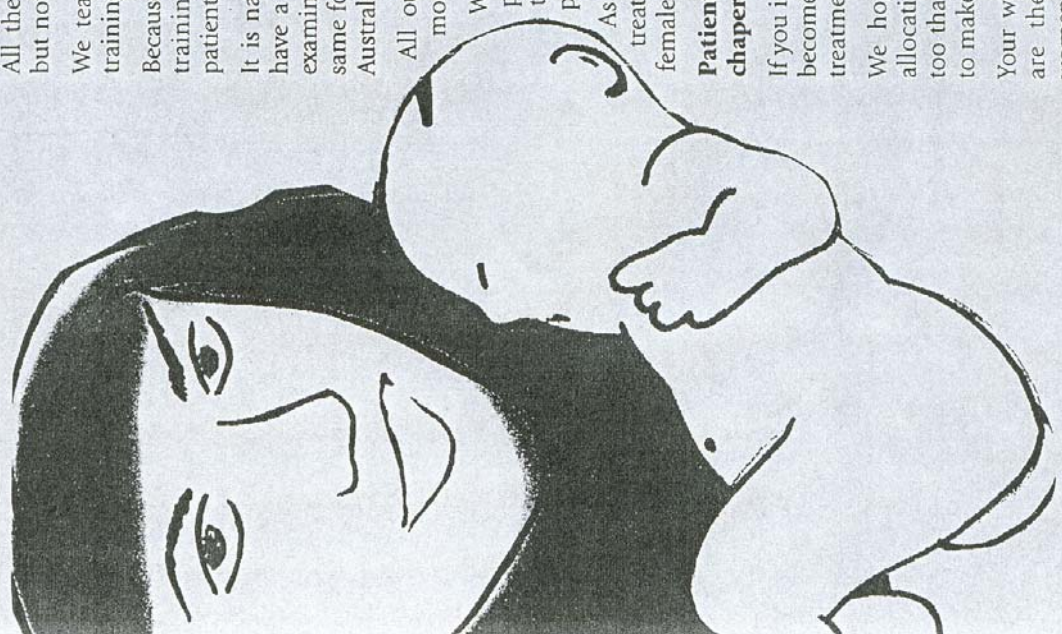
As a public patient and because your treatment is free, you will be seen by both female and male members of staff.

Patients seeing male staff are always chaperoned by a female attendant.

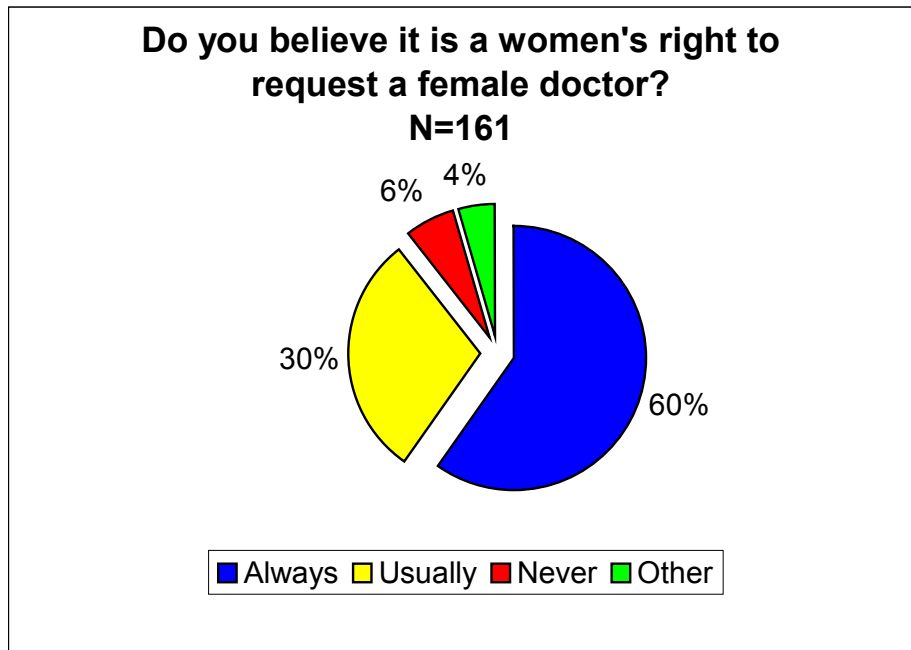
If you insist on a female doctor you must first become a private patient which means your treatment is no longer free.

We hope you understand our reasons for allocating patients equally to staff and hope too that you will cooperate with us as we try to make our clinic run on time and smoothly.

