Beyond Preference: How Religious Values Shape Muslim Women's Access to Healthcare

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ABSTRACT

The intersection of cultural, religious, and systemic factors influences healthcare access and decisions for Muslim women. Modesty concerns and preferences for gender-concordant care often leads to delays or avoidance of care. Beyond patient preferences, underrepresentation of women in the medical field, gender-based discrimination, and institutional barriers hinder equitable care, leaving the need for female physicians unmet. It is crucial to implement a multifaceted approach that includes increasing Muslim female representation in the medical field, integrating cultural and religious competence into medical training, and fostering inclusive healthcare environments. Key institutional changes include providing female mentors, offering opportunities for women in leadership roles, and enacting policies such as equitable parental leave, flexible scheduling, and guaranteed childcare. Enhanced cultural awareness training, utilizing tools such as concept mapping in medical schools, can also help foster a more inclusive environment. These steps are critical for ensuring that Muslim women receive respectful, comprehensive, and culturally sensitive care, while also serving as a model for culturally competent care for other underrepresented groups. Further research on Muslim women's health and partnerships with religious leaders and the Muslim community are also recommended to better inform policymakers, public health leaders, and institutions, thereby improving care for this population and benefiting the overall healthcare system.

MUSLIM WOMEN PATIENT BELIEFS, PRACTICES AND BARRIERS TO THEIR HEALTHCARE

Patient comfort alongside healthcare access lays the foundation for equitable and sensitive healthcare for patients. For Muslim women whose cultural and religious practices frequently influence their interactions with medical professionals, barriers for comprehensive care remain pervasive (Mahayosnand et al., 2024). More specifically, Islamic teachings emphasize

modesty in interactions between a single man and woman, discouraging them from being alone together in a room and having any physical contact. Hence, Muslim women often have a preference for female physicians to avoid being alone with a male and to avoid unnecessary physical contact with the opposite sex.

Muslim women particularly express a strong preference for gender-concordant care in fields such as obstetrics and gynecology, in which physical examinations often require high levels of intimacy. Many Muslim women report delays in seeking care when a female physician is unavailable. The lack of culturally competent and gender-concordant care has been associated with feelings of discomfort, perceived discrimination, and a generally negative experience within the healthcare system. These preferences function as social determinants of health that shape and reinforce patterns of delayed care and avoidance of healthcare within this population (Vu et al., 2016).

It is critical to understand that modesty concerns are not merely preferences, and that these values shape real-world healthcare decisions for many Muslim women. A survey of 254 Muslim women in Chicago found that 53% reported delaying care because they would have preferred a female physician. In a mixed-methods study of 21 patients attending dermatology appointments, many preferred gender-concordant care when procedures were cosmetic in nature rather than medical (El-Banna et al., 2023). Most felt comfortable when dermatologists exposed only small areas of skin at a time and explained each step of the exam as they went along. Some patients also avoided disclosing their religious concerns, suggesting that fear of anti-Muslim bias may marginalize them even further. These examples underscore the need for culturally competent, inclusive care environments that proactively address the intersection of religion and medicine.

Beyond modesty concerns, many Muslim patients find it difficult to adhere to their medical regimens while being religiously observant. Some report challenges due to the presence of prohibited ingredients such as gelatin or ethanol in medications, and the difficulty of adjusting dosing schedules during the month of Ramadan (Lou & Hammoud, 2015). These concerns were often reported to be avoided in conversations with physicians, as patients fear being misunderstood or judged.

For Muslim patients, trust in a physician depends not only on medical expertise but on cultural and religious sensitivity. Muslim women survey participants stated that respect for Islamic beliefs and knowledge of practices like Ramadan fasting were critical (Lou & Hammoud, 2015). Greater satisfaction was reported when providers valued patient rights, explained female health exams clearly, and helped them navigate the U.S. healthcare system with sensitivity to their religious and cultural identities (Simpson & Carter, 2008). Successful healthcare interactions that acknowledge both medical expertise and cultural sensitivity are essential for improving care experiences for Muslim women (Lou & Hammoud, 2015; Simpson & Carter, 2008).

