

Gender Preferences in Healthcare: A Study of Saudi Patients' Physician Preferences

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Background and Objective: Cultural and social factors, including physician gender, shape patient-provider relationships in Saudi Arabia. Preferences extend beyond clinical competence to include characteristics like gender and perceived traits, potentially introducing biases. This study examines Saudi patients' gender preferences when selecting physicians.

Method: A descriptive, cross-sectional study was conducted using a survey distributed via social media from February 11 to March 23, 2024. The study was conducted across various regions of Saudi Arabia, with participants recruited via social media platforms using convenience sampling aged 18 years and older who were actively pursuing medical care. A total of 3949 participants (37.9% males and 62.1% females) with a mean age of 33.43 years and a standard deviation of 19.08 were included. The response rate was 99.1%. Data analysis, including descriptive statistics and subgroup comparisons, was performed using JMP version 14 Pro.

Results: The sample showed a predominance of females (62.1%) and younger participants (18–25 years). Female participants preferred female doctors for general exams (67.9%), while males preferred male doctors (63.3%). Gender preferences were strongest for intimate examinations, with 90.8% of females and 72.3% of males favoring same-gender physicians. Similar patterns emerged in specialties like urology, where 71% of males preferred male physicians, while 64.4% of females preferred female physicians.

Conclusion: Saudi patients exhibit gender preferences influenced by expertise, communication skills, and cultural norms. Gender significantly impacts comfort and satisfaction, especially in sensitive contexts like intimate exams and childbirth. These findings underscore the importance of gender-sensitive workforce planning to align physician assignments with patient preferences, enhancing satisfaction and trust. Future research should explore psychological and systemic factors driving these preferences to optimize patient-centered care and healthcare delivery systems.

Keywords: physician–patient relationship, gender preferences, patient's satisfaction, healthcare delivery, medical care preferences

Introduction

In scientific research, the relationship between patients and their healthcare providers holds significant importance. One intriguing aspect that emerges within this dynamic is the potential influence of a physician's gender on patients' selection of their treating physicians. Gender, recognized as a social factor, has long been acknowledged for its ability to shape interpersonal interactions and impact individuals' perceptions and preferences.¹

Recent studies on gender preferences in selecting healthcare providers in Saudi Arabia have highlighted notable gaps. Alotaibi et al focused on the Western region of Saudi Arabia but did not include other regions where cultural and logistical factors may vary, nor did it explore reasons behind these preferences or differences across surgical specialties.² Similarly, Alyahya et al provided generalized findings without examining demographic-specific trends or the role of communication styles.³ Both studies also overlook broader influences, such as societal changes and physician competency, leaving significant areas for further exploration.

However, in recent years, transformative changes in Saudi Arabia's healthcare landscape have occurred, as the country has actively promoted the inclusion of women across various professional domains, including medicine.⁴

Understanding patients' preferences for physicians of a specific gender can provide valuable insights into healthcare delivery and patient satisfaction. Therefore, this study aims to examine the preferences of the Saudi population regarding the gender of their treating physicians. By investigating how gender influences patients' choice of healthcare providers, the research seeks to uncover the intricate relationship between cultural norms, patient preferences, and healthcare delivery in Saudi Arabia.

Patients' choice in selecting their doctors extends beyond medical competence, as factors like gender, race, and perceived socioeconomic status also play a role.⁵ This introduces the concept of gender bias, where patients may unconsciously overlook qualified physicians who differ from their preconceived notions of the traits a doctor should embody. Notably, studies within the field of otorhinolaryngology have revealed gender preferences for specific subspecialties.⁶ Such preferences may be influenced by perceptions of expertise and the ability to relate to patients' experiences.

Additionally, studies have shown varying degrees of gender preference among patients when selecting surgeons. While some participants expressed a preference for male surgeons, citing traits such as optimism, endurance, experience, confidence, and surgical skills, others favored female surgeons for their empathy and patience. Conversely, a significant portion of participants expressed no gender preference.² These findings highlight the complexity of patient preferences and underscore the need for further research into how these dynamics interact with the evolving cultural and professional landscape in Saudi Arabia.

This study aims to address these gaps by examining how gender preferences among patients in Saudi Arabia influence their choice of treating physicians. The goal is to provide insights into the interplay between cultural norms and healthcare delivery, ultimately contributing to the development of more inclusive and patient-centered healthcare practices. Additionally, this study considers demographic factors, such as income levels, that may have an unrecognized role in shaping gender preferences in physician selection.