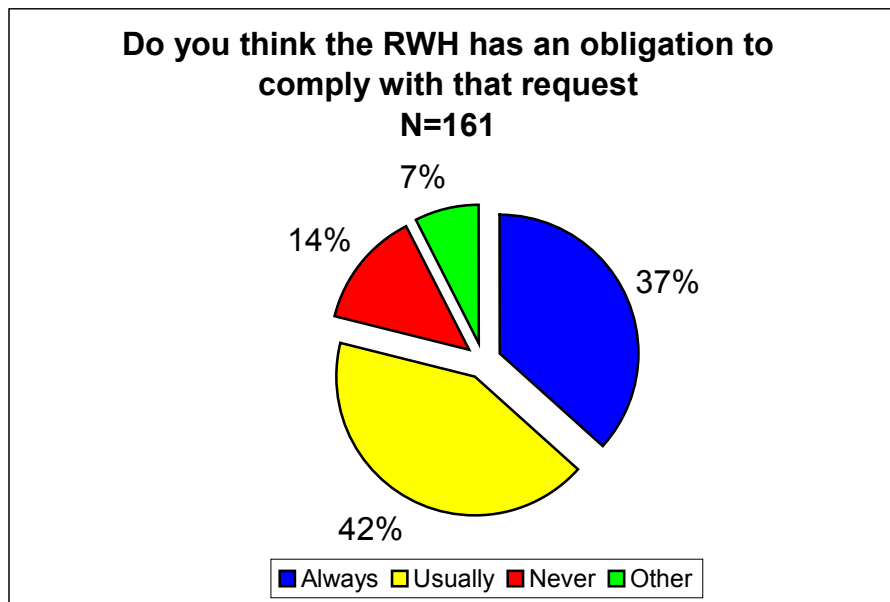
Your well being and your baby's well being are the reason this hospital treats only women. It is our only concern.



Results



Other: Occasionally



Comments:

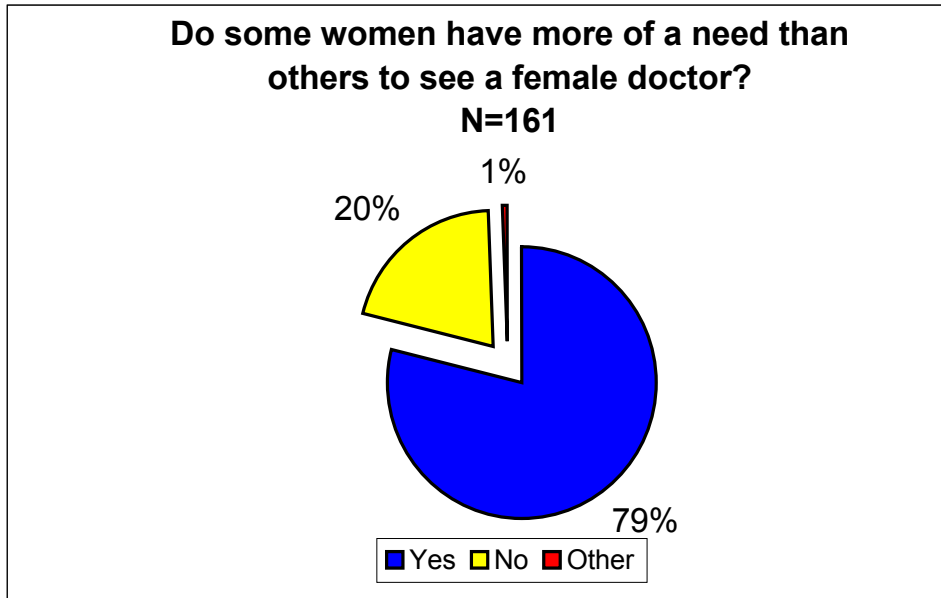
“ As far as possible, within the bounds of safety for mother and baby”

“It is not an obligation”

