Cambridge Quarterly of Healthcare Ethics (2023), 32: 3, 406–413
doi:10.1017/S0963180122000731

CAMBRIDGE UNIVERSITY PRESS

ARTICLE

"When Appearances Matter: A Taxonomy and Ethics for Demographic-Based Provider Requests"

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Abstract

Requests by patients for providers of specific demographic backgrounds pose an ongoing challenge for hospitals, policymakers, and ethicists. These requests may stem from a wide variety of motivations; some may be consistent with broader societal values, although many others may reflect prejudices inconsistent with justice, equity, and decency. This paper proposes a taxonomy designed to assist healthcare institutions in addressing such cases in a consistent and equitable manner. The paper then reviews a range of ethical and logistical challenges raised by such requests and proposed guidance to consider when reviewing and responding to them.

Keywords: demographic backgrounds; taxonomy; prejudices; justice; equityethical; challenges

Introduction

Increased concern regarding structural racism both within and outside the healthcare system in the United States has focused attention on the ongoing challenge of patient bias against providers. Unfortunately, such bias remains common and has numerous deleterious effects on provider well-being, workplace morale, and societal welfare.[1] Although such bias may present in many forms, a particularly problematic manifestation occurs when patients make requests for or against being treated by physicians, nurses, or other staff members of particular racial or ethnic backgrounds, religions, genders, sexual orientations, or other demographic categories. The seminal work of Kimani Paul-Emile has offered effective guidance for addressing pernicious bias and "demeaning behaviors," such as requests based on animus, false beliefs regarding competence, and irrational prejudice.[2,3] Such pernicious bias has been the subject of proposals for "zero tolerance" policies.[4] In addition, accommodations based on racial animus may be illegal under Title VII of the Civil Rights Act of 1964.[5] Conversely, this law also protects patients, ensuring that no individual can be denied care based on their race, color, or national origin. Healthcare provider requests for patients based on demographic characteristics are generally impermissible, but to the degree any unusual exceptions might arise, they are beyond the scope of this paper. Hospitals and healthcare institutions have increasingly implemented formal policies to address patient bias, although clearly more must be done.[6] The authors of this article strongly support such efforts.

At the same time, not all demographic-based patient requests stem from animus, and even a subset of those that do may be grounded in legitimate clinical or experiential concerns. For example, patients from communities that have historically been neglected or mistreated by the healthcare system may have persuasive reasons for requesting providers from similar backgrounds.[7] The victim of a hate crime may not feel comfortable talking to a psychotherapist whose background is identical to that of her attacker. Congregants of certain religious communities may have rules regarding the gender of providers who may offer gynecological and obstetric care. Which of these requests to honor, and under what circumstances, raises complex tensions regarding patient autonomy, healthcare equity, the rights of providers, and the

goal of creating a just society. In order to facilitate policymaking in this fraught area, the first step is to generate a taxonomy of such requests. This article attempts to classify such requests into distinctive categories in a way that also ranks them roughly from most to least reasonable—although without attempting to draw a line between those that should be honored and those that should be rejected. The article then considers the most significant ethical issues that institutions and policymakers may wish to consider in determining which demographic-based requests by patients should be indulged.

It is important to note that these issues are longstanding, although they have likely increased as one of the consequences of a more pluralistic society. Historically, many American hospitals had religious affiliations or served particular cultural communities—so in the early twentieth century, New York City had Italian Hospital (later Cabrini Medical Center), German Hospital (now Lenox Hill Hospital), Presbyterian Hospital, Lutheran Hospital, Methodist Hospital, and multiple Catholic and Jewish Hospitals. As a result, some patients—but not all—could expect providers who "looked like them" and understood their experiences. Far more disturbing, racial segregation forced blacks and whites into separate hospitals until the 1960s in many areas of the country, largely ensuring an unequal healthcare system resulting in poor health outcomes for blacks.[8,9] Although patients from groups historically excluded from the medical profession have long grappled with being treated by doctors from other backgrounds, the racial and religious integration of society over the last two generations has forced other patients to engage for the first time with doctors who defy their demographic expectations or prejudices. Finally, it is worth noting that such prejudices also have long histories and may be paradoxical. In his well-known article on patient preferences, "Doctor, Talk to Me," the late essayist Anatole Broyard—an African American who lived his professional life passing as white—wrote, "My father, who was an old-fashioned Southern anti-Semite, insisted on a Jewish doctor when he developed cancer of the bladder." His father's preference stemmed from a belief that Jews were more competent physicians, and Broyard noted that he inherited in himself a "certain predisposition…in favor of Jewish doctors."[10] Needless to say, as our society grows more diverse, the complexity and nuance of these issues will only increase.