Despite the public health importance of culturally and religiously competent care, many healthcare systems remain ill-prepared to meet the

needs of Muslim women. Some examples of clinical practices that overlook these religious values include bringing male trainees into female patients' rooms without consent, making assumptions about patients' sexual activity based on age, or presuming nonadherence to medication during Ramadan (El-Banna et al., 2023). These shortcomings exacerbate health disparities within this population and highlight the need for targeted public health initiatives to promote understanding and respect for the cultural and religious values of diverse patient populations.

This need is only becoming more urgent as world conflict drives a shift in patient demographics across the world. According to the United Nations Refugee Agency, over 108 million individuals have been forcibly displaced worldwide with a majority coming from predominantly Muslim countries including Syria, Palestine, and Afghanistan (Zagloul et al., 2024). In the last decade, 36% of all refugees admitted to the U.S. were Muslim. Many of these refugees come from conflict-ridden regions where their rights to healthcare have been stripped away.

In particular, it is crucial to consider that Muslim female refugees have had little access to reproductive and menstrual care (Mahayosnand et al., 2024). As such, it is critical to understand the context within which the patient views healthcare during every encounter. When providers do not recognize differences and nuances that make up the patients' identities, Muslim patients are less likely to disclose their needs, engage in open discourse, or trust the care that they receive.

Framing these challenges as an imminent public health concern stresses the need for urgent policy changes and educational reform. This paper will examine how the religious values of Muslim women shape their healthcare access, while also exploring the barriers faced by Muslim women physicians and outlining institutional changes needed to advance culturally responsive and equitable healthcare.

THE NEED FOR INCREASED MUSLIM WOMEN PROVIDERS AND BARRIERS THEY FACE

Increasing female representation, specifically Muslim female representation, in medicine (particularly in primary care, obstetrics-gynecology, and emergency medicine where timely care is critical) can help reduce preventable healthcare disparities (Vu et al., 2016). When healthcare providers share and respect Muslim women patient values, they are more likely to seek care, disclose health concerns, and follow up (Mahayosnand et al., 2024). Muslim female patients are more likely to seek preventative services when interacting with female physicians who understand and share their values.

However, increased representation of women in medicine comes with its own obstacles. Women in medicine face the "paradox of being hypervisible and invisible," which is a phenomenon that emphasizes how women are marginalized from meaningful discourse (Khan et al., 2022). Simultaneously, female medical professionals (who themselves are patients in their personal lives) are often victims of discrimination or targets of

conversations themselves. For many female physicians, this reality strongly influences their career decisions, deterring them from pursuing or continuing practice in the field. While women now make up more than 50% of medical students in the U.S., they represent only 32% of U.S. medical society presidents (Menezes et al., 2025). Representation at the highest levels of medicine is critical for structural inclusion (Arya et al., 2021).

Women make up 36% of all active physicians while only representing 22% in general surgery and 15% in vascular surgery. These disparities make it difficult for Muslim women to find female providers. Cardiology, a field dominated by preventative care and early detection of pathologies, has only 15% of female physicians (Menezes et al., 2025). By delaying care and not seeking out preventative services due to modesty concerns, Muslim female patients are thus at a greater risk of adverse outcomes.

To this day, medical education continues to sway women toward roles considered more flexible and family friendly, while their male counterparts are encouraged to pursue competitive and academic roles (Khan et al., 2022). Furthermore, when represented in such specialties, 67% of female vascular surgeons and 80% of female trainees have reported experiencing discrimination. Harassment and lack of support for female physicians limit patient choice and perpetuate inequality further (Arya et al., 2021).

Muslim women are often deterred from pursuing medicine due to alienation from peers, microaggressions, and a general lack of recognition (Khan et al., 2022). In particular, many Muslim female physicians chose to wear a head covering also known as the hijab for modesty and religious expression. However, there is a misguided perception that the hijab is a means of oppression. In reality, choosing to wear a hijab is an outward proclamation of one's identity and is an empowering act that reaffirms agency and autonomy. However, such outward expressions of religion further marginalize the voices of Muslim women in medicine.