Methods

Study Design, Setting, Participants, and Questionnaire Design

A descriptive cross-sectional study was conducted using a validated questionnaire adapted from a prior study by Alyahya,³ with modifications to align with this investigation's objectives. The questionnaire was structured into five sections. The first section collected demographic details such as age, gender, marital status, educational level, region, and income level. The second section assessed participants' preferences regarding physicians' personal qualities, categorized into psychological understanding, expertise, communication, and listening skills. Respondents chose "Preferred male doctor", "Preferred female doctor", or "No gender preference" for each quality. The third section addressed whether a physician's gender influenced the participant's interaction and acceptance of the treatment plan, with "Yes" or "No" as response options. The fourth section explored gender preferences in specific healthcare scenarios, with the same response options as the second section. The fifth section examined preferences for the physician's gender across various medical specialties, including internal medicine, emergency medicine, obstetrics and gynecology, general surgery, and others.

The questionnaire underwent pilot testing with 12 volunteers from the target population to ensure clarity, comprehensiveness, and relevance. Feedback from the pilot study was incorporated into the final version, and reliability was assessed using Cronbach's alpha. Content validity was confirmed by expert review, while a translation and back-translation process ensured linguistic and cultural equivalence for the English version used in analysis. It was developed based on existing literature and adapted to the local context. Initially scripted in Arabic, it was professionally translated into English for analysis. Validity and reliability testing preceded its distribution to ensure accuracy.

The final questionnaire was distributed via social media platforms, including WhatsApp, Telegram, and X (formerly Twitter), to reach a broad segment of the general population seeking medical care in Saudi Arabia. The study targeted adults aged 18 years and older actively pursuing medical care across diverse healthcare settings, excluding participants younger than 18 or residing outside Saudi Arabia. Convenience sampling was used to include participants from various demographic groups. The study was conducted from February 11 to March 23, 2024.

Ethical Considerations

This study adhered to the ethical principles outlined in the Declaration of Helsinki and was approved by the Institutional Review Board (IRB) at Taif University (Number HAO-02-T-105). Informed consent was obtained electronically through an online process. Participants were directed to an information page outlining the study details and asked to confirm their agreement to participate by checking a consent box before accessing the survey questions. They were assured of voluntary participation, the ability to withdraw at any time, and the confidentiality of their responses, as no personally identifiable information was collected.

Statistical Considerations

Statistical analysis was performed using JMP version 14 Pro. Descriptive statistics summarized categorical variables with counts and percentages, while relationships between key variables were analyzed using the Chi-Square test. For example, the analysis examined whether gender preferences for specific specialties correlated with participants' demographics. The alpha level for statistical significance was set at 0.05.

Results

A total of 3,949 participants were included in the study. The sociodemographic characteristics of the study population revealed that the majority of participants were female (62.09%), with over 30% aged between 26 and 45 years, while only 4% were 60 years or older. The mean age of participants was 33.43 years (SD = 19.08). Most participants held a bachelor's degree as their highest level of education, and a significant proportion (68.90%) resided in the Western region of Saudi Arabia. Additionally, three-quarters of the respondents reported a moderate-income level (Table 1).

Table 1 Sociodemographic Characteristic of the Studied Sample n=3949

Demographics		N (%)
Gender	Male	1497 (37.91)
	Female	2452 (62.09)
Age	18–25	1812 (45.89)
	26–35	562 (14.23)
	36–45	663 (16.79)
	46–59	754 (19.09)
	>60	158 (4)
Marital status	Married	1752 (44.37)
	Single	2019 (51.13)
	Divorced	128 (3.24)
	Widow	50 (1.27)
Educational level	Primary school	34 (0.86)
	Elementary school	82 (2.08)
	High school	844 (21.37)
	Bachelor's degree	2681 (67.89)
	Higher degrees	308 (7.80)

(Continued)

Table 1 (Continued).

Demographics		N (%)
Region of residence	Western	2721 (68.90)
	Eastern	218 (5.52)
	Northern	138 (3.49)
	Southern	247 (6.25)
	Central	625 (15.83)
Income level	Low	553 (14)
	Moderate	3005 (76.10)
	High	391 (9.90)

Abbreviation: N, number of participants.

Gender-based preferences for physician qualities showed statistically significant differences across all categories ($p < 0.0001$). While 64.3% of participants expressed no gender preference regarding psychological empathy, females exhibited a greater preference for female physicians (22.8%) compared to males (12.85%). Conversely, males were more likely to prefer male physicians for this quality (32.3%) compared to females (13.89%). For specialty expertise, the majority (69.5%) indicated no gender preference, but males favored male physicians (39.7%), nearly double the proportion of females (18.8%) who shared this preference. Similar patterns were observed in communication skills, where 56.4% expressed no preference, but males preferred male doctors (45.4%) more than twice as often as females (17.9%). In listening proficiency, 52.24% had no preference; however, females were more likely to prefer female physicians (28.3%), while males more often preferred male physicians (33.9%) (Table 2).