Taxonomy

This article identifies seven distinct circumstances in which a patient (or proxy of an incapacitated patient) may request a provider based on demographic characteristics, each discussed below. Needless to say, in clinical practice cases may incorporate the attributes of more than one scenario, or will exist in gray areas between the two. In addition, sometimes motives will prove mixed: For example, the male urology patient who wants a male urologist both for religious reasons *and* because he falsely believes men to be more competent surgeons.[11] A black patient may express preference for concordant providers as a member of a historically discriminated minority community *and* against providers of a different minority group because of xenophobia.[12] Each of these situations raises specific concerns:

Clinical Justification

Persuasive clinical justifications for honoring demographic-based requests will surface rarely, but they do occur. Often these will arise regarding incapacitated patients. For example, a patient with schizophrenia may have delusions or paranoia regarding individuals of a specific background—including her own—and may become fearful or noncompliant when treated by such individuals. In these cases, not only may honoring such a request be justified on a therapeutic basis, but an argument might even be offered for only assigning certain providers—even in the absence of formal patient request. Similarly, the child of a patient with dementia might request a female home health aide for her mother, because the mother has repeatedly become panicked in the past at encountering a male HHA in her home, believing that he was a stranger and an intruder. In such circumstances, extreme care must be taken to explain to all staff members the basis for the decision. It should be emphasized that the purpose is not to acquiesce to prejudice but to address specific clinical needs. Other demographic-based requests may apply to competent patients but originate from the unconscious. In psychotherapeutic relationships, transference

or the unconscious response of a patient toward the therapist based on past experiences—which may be grounded in the demographic background—may play a significant role in therapeutic progress.[13] For some, bringing the interracial dyad dynamic into the conscious may be a catalytic process. For others, transference may be an impedance to therapy. In practice, transference typically declares itself after a provider-patient relationship is already established and any clinical benefit or drawbacks may be difficult to predict. Clinical justification should be applied conservatively, and only when the reason for doing so is clear, of significant therapeutic importance, and justified by the specific nature of the patient's disease.

Personal History Justification

All patients enter the therapeutic relationship with a wide range of experiences, both inside and outside the healthcare setting, some positive and others negative. However, a far smaller group of patients have endured experiences so negative with an individual or individuals of a particular demographic group they request not to be treated by other individuals of that demographic. At the extreme, such encounters may provoke symptoms of PTSD, raising the potential justification to a clinical one. For example, an American veteran previously held as a prisoner of war in Vietnam might have flashbacks when interacting with Vietnamese-American providers. Even in the absence of clinical need, certain experiences may prove so traumatic that they impact a patient's reported needs. These might include hate crimes survivors objecting to providers of the same background as their perpetrator or a refugee of ethnic persecution abroad objecting to treatment by a physician belonging to the persecuting group. The nature and severity of the experience might reasonably influence whether or not to honor such a request, as should concern for the impact on providers. A sexual assault victim arguably has a greater claim to avoid a provider who shared the identity of her assailant than does the victim of car theft. Because the impact of any personal experience is subjective and because these patients would be competent and conscious of their decisions, the category of personal history justifications carries the risk of provider demoralization and endorsement of prejudice against a demographic group. At the intersection of race, rape, and gender, in the 1800s, sexual violence was used as an excuse to lynch black men.[14] Conversely, black women—living with intergenerational transmission of trauma and more likely to experience sexual violence than women overall—are much less likely to report them.[15] However, the goal should not be shifting the burden of proof onto victims of trauma, but rather, asking the question whether there are sensitive team-based approaches to addressing trauma without excluding persons of an entire demographic.