RECOMMENDATIONS TO ADDRESS MUSLIM WOMEN PATIENTS' & HEALTHCARE PROVIDERS' NEEDS: START AT MEDICAL SCHOOL

To address these challenges, it is critical to implement systemic changes starting with medical education that better empower women to enter and succeed in all specialties. For example, integrating structured curricula, such as concept-mapping grounded in Islamic principles, can help students critically engage with the cultural and religious implications of patient care early in their career. Furthermore, by tackling gender norms, providing mentorship, and creating culturally sensitive environments, barriers that hinder Muslim women and other marginalized groups from fully participating in and shaping the medical profession can be dismantled. Female mentors are crucial in breaking such cycles as they can offer guidance to younger females and model how to navigate demanding careers. Additionally, creating a more safe and inclusive work environment for female

physicians translates directly into greater access and choice for patients (Arya et al., 2021).

Institutional changes such as the enactment of equitable parental leave, flexible scheduling, and guaranteed childcare are recommended (Khan et al., 2022). Further systemic change should include having female providers on staff most of the time or at all times, providing longer gowns to patients with modesty concerns, and most importantly, structuring access within the context of the setting in which the care is being provided (Vu et al., 2016). Increasing the opportunity for Muslim females in medicine who are also patients to voice their opinions is also necessary (Khan et al., 2022). By increasing support for female clinicians, Muslim women will receive better and more timely and respectful care when providers reflect their values (Arya et al., 2021).

Medical students can also benefit from a greater focus on public health research that prioritizes the study of healthcare disparities, as it will allow for more advocacy on the behalf of marginalized groups whose preferences and cultural needs are often overlooked in traditional medical settings (Haque, 2024). It is critical to not only create inclusive spaces but also allocate resources to research the needs of this community in order to implement informed institutional change (Khan et al., 2022). Medical education must go beyond surface-level diversity efforts and integrate Islamic and other religious perspectives into medical training. An example of this effort is the use of concept mapping exercises that are rooted in Islamic bioethics which would allow students to critically engage with ethical dilemmas through the lens of Islamic principles (Al Rashid et al., 2024). Beyond Islamic principles, concept mapping would allow students to consider each case study through the perspective of justice, compassion and respect for life. However, successful implementation of such changes requires more than simple content incorporated into the curricula. It requires medical schools to create classroom environments that foster open dialogue and respect diverse religious engagement. Integrating these perspectives into medical education will move the healthcare system a step closer to being more culturally aware and to making gender-concordant care a standard rather than an exception for diverse patients.

Cultural and religious competence, along with open-mindedness of healthcare providers, are central to equitable healthcare access for Muslim women. Embedding these priorities into institutional policy, beyond individual provider efforts, offers a direct path to reducing preventable disparities and improving trust in care. Increasing representation of Muslim physicians in medicine, adding religiously informed content into medical training, and implementing supportive institutional changes are key to addressing the needs of Muslim women. As the demographics of patients in the United States continue to evolve, these reforms have the potential to improve care not only for Muslim women but also for other patients whose cultural or religious needs may be unfamiliar to healthcare providers. It is critical to recognize the challenges of Muslim women as a public health

priority and crisis in order to take meaningful steps toward a more equitable future of healthcare.

Health policymakers, public health leaders, and institutions have an opportunity to prioritize the proposed reform practices and policies for the betterment of the country's public health. By implementing these improvements to Muslim women's cultural and religious care, particularly by improving communication skills that involve respect and compassion, the experiences of Muslim women patients will be enhanced. Such program implementation serves as a model for providing competent care to other underrepresented groups. There is also a need for public health academics to further study Muslim women's health, while also evaluating the effectiveness of reform program implementation. The ongoing research of the ever-growing diversity of the country's demographic demands the continuous need to address disparities – thereby providing crucial evidence that best guides policy decisions and interventions. Lastly, there is a need to engage religious leaders and the Muslim community and build partnerships with the healthcare system to build trust and better facilitate optimal care coordination.

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