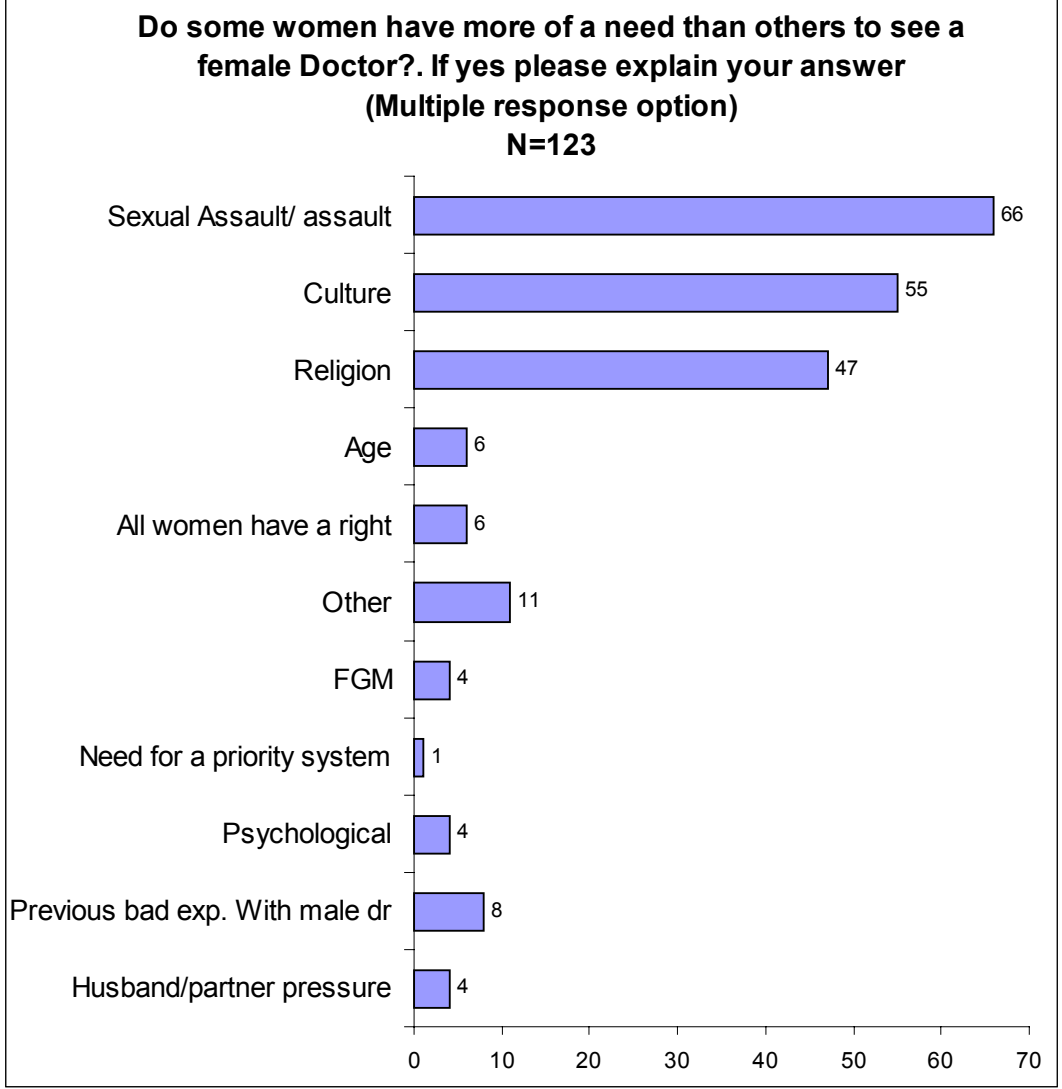
“It depends on the circumstance. Patients should have the best care and gender is secondary”

“I don’t think we have an obligation to comply but if there is an opportunity to provide it then I think we should”

Other: whenever possible, occasionally, sometimes



Comments: occasionally, not necessarily a right



Other includes: Lesbians, time of menstruation, prisoners, drug affected women.

Comments:

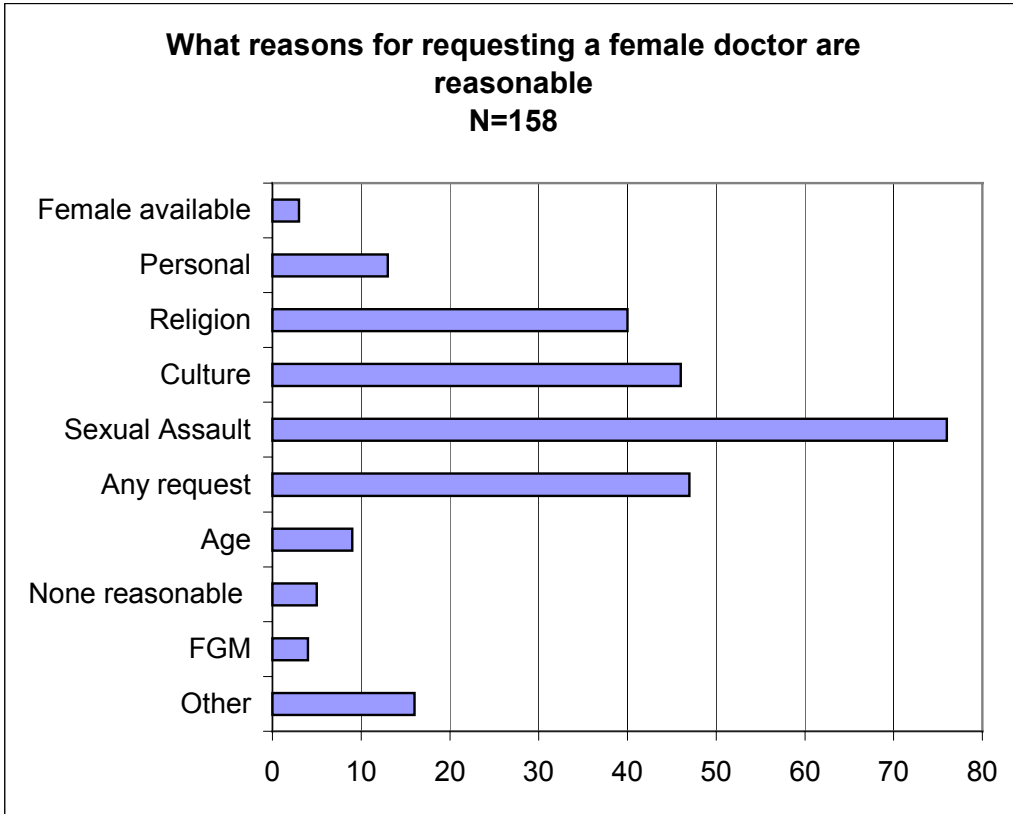
“Patients may not understand that gender and experience may not match. If patients understand the effects of their gender choice they may not care so much”