Requests for Concordant Providers

Patients may have a range of persuasive reasons for requesting doctors from their own racial, ethnic or religious communities. These reasons may prove even more compelling when the patients belong to vulnerable communities that have been historically underrepresented in medicine or discriminated against more broadly, contributing to worse health outcome measures. black non-Hispanic populations have twice the infant mortality rate when compared to white non-Hispanic populations.[16] African Americans, wary both of medicine's racist legacy in the experimentation of black bodies (e.g., J. Marion Sims, Tuskegee) and their own lived experience with white providers, may not trust white physicians or therapists.[17,18] Increasingly, data have shown that black patients actually receive better care from black doctors.[19,20] Among Asian Americans, psychiatric disorders are underrecognized and services underutilized.[21] Linguistic minorities may prefer a native speaker of their languages over the use of a translator, particularly in settings such as psychotherapy, where the nuance of expression may matter significantly. Members of distinctive or insular religious communities may doubt that a non-member can understand their values, especially in areas that raise high-stakes ethical considerations, such as end-of-life decision-making. LGBTQ patients—who are at significantly elevated risk of attempting and completing suicide—may prefer providers with similar identities.[22,23] The affirmative nature of the request in such cases, especially if they are not common, may limit the burden on excluded staff. It is likely easier to accept being excluded because one does *not* belong to a group than because one does. In fact, the danger here may be an additional burden placed on physicians of underrepresented backgrounds, whose own needs

must be respected and who should be compensated appropriately for any additional care they choose to provide. Needless to say, no provider should be "voluntold" to provide care under such circumstances.

Requests Against Providers—Community Experience

Some individuals, based on their community experience, will seek a concordant provider; others, based on a different set of community experiences, may object to a provider of a specific background. Unlike in cases with a personal history justification, these claims are not based on individual experiences, but rather on experiences previously inflicted on one's group—the difference between a Jewish Holocaust survivor objecting to a German provider and a Jewish patient who is not a Holocaust survivor objecting to a German doctor based on the collective experience of the Jewish people. (Of course, the descendants of Holocaust survivors raise a challenging case in between.) These requests may be predicated on specific historical events: An Armenian-American patient objecting to a Turkish provider in light of the Armenian genocide or a Palestinian patient objecting to an Israeli and/or Jewish physician on account of the Nakba. Or they may prove more broad-based: A member of a racial minority community objecting to all white physicians, but accepting any physician of color, because whites are perceived to be oppressors. One challenge in such cases is the fear of validating or perpetuating prejudices, often when the excluded provider has no meaningful connection to the events of historical concern. Another is that excluding a provider based on their demographics is likely to prove far more demoralizing than including one. If particular groups are systematically excluded, and the burden consistently falls more heavily on one group than others, this may perpetuate broader discrimination in society as well. The frequency and impact of such requests should be considered by policymakers. The number of Armenian-American patients rejecting Turkish providers is likely to prove few; in contrast, many patients might have sought to avoid Muslim or Middle Eastern-born physicians in the aftermath of the 9/11 attacks, demoralizing those providers and perpetuating broader stereotypes and discrimination.

Religion and Culture-Based Requests

Athough many patients may prefer providers who share their backgrounds, some religions have specific requirements regarding who may provide care under certain circumstances. Cultural competence is essential to understanding such requests, as they may appear complex or layered to outsiders. For example, in some Islamic traditions, hierarchies regarding gender exist in patient care: "Preference is given to a Muslim physician of the same sex, followed by a non-Muslim of the same gender, then a Muslim physician of the opposite gender and lastly a non-Muslim of the opposite gender."[24] Some Orthodox or *Haredi* Jews may not permit women to be touched by male providers.[25] Often perspectives differ within religions.[26] Historically, religious concerns have been treated with particular deference by both American law and by the medical ethics community. A challenge arises when the line between religious rules and cultural preferences is murky; for instance, many Orthodox Jewish women prefer female gynecologists, possibly independent of religious dogma.[27]

Requests Conforming to Social Norms

Among the most challenging scenarios are those in which the patient makes a demographic-based request that has no specific clinical, personal, or group justification—but nonetheless conforms with hidebound traditions or accepted social norms. The paradigmatic example is the female patient who requests a female obstetrician to deliver her baby. The justifications for honoring such a request are not nearly as strong from a purely rational perspective as in the other situations described above: no evidence suggests either mothers or babies have better outcomes with female obstetricians. Of course, there is a history of sexism in and outside medicine, so it is possible female patients do not fully trust male providers. An even more challenging example might be the male patient who requests a male urologist on the grounds that he does not feel comfortable with women seeing or touching certain parts of his body. In such a case, the claim of mistrust based on a legacy of sexism is not available. Yet our society may still

choose to honor such requests because they are based on widespread values and are socially acceptable. However, it should be noted that requests based on racial or religious animus were once socially acceptable in many circles, and that honoring such requests likely has an impact on the number of women both entering and advancing in the field of urology.