The perceived impact of physician gender on patient interactions and acceptance of treatment plans revealed a nearly even split, with 50.75% reporting no impact and 49.25% indicating that gender influenced these factors (Figure 1).

Patient gender preferences in various healthcare scenarios demonstrated statistically significant differences ($p < 0.001$). While 55.8% of females and 47.8% of males indicated no preference for physician gender when taking medical histories, females showed a strong preference for female doctors in general examinations (67.9%) and psychological discussions (48.1%). Male participants, on the other hand, preferred male physicians for surgical procedures (67.5%),

Table 2 Gender Preferences for Specific Qualities and Abilities of Physicians

Statements	Gender Differences n %						P value
	Prefer Male Doctor		Prefer Female Doctor		No Gender Preference		
	M	F	M	F	M	F	
Psychological Empathy	484 32.33	315 12.85	208 13.89	560 22.84	805 53.77	1577 64.31	0.0001*
Specialty Expertise	594 39.68	462 18.84	103 6.88	286 11.66	800 53.44	1704 69.49	0.0001*
Effective Communication Skills	680 45.42	440 17.94	215 14.36	630 25.69	602 40.21	1382 56.36	0.0001*
Listening Proficiency	508 33.93	476 19.41	363 24.25	695 28.34	626 41.82	1281 52.24	0.0001*

Note: *A statistically significant p-value ($p < 0.05$).

Does the physician's gender have an impact on your interaction with them and whether or not you accept the treatment plan?

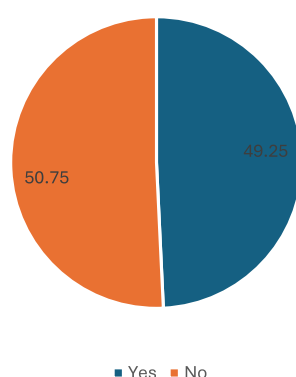


Figure 1 Impact of Physician Gender on Patient Interaction and Treatment Acceptance.

life-threatening conditions (63.4%), and general examinations (63.3%). Preferences were most pronounced in genital examinations, where 90.78% of females preferred female physicians, and 72.3% of males preferred male physicians. Female participants also showed strong preferences for female physicians in breast examinations (90.8%) and delivery management (77.3%) (Table 3).

In medical specialties, male participants consistently preferred male doctors in general surgery, orthopedic surgery, and urology, with the highest preference for male physicians observed in urology (71%). Female participants preferred female doctors across most specialties, particularly in urology (64.4%).

Income-level analysis revealed no significant correlation between income and gender preferences for most medical specialties. However, a statistically significant difference was observed in internal medicine ($p = 0.02$). Participants with

Table 3 Gender Preferences in Patient-Physician Interaction Across Various Medical Scenarios

Medical care scenario	Gender Differences (n, %)						P value
	No Gender Preference		Prefer Female Doctor		Prefer Male Doctor		
	M	F	F	M	F	M	
Taking the patient's medical history	66244.22	40,416.48	1208.02	68,027.73	71,547.76	136,855.79	0.001*
General examination	94863.33	2058.36	1328.82	166,667.94	41,727.86	58,123.69	0.001*
Discussing family or psychological problems	66344.29	35,614.52	30,820.57	117,948.08	52,635.14	91,737.40	0.001*
Managing Life-threatening conditions	94963.39	74,830.51	563.74	43,717.82	49,232.87	126,751.67	0.001*
Performing Surgical procedure/ operation	101067.47	90,036.70	382.54	43,317.66	44,929.99	111,945.64	0.001*
Performing Genital examination	108272.28	572.32	1409.35	221,290.21	27,518.37	1837.46	0.001*
Performing Breast examination For women n=2441		532.17		221,690.78		1727.05	
Management of Delivery For women n=2437		1355.54		188,477.31		41,817.15	

Note: *A statistically significant p-value ($p < 0.05$).

Abbreviations: M, male participants; F, female participants.

high income levels were more likely to prefer female physicians, while those with low-income levels tended to favor male physicians. This finding highlights the need for further research to better understand the nuanced relationship between income and gender preferences in physician selection, particularly in internal medicine.