“I strongly believe that if women have had traumatic experiences with either male doctors or males then it is of greater need than those who just prefer it”

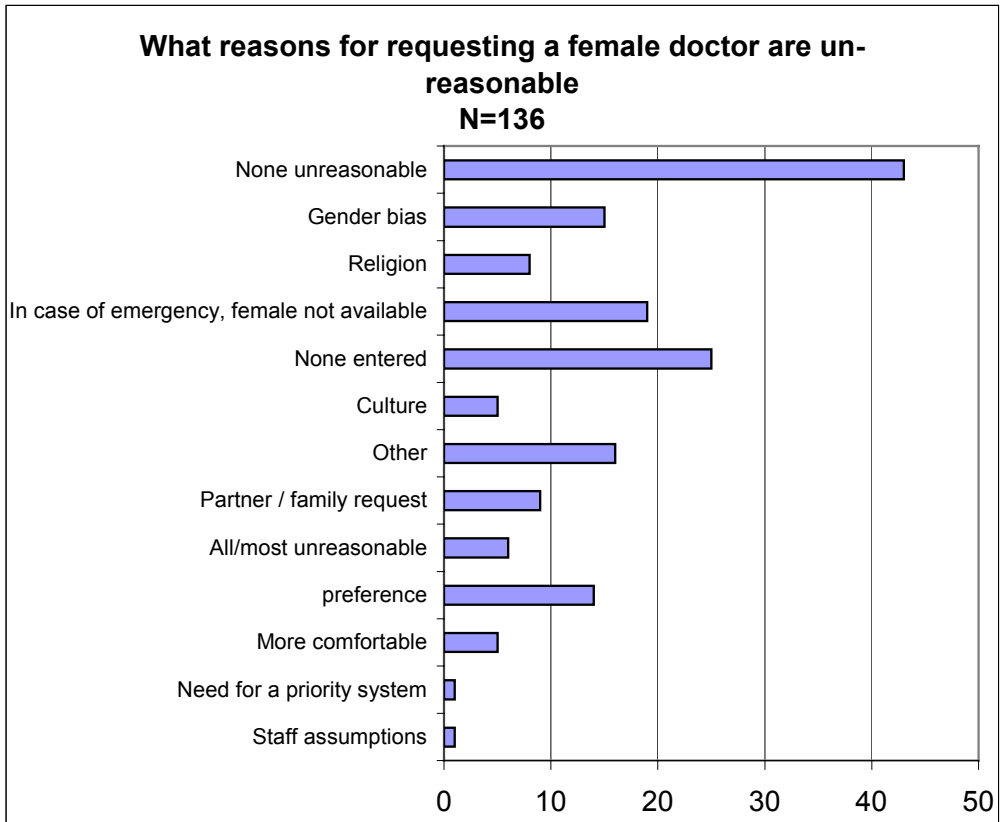
“Any request would be reasonable according to the female client. What is reasonable to “A” may not be reasonable to “B”

“Some have severe partner or religious pressure to avoid males.”

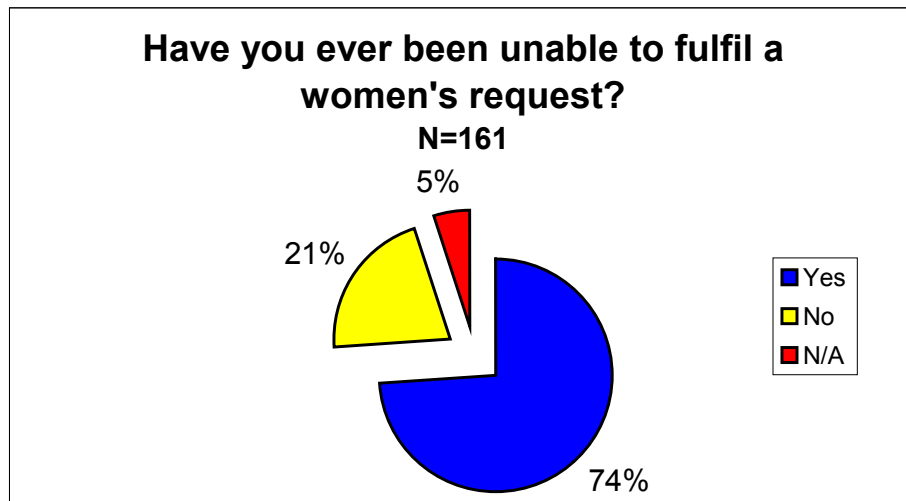
“Women who have a history of sexual assault”



Other: Past bad experience, internal exam required, request from husband



Other: non internal examinations, shyness, had one last time



N/A: results are from female care providers.