Animus/Pernicious Prejudice

The final category of demographic-based requests will likely be far more familiar to many clinicians and is discussed extensively in the literature: Requests based on animus or bias against a particular group or groups without any persuasive justification in clinical, personal, historical or religious experience. Requests may be based on false perceptions of competence, such as the belief that providers of a certain demographic are less capable of providing care. Alternatively, such requests may be proffered under the broad guise of "discomfort" or "unease" with members of a particular group, even couched in the language that it is "not personal." Or they may be couched in terms of preference: "My son feels more comfortable with a female pediatrician." At the extreme, such prejudice may reflect racism or bias that does not even attempt to couch itself in reasoned justification. Such requests are likely to have a highly detrimental impact on the providers targeted. As discussed below, hospitals should have clear guidelines and policies for addressing such circumstances in order to protect their employees.

Discussion of Ethical Issues

Although. some cases for demographic-based requests may be resolved directly in the clinical care setting, especially those that must be addressed in real time, the high-stakes, controversial, and nuanced nature of these incidents will often benefit from the input from a hospital ethics consult service or committee. In approaching such cases, hospital ethics teams should first gather information to ascertain the underlying motivations behind such requests. An emphasis should be placed on reserving judgment until the context of the request is fully understood—as a preference that initially appears innocuous may ultimately prove problematic, or even pernicious, or vice versa. Reassurance and informal mediation should be attempted when possible, as this has the potential to defuse many conflicts. Only when the patient's preferences remain resolute should the ethics committee recommend specific guidance on whether and how to accommodate a particular request. In doing so, the rationale for their recommendation should be conveyed to both the patient and to all relevant staff directly or indirectly impacted by this guidance.

Honoring requests for providers of specific demographic backgrounds raises a wide range of challenging ethical issues. An exhaustive list of these concerns is not possible, but six of the most significant are raised below. Institutions should take into account these issues as they develop policies in this area and when the ethics committee considers each request.

Impact on Providers and Society

Each decision to honor a demographic-based patient request has an impact beyond the treatment of that specific patient. At the most immediate level, the decision will affect the care team—not just those excluded, who may be humiliated or demoralized, but also others of different backgrounds who may fear similar exclusion in the future. Needless to say, such exclusions will have an impact on broader workplace morale. If such requests are widely understood to be honored, their numbers may increase. A handful of incidents, if tolerated, may lead to circumstances in which providers of particular backgrounds face a far greater onslaught of request for exclusion that may significantly impact their ability to practice. These requests may also help justify bias and prejudice in society at large. On the other hand, certain concordant and religious-based requests are far less likely to generate internal demoralization or external prejudice. But, as discussed above, requests for concordant providers may also place increased undue burden on underrepresented providers. Institutional policymakers should not merely assess each request on its individual merits, but also in the framework of larger societal forces and the global impact on the workforce and the healthcare system.

Honoring Requests Versus Offering Choices

In many cases, patients will make overt requests for providers of specific demographics; in others, family members may voice such preferences on behalf of incapacitated patients, or physicians may indicate a clinical need in the case of certain patients with psychosis or dementia. More challenging is the question of whether institutions should ever offer concordant providers proactively. In some circumstances, this approach has become widely accepted: Patients who are fluent in English as their second language are generally still offered a translator who speaks their first language, if they prefer one. Whether and when patients from racial minorities or the LGBTQ community should be offered the option of concordant providers in certain circumstances, such as for psychotherapy, raises more complex questions. One wants to maximize patient autonomy, but one also does not wish to reduce the patient down to their demographic characteristics. However, cases may arise during the course of clinical care, especially when the patient has given indications of doubt regarding trust in a non-concordant care team, in which one might consider raising the broader issue of demographic concordance, and, if the patient appears receptive, broaching the question of assigning a concordant provider. One option is to have clinical teams specifically created for the healthcare needs of historically discriminated communities. Therefore, even if patients are scheduled with non-concordant providers, there is an institutional commitment to these vulnerable communities.