Discussion

This study identified significant differences in the perception of personal traits and skills of healthcare professionals between male and female respondents. Notwithstanding these differences, a substantial proportion of participants indicated no specific preference for the gender of a physician in aspects such as psychological empathy, specialty expertise, effective communication skills, and listening proficiency. These observations align with previous research indicating a general absence of preference for both male and female physicians in terms of credibility, knowledge, and cooperative abilities.³

Approximately half of the respondents believe that the gender of their physician does not influence their interactions or acceptance of treatment recommendations, while the other half perceives it as influential. This is somewhat consistent with a French study that found gender discordance might exacerbate conflicts during consultations, particularly concerning recommendations for weight loss between male physicians and female patients.⁷ Another study corroborated the influence of shared gender on patient-doctor interactions and outcomes.⁸

Understanding gender preferences in healthcare can significantly inform policy and practice by highlighting the importance of tailoring healthcare delivery to patient preferences. Incorporating gender sensitivity into healthcare systems may enhance patient-provider relationships, leading to improved patient satisfaction and health outcomes. Future policies could leverage these insights to guide workforce planning, ensuring availability of diverse physician options across specialties to meet patient needs.⁹

Data presented in Table 3 indicates a pronounced gender preference in scenarios requiring personal care or invasive procedures, such as genital examinations, breast examinations, and delivery management, where female patients overwhelmingly preferred female doctors.¹⁰ In contrast, life-threatening conditions and surgical procedures did not elicit a strong gender preference among women, unlike men, who generally preferred physicians of their own gender. These findings diverge slightly from those reported by HA Nolen et al, where no significant gender preference was noted in emergency department scenarios.¹¹ However, in surgical interventions, a preference for male physicians was documented by both male and female patients, as noted by Ashraf A. Zaghloul et al.¹²

The strong preference exhibited by patients may stem from a desire for comfort, privacy, and a shared gender identity, particularly in vulnerable medical situations. The intimate nature of certain examinations and the potential for discomfort may drive patients to select a physician with whom they share a gender identity, anticipating a higher level of empathy and personal comfort.¹³

Psychological factors such as regional cultural norms could also play a significant role. For instance, Saudi Arabia's cultural emphasis on modesty and gender separation in certain settings may explain these preferences. These norms likely shape patient expectations and choices, particularly in specialties such as obstetrics and gynecology or urology.¹⁴ For instance, a substantial proportion of Saudi women believe that obstetrics and gynecology should be exclusively managed by female physicians, highlighting the critical role of cultural norms in informing patient expectations and healthcare choices.¹⁵

Furthermore, male respondents frequently expressed a preference for male physicians across various medical interactions, including general examinations, psychological discussions, management of serious conditions, and surgical procedures. This preference might stem from perceived similarities in understanding and communication, which could enhance comfort during medical consultations. Dagostini et al found that comfort with physicians of the same gender was a predominant reason for gender preference, especially in intimate or uncomfortable examinations.¹⁶

Additionally, as revealed in Table 4, male participants consistently preferred male physicians in fields like internal medicine, emergency medicine, and ophthalmology. This preference was even more marked in general and orthopedic surgery, with the highest preference observed in urology at 71%. Similar findings were reported by Steinkohl et al, who noted a preference for male urologists among patients with prostate disease.¹⁷ Female participants showed more balanced preferences across most specialties, with notable exceptions in urology, where 64.4% preferred female physicians.

Table 4 Gender-Based Preferences of Medical Specialists

Medical Specialties	Gender Differences (n, %)						P value
	Prefer male doctor		Prefer Female Doctor		No Gender Preference		
	M	F	F	M	F	M	
Internal medicine	76651.17	453 18.47	815.41	73,529.98	650 43.42	1264 51.55	0.0001*
Emergency medicine	76250.90	565 23.04	795.28	39,916.27	65,643.82	1488 60.69	0.0001*
General Surgery	93462.39	75,530.79	463.07	38,915.86	51,734.54	130,853.34	0.0001*
Ophthalmology	71647.83	77,931.77	986.55	25,610.44	68,345.62	141,757.79	0.0001*
ENT	66144.15	60,224.55	825.48	35,614.52	75,450.37	149,460.93	0.0001*
Urology	106671.21	2399.75	936.21	157,964.40	33,822.58	63,425.86	0.0001*
Plastic surgery	53535.74	47,619.41	29,719.84	75,130.63	66,544.42	122,549.96	0.0001*
Dermatology	53235.54	34,714.15	24,116.10	77,731.69	72,448.36	132,854.16	0.0001*
Pediatrics	36924.65	51,220.88	42,828.59	30,712.52	70,046.76	163,366.60	0.0001*
Orthopedic	92361.66	73,930.14	392.61	2279.26	53,535.74	148,660.60	0.0001*
Psychiatric	62041.42	41,516.92	26,717.84	86,835.40	61,040.75	116,947.68	0.0001*
Neurology	81854.64	72,829.69	614.07	2259.18	61,841.28	149,961.13	0.0001*
Anesthesia	70847.29	67,027.32	966.41	35,614.52	69,346.29	142,658.16	0.0001*

Note: *A statistically significant p-value ($p < 0.05$).