Have you ever been unable to fulfil a women's request. If yes what was the situation and what was the response from the women to the refusal to fulfil the requests for a female doctor:

- When a patient requests a female doctor and it is explained to them it will result in a very long wait, or what the appointment will involve, many patients agree to see a male doctor.
- The response is always negative
 - Women chose not to seek medical care when a female doctor was not available (patient presented following a trauma/sexual assault)
 - Patients seek outside treatment/clinics with female doctors.
 - Patient agree to see male doctor, with a chaperone
 - Husband/partner refusing treatment for wife/partner from a male doctor.
 - Midwife examined patient when female doctor unavailable.
 - Patient re-books appointment for another time, when a female is available

"?ROM preterm, needing a speculum exam to confirm. The woman was about to leave hospital rather than submit to male doctor exam. The situation was defused when a midwife skilled in the use of specula was able to perform the exam"

"The women decided to agree to a male with a chaperone"

"last week in theatre – female surgeon but Muslim women requested female anaesthetists, theatre tech etc. => Cancelled"

"One husband rudely demanded a women's hospital should have women doctors – I asked if he was happy for a 5yrs old to take out appendix at the Children's Hospital!!"

"No male doctors available on duty – some have understood and accepted the male"

What response could we reasonably make to women making this request

A. In offering ways to meet it:

- Out first concern is the patient/baby well being
- Maintain clear and honest communication – educate patients/families
- Employ more female doctors
- Explain that we will try but it may result in delays
- Have a female rostered on each day
- Most requests should be discouraged
- It is impossible to meet requests
- Book another clinic time and/or offer other alternatives
- Make it clear at first appointment the limitations
- Have all female clinics, especially when intimate exams are needed

B. In not being able to fulfil the request.

- Have private care
- Go outside of hospital
- Make next available appointment
- Not hospital policy
- Explain that they are not available and can't guarantee request
- Explain the male doctors are just as caring/qualified
- Staffing limitations
- Offer a support person to accompany patient
- Public hospital does not allow for a choice of provider
- Offer midwife practitioner as alternative

Do you see any issues arising by making female provider care an option for women?

- Availability of staff
 - Funding is not available
 - More education about our staffing/ care providers
 - Females are not necessarily better providers/more caring/better skilled
 - Often misinformed views
 - No females in labour wards
 - Demand will exceed supply
 - Some patients have unreasonably expectations of female doctors
 - Over worked female doctors, increase stress
 - No issues would arise
 - Male O&G trainees may have reduced patient contact/experience
 - Discrimination against males
-
- “Yes a vastly improved reputation for the RWH amongst women in Victoria. Women centred medical care”
 - “It is discrimination against male O&G and probably not legal”
 - “Yes. This is impossible to do 24 hours a day 7 days a week due to on call. Routine offering of female only doctor at booking is both unrealistic and downright misleading. It should be a request”

- “No, there is a percentage of the population who would love this model and others who would be happy to have other care models”

Can you suggest any solutions of dealing with this issue

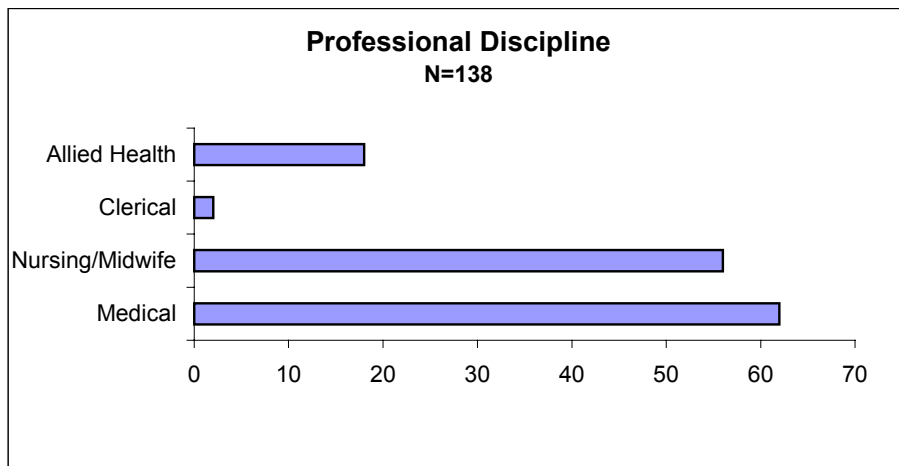
- Employ and train more female doctors
- Midwife lead care and minimise obstetrician care in ‘normal’ pregnancies
- Have only female doctors
- Written hospital policy available to patient – in different languages – explaining the reality of the situation
- Educate all doctors about different cultural/religious needs of women
- Public hospital so can not guarantee female doctor
- Re-educate public about the services we can provide/expectations of hospital
- Make it clear from first appointment that cannot always provide female doctor
- Policy of no sexual discrimination
- Don’t offer option/service
- Don’t use the sticker system
- “Making it clear to patients from their first dealings with the hospital that we cannot provide female doctors on request”

Staff were asked to prioritize six different scenarios into order of the more reasonable grounds for requesting to see a female doctor to the least reasonable.