Administrative Burden/Assessing Motives

In some cases, the motivation for a demographic-based request may not be readily apparent to the care team. For instance, is a religious patient's request for a male surgeon based on an authentic religious value or an irrational prejudice regarding the competence of female surgeons? Factfinding may be crucial in such circumstances: Before ruling on a request, the care team should directly explore the patient's motivations to better understand his needs. Attentive and respectful listening may help avoid such situations entirely. For example, if the patient's motives are based on false beliefs regarding the abilities of female surgeons, the providers may be able to assuage these concerns with reassurance. Unfortunately, such factfinding can impose an investigative or administrative burden on hospitals and providers. It also risks a moral hazard: If patients come to realize that religious-based gender requests will be honored while competence-based gender requests will not, unscrupulous patients will begin to disguise the latter as the former.

Disparate Impact

Not all patients are affected equally by policies regarding demographic-based requests because wealthier patients may be able to avoid the circumstances that require making such requests entirely. In the United States, a wealthy patient may be treated by a private attending of her own choosing rather than a service attending assigned by the hospital. Such a private provider can be selected for any reason—even based on racial animus—with no questions asked. Wealthy patients may hire their own home health aides with similar discretion, rather than acquiring care through agencies. Even room assignments can help the well-heeled pursue their biases: An indigent patient often has no choice regarding the demographics of her roommate, whereas a wealthy patient can avoid the issue by paying for a private room. Patients paying out of pocket for care will have even more discretion over their provider choice in the outpatient setting. Of course, one should not permit prejudice by the poor simply because it is permitted to the rich. However, in some settings, such as HHA selection, institutional policymakers may wish to take this disparate impact into account as they carve out exceptions.

Per se Rules Versus Discretion

As the range of scenarios raised in this article suggests, no policy can possibly enumerate an exhaustive list of the specific requests that may arise in the clinical setting. Our taxonomy is a rubric, not a

pharmacopeia. At the same time, having a clear, written policy in advance to address such requests helps avoid arbitrariness and bias in adjudicating specific cases and can help reassure patients that they are not the victims of such bias if their requests are rejected. Having clear principles that can guide providers, especially on nights and weekends when a full ethics or legal team may not be available, is essential for good management. At the same time, providers need adequate training to apply those principles justly and equitably as specific circumstances arise.

Sources of Authority

The most challenging aspect of implementing a policy in this area may be which sources of authority to rely on in making decisions. To paraphrase Martin Luther King Jr., policymakers must decide to what degree they are thermometers, reflecting society's values, and to what degree they wish to be thermostats, trying to influence societal values. Ethics may also be constrained by practical and logistical concerns: Some religious patients, for example, may refuse providers of a particular gender under all circumstances, choosing to forgo care rather than risk violating religious doctrines. Ethics committees and legal officers must ask themselves whether they would actually let a patient with capacity suffer severe morbidity or mortality rather than honoring a bias-motivated request. Such cases afford no easy answers. Having policies formulated by committees that are diverse in demographics and professional experience can help address these concerns, but sometimes ethical solutions will remain elusive.

Conclusions

In an ideal world, requests by patients for providers belonging to specific demographic groups would never arise—because the underlying reasons for such requests would no longer prove relevant. Unfortunately, a wide range of historical forces and present-day structures leads patients to express such preferences regarding their providers. Although some requests are pernicious and reflect prejudices that should never be sanctioned, others may prove more persuasive, in particular, contexts for particular patients. A rule well-suited for one set of circumstances may impose an injustice in another. As healthcare institutions develop policies to address patient bias, they should do so with close attention to the varied nature of and motives underlying such requests. This article is focused on the United States healthcare system; international comparisons will require further research, taking into context each country's unique culture, history, and value system. However, although specific laws may vary, the principles outlined should still be applicable. Although a taxonomy does not direct institutions regarding which requests to honor and which to reject, a systematic approach can ensure that similar cases are treated similarly, which is essential for justice in the healthcare setting.

Conflicts of Interest. The authors declare none.

Notes

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Cite this article: Wu C. C and Appel J. M (2023). "When Appearances Matter: A Taxonomy and Ethics for Demographic-Based Provider Requests". *Cambridge Quarterly of Healthcare Ethics* 32: 406–413, doi:10.1017/S0963180122000731