Abbreviations: M, male participants; F, female participants.

Conversely, a higher proportion of women expressed a preference for male orthopedic surgeons compared to those preferring female surgeons, reflecting findings similar to another study.³

Research on patient preferences for physician gender reveals complex patterns across cultures. In Western settings, many patients show no specific gender preference for physicians overall. However, preferences emerge for certain specialties, particularly those involving intimate examinations. For example, patients prefer same-gender physicians for gynecology, urology, and other specialties involving pelvic or breast exams.^{16,18} In Non-Western contexts, stronger gender preferences are observed. A study in the Middle East found significant preference for female endoscopists among female patients.¹⁹ Similarly, South Asian immigrant women in Canada showed a higher preference for female physicians compared to European-descent women, especially for gynecological exams.²⁰ These findings highlight the importance of considering cultural factors in understanding patient preferences for physician gender across different healthcare settings and specialties.

Additionally, differences in communication styles between male and female physicians may influence patient preferences. Early research by Hall and Roter, as well as Sandhu et al (2009), highlights that female physicians often adopt a more patient-centered communication style, which can improve patient satisfaction and trust. Exploring how these differences relate to our findings could provide a more comprehensive understanding of the results and guide future research.^{1,21}

These insights underscore the complexity of patient preferences regarding physician gender, highlighting the need for sensitivity in physician allocation, particularly in specialties involving intimate or potentially uncomfortable procedures.

This study has several limitations. Although the investigation included 3,949 respondents, there was a notable gender imbalance, with a predominance of female participants, potentially biasing the findings toward female perspectives, particularly in areas involving gender preferences. The majority of respondents were aged 18–25, limiting the generalizability of the findings to older age groups, who may have different healthcare preferences and experiences. Additionally, a substantial portion of participants resided in the Western region of Saudi Arabia, where cultural norms

related to modesty and traditional gender roles may have influenced preferences, especially in specialties requiring physical examinations.

While the high response rate strengthens the study's statistical power, these demographic and geographic imbalances warrant cautious interpretation. Furthermore, the universal healthcare structure in Saudi Arabia, which limits patients' ability to freely choose their physicians, may also impact the generalizability of the results.

Future research should address these limitations by targeting diverse age groups, underrepresented regions, and varied healthcare settings. Employing stratified sampling methods could ensure better demographic balance, while qualitative approaches could uncover the cultural and psychological factors driving these preferences. Longitudinal studies would also help explore how gender preferences change over time. Additionally, the exclusive use of social media for survey distribution may have introduced selection bias, favoring individuals with internet access and social media activity. Future studies should consider combining online and offline distribution methods to include broader populations.

Conclusion

This study highlights the nuanced preferences of patients in Saudi Arabia regarding the gender of their treating physicians across various medical specialties and scenarios. These preferences are shaped by practical considerations, such as perceived expertise and communication skills, alongside psychological and cultural factors, particularly in sensitive or intimate medical situations. Psychological factors, including the perception of greater empathy and comfort with same-gender physicians, and cultural norms emphasizing modesty and gender roles, play a significant role. For example, female patients strongly prefer female physicians for genital examinations, breast examinations, and childbirth management, reflecting the importance of privacy and shared gender identity in these contexts.

The findings have practical implications for healthcare systems, particularly in tailoring physician assignments to align with patient preferences, thereby improving trust, satisfaction, and treatment outcomes. Future research should explore the influence of gender-sensitive communication styles, religious and regional variations, and preferences across broader age groups to deepen understanding. Longitudinal and qualitative studies can provide further insights into the cultural and psychological factors driving these preferences, helping develop policies that enhance patient-centered care.

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Author Contributions

All authors made a significant contribution to the work reported, whether that is in the conception, study design, execution, acquisition of data, analysis and interpretation, or in all these areas; took part in drafting, revising or critically reviewing the article; gave final approval of the version to be published; have agreed on the journal to which the article has been submitted; and agree to be accountable for all aspects of the work.

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