- A history of sexual assault was clearly seen as the highest priority.
- Women with a history of FGM needs a vaginal examination were the second priority
- A Muslim women’s husband adamant she is to see a female doctor was seen as the third priority
- Lesbian women requesting a female doctor because she feels more comfortable was the 4th priority
- A woman requesting a female doctor in emergency for an internal exam, as she feels embarrassed was seen as the 5th priority.
- Requesting a female doctor because ‘the listen to what I have to say’ was the lowest priority

“I believe all reasons/scenarios are valid and very real for the women I encounter in the hospital. Number 6 (noted as Muslim women’s husband requesting female doctor) should be able to see a male doctor if comfortable and want to regardless of what her partner states. However in regard to domestic violence safety for her post visit needs to be considered. The women should always be asked her preference”

“These (list of scenarios) are value judgements based on provider perceptions”



“I would be extremely disappointed if this modern institution were to begin permitting discrimination on the basis of sex. We can try to met requests not demands but the best health provider should be the one rostered for the job.”

Responding to requests for female (or other) health care providers

Background

The Royal Women's Hospital expects all staff and students to work in a cultural and gender sensitive framework and to respect women's individual rights and needs.

All staff are expected to be respectful and supportive of the role and professionalism of their colleagues regardless of gender and to avoid propagating gender stereotypes in their work.

Staff are rostered according to their skills, training and experience, not their gender, with the aim of providing the best possible care to all women

The Royal Women's Hospital notes that attempts to meet requests for female providers in outpatient care have led to unrealistic and unfulfillable expectations for gender preference to be met in non-elective situations such as delivery suite, emergency department and operating theatres. They have also resulted in workload and possibly training imbalances.

The Hospital recognizes that for some women it is important to see a female health care provider and acknowledges their right to request a female health care provider.

Requests may also be made for male doctors or other particular practitioners: the same principles apply to requests for particular providers for any reason.

Routine practice

Information about provider gender is included with other **information routinely sent to women on booking**.

Open clear communication about provider gender issues should be provided as early as possible in each woman's episode of care to create realistic expectations and avoid disappointments.

A **referral pathway** summarizes the response and referral pathway for women making requests for particular providers

Women requesting female doctors are to be counselled on this issue by midwifery staff. This will normally be arranged through the triage process for antenatal and gynaecology bookings and occur prior to the first medical consultation. This discussion is intended to ensure that the woman's needs and concerns are understood and that her expectations of care are realistic. It should be recorded in the medical record with a stamp for future reference.

This counselling will include that **choice of provider gender cannot be offered in operating theatres, birthing suites, the Emergency Department or specialized or urgent circumstances**. It is therefore expected that when all women have experienced this booking/counselling process, it will be unusual for a woman to arrive in such areas with unrealistic expectations.

Women making such requests will be provided with an **information sheet about provider gender issues**.

A small number of **elective appointments (2-3 per female doctor) will be reserved**, when available, for women who are prepared to book ahead to see a female doctor.

Women without obstetric complications may choose **midwife antenatal care**. Those without symptoms seeking Pap smears and “well women” checks can choose the **Well Women’s Service**, which is staffed by midwives, most of whom are female. If symptoms or complications develop, care will need to be provided by the most appropriate rostered staff. Women may also attend the **Women’s Health Assessment Clinic**, for a health assessment with a nurse practitioner followed by referral as appropriate to RWH or other services.

“Female doctor preferred” stickers on patient medical records are uninformative, have no status and should be removed and/or disregarded.

Responding to specific requests

It may be helpful in discussion to understand why the request is important to a particular woman; requests may for example be based on culture, personal history, past experiences or on gender generalizations such as beliefs that ‘women doctors are more sensitive’. A reasonable expectation that her concerns will be listened to by the provider she sees is likely to help.

If a request is received **on the day of an appointment** the woman will be asked to discuss the request with the triage staff and either continue with her appointment as booked or **rebook** if deemed appropriate by the triage staff. There will be no transfer of patients to female doctors without discussion with the triage and/or medical staff concerned.

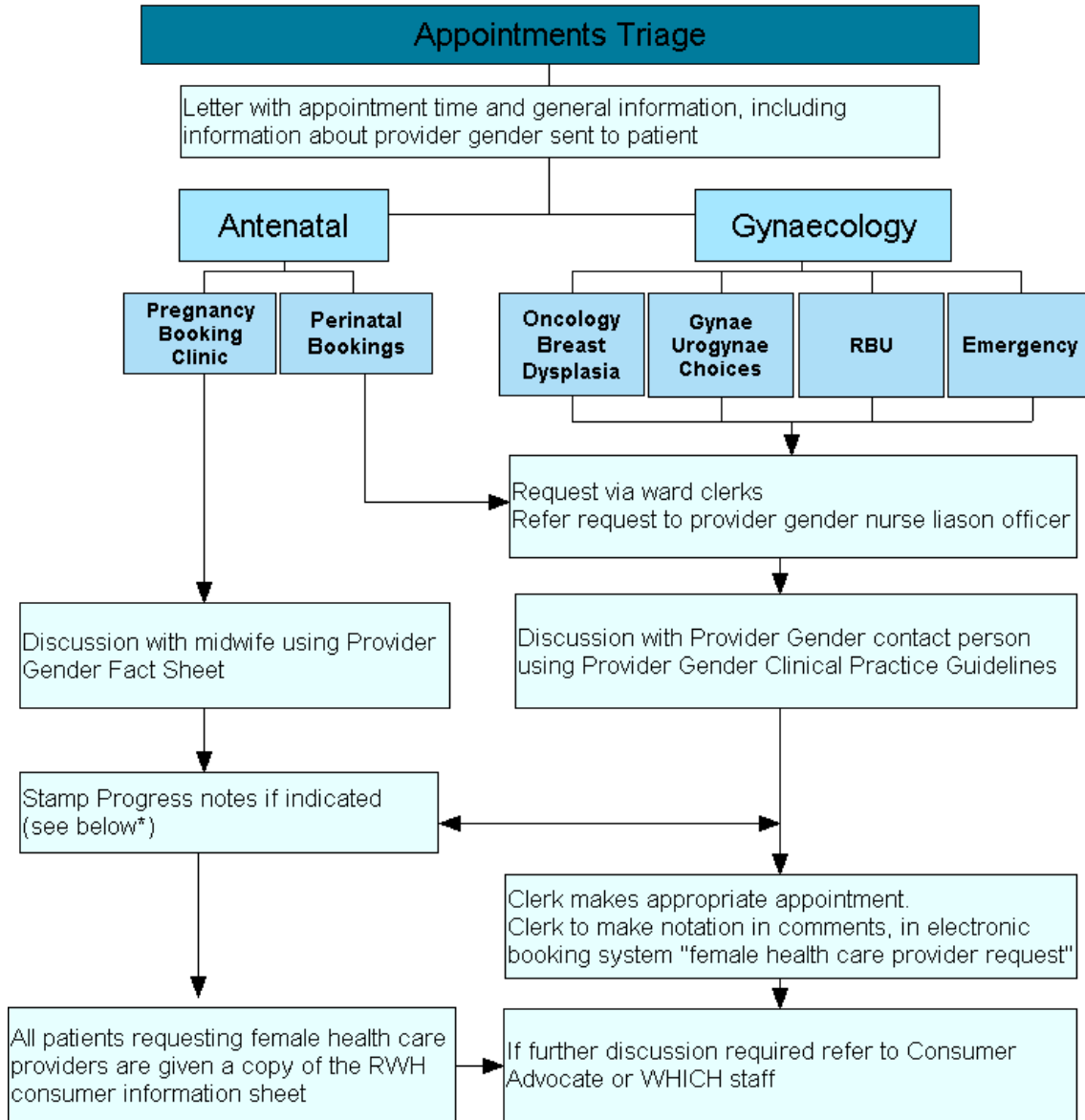
If a woman is **not prepared to have a vaginal examination** performed by the allocated doctor it is not appropriate or best practice for the examination to be performed by a doctor not involved in the full consultation. If a clinically indicated vaginal examination is refused after history taking, it may be necessary to make a **further appointment** for full assessment.

If a request is received in an **acute or urgent situation**, especially Emergency Department, operating theatres or birthing suites, the woman should be advised that such **requests cannot normally be met**, as it is not appropriate to second a doctor away from rostered duties for an examination, consultation or procedure that could be attended to equally well by the allocated doctor. A woman always has the right to refuse care offered, and such refusal should be fully informed. The senior registrar on duty should be advised if such refusal occurs.

In **exceptional circumstances**, if a clinician believes care will be significantly compromised as a result of refusal to accept care by a particular clinician, the senior registrar on duty must consider the relative risks of refusing the request in accordance with this policy and the consequences of calling another doctor away from his or her rostered duties. If necessary, the consultant on call should be involved in this decision making.

This policy does not preclude senior staff of the relevant discipline from deciding on clinical grounds to accommodate a particular request if a suitable clinician is reasonably available and willing to do so without unreasonably compromising the care of other women.

Provider Gender Referral Pathway



PROVIDER GENDER REQUEST * 'Stamp'

- Prefers woman doctor if available
- Prefers woman doctor and prepared to wait/rebook/have midwife care when appropriate
- Would like female/advocate present for consult if male doctor
- Would like female/advocate present for internal examination if male doctor
- understands cannot guarantee female doctor

- Pregnancy Booking Clinic
- Outpatients triage
- Other

Staff name (Block Letters)
Staff Signature
Date
Comments:

**GENERAL INFORMATION: APRIL 2003
I WANT TO SEE A WOMAN DOCTOR**

When you want to see a female doctor

In Australia fewer than one in five obstetricians and gynaecologists are women. The proportion at the Royal Women's Hospital is closer to one in three. Over half of our junior medical staff are women.

We understand that some women feel more comfortable with a female doctor or health carer when talking about having a baby, sexual health matters or when they need to have a vaginal examination. Sometimes you will see a female doctor, but other times it will not be possible.

We have prepared this information sheet to explain why you will not always be able to see a female carer.

Our medical teams are organised so that care can be given as safely and promptly as possible to all women who attend the Hospital. All our medical staff are rostered to work according to their skills and experience.

Every doctor on duty has a set of tasks and is given a number of patients to care for. When doctors are called away from their rostered duties, their patients have to wait longer for their care, or may even have their health put at risk. All our patients will receive the best care when all doctors are able to perform their rostered duties. This means we cannot usually meet your request to see a doctor other than the one who is rostered to care for you.

All our doctors, male and female, and our students are trained to be respectful and to treat your personal information confidentially. These days they are also trained specifically to understand and respect the concerns some women may have about cultural and gender issues. All our male and female doctors receive the same training, so are equally prepared to provide you with excellent care.

GENERAL INFORMATION: APRIL 2003

I want to see a female doctor (Continued)

Part of our responsibility at The Royal Women's Hospital is to train future doctors, midwives and other health professionals, so that your children and future generations will receive good health care. When you allow both male and female staff, and students, to care for you, you are helping to make sure that all our doctors are fully trained.

When will it be possible to see a female doctor?

We **usually cannot** meet a request for a female doctor in these places:

- Birthing suites
- Operating theatres: this includes elective surgery
- Emergency Department.

We **sometimes cannot** meet a request to see a female doctor in these situations:

- If a woman has a **medical problem requiring specialist care**. It is not always possible because some of our doctors are more senior and have more experience in particular specialist areas. Also, there are times when only one doctor with the right skills for your particular needs is available. The best doctor for your needs may be male.
- If you have an **urgent need** for an appointment or care, the doctor rostered to provide such care may be a male.
- If a doctor is called away for an **emergency** or is on **sick leave**.

If you have specific concerns about seeing a male *or* female doctor, you are able make an appointment to see a midwife to discuss this.

We are usually able to meet a request to see a female health professional in these situations:

- **Pregnant women with no health problems** can usually have most of their care during pregnancy and birth provided by midwives, most of whom are female. However if complications arise, it will be necessary to see the most appropriate doctor on duty. This doctor may be male or female, but will provide the best care.

GENERAL INFORMATION: APRIL 2003

I want to see a female doctor (Continued)

- **Women who are attending the hospital for a general health check-up**, who do not have symptoms, may be able to attend the Well Women's Service or the Women's Health Assessment Clinic Midwives, most of whom are female, staff these services.

- **Women who are prepared to wait longer** to see a doctor may make an appointment to see a female doctor, but only a limited number of these appointments can be reserved. These appointments usually need to be made well in advance and even then, for any number of reasons; the doctor may not be available on the day.

Please note that this will sometimes apply to other health care workers as well.

When you are worried about having a vaginal (internal) examination

Many women will not need to have a vaginal examination, especially for pregnancy check-ups. Ask the midwives how likely it is that you will need a vaginal examination.

You can choose not to have a vaginal examination although sometimes it is the only way for a doctor understand your problem. It is usually important that the same person you talk to about your health concerns also does the vaginal examination.

If you do need to have a vaginal examination, you are able to have another person with you. This may be a friend or relative, a midwife or other female staff member.

Although we can sometimes meet your request for a female doctor, it is important that you know that we cannot guarantee a female doctor at every appointment.

Finally

If you have any concerns about your care, have experienced any problems, or if you have any suggestions on ways we can improve our care or the training our staff or students receive, you can contact the consumer advocates to discuss your concern. Consumer advocates are able to help you with any concerns you may have about hospital staff or care while attending the hospital. The Consumer Advocate can be contacted by phone on **9344 2351** or **9344 2000**

You can also call language services and ask for their assistance in speaking with the consumer advocate. Call **9344 2245**.

Appendix 11.9 Provider stamp for medical record

PROVIDER GENDER REQUEST

Prefers female care provider if available

Prefers female care provider and prepared to wait/rebook/have midwife care when appropriate

Would like female/advocate present for consult if male care provider

Would like female/advocate present for internal examination if male care provider

understands cannot guarantee female care provider

Pregnancy Booking Clinic

Outpatients triage

Other

Staff name (Block Letters) _____

Staff Signature _____

Date _____

Comments: