VOICES IN BIOETHICS

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No Men Allowed

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I stood in the very back of the nurses' station in the OB-GYN ward of the hospital, looking out at the scene of nurses, fellows, and doctors gathering around a single four by three foot whiteboard. This whiteboard, the very center of everyone's attention, was divided into neatly drawn cells each filled with words, phrases, numbers, and symbols. The towering attending stood beside me. He was calm and collected and he scanned the room with his gaze, taking a mental note of the space. He was the one I was shadowing that day.

After a few more moments, the room had become filled with the ward's mostly female medical staff. A few male clinicians filed in and sat down, sprinkled amongst their colleagues. As soon as the attending made eye contact with a nurse in the front of the room, she stood up, commanding the room's attention.

In what seemed to be a daily procedure, the nurse gave an overview of each of the patients written on the whiteboard. Each patient was endowed her own row of cells that separated her information from the others. Amongst the drawn cells, her medically relevant information and data were divided into a few categories: gestation/partition, medications, medical history, age, etc. The final column was titled "Other."

The nurse systematically went down the list of patients, from top to bottom, one by one, using the information in the cells to guide her explanations. Other than the occasional question from a staff member, or additional remark, most individuals in the room remained silent. The process was fairly quick and efficient.

As the only non-medically trained individual in the room, I tried my best to listen for any words or phrases I might recognize, and I did my best to make sense of the medical jargon. Whenever I was lost in translation, I looked back to the "other" information, a kind of home base for me. I found comfort in the "layperson's" terms—"Spanish-speaking," "Penicillin allergy," etc— seeing as those were the ones comprehended more fully.

Eventually, the nurse at the front stopped on the final patient. As she spoke, my eyes automatically darted towards the "other" cell on the far right-hand corner: "From Somalia," "Female circumcision," and "No men allowed." Intrigued, I waited to hear the nurse go into explanation about this information, but to my disappointment, she skipped over it, not mentioning any of the phrases.

With the conclusion of the nurse's lecture, the staff shuffled out, returning to their respective posts and designated areas. The attending walked over and entered a glass room, conjoined to the nurses' station, and motioned me in to follow. A fellow and a couple of other doctors—all male—filed into the same room. Switching over to their medical language once again, they hurriedly discussed other patients in the brief moments they had before their day really started. I stood on the side watching them interact. Nevertheless, I became increasingly more confused by something that was not making sense to me.

After a few minutes, the fellow and other doctors exited out of the room, and the attending stayed behind. Alone now, I mustered up the courage to ask him a question.

"So, you know the last patient on the whiteboard…the one where it was written "From Somalia," "Female circumcision," "No men allowed"?

"Yes."

"I can't help but notice that you and the other doctors who are working right now are all…men. What happens if there is an emergency and the patient needs help? It says 'no men allowed.'"

His answer, more or less: too bad, we go in.

His answer was simple, confident, and matter-of-fact. Yet, I didn't feel any relief from hearing it. I wasn't sure I agreed with the answer, but I feared making myself look like a fool by asking any follow-up questions. Instead, I remained silent, letting the moment pass.

"Well let's go see our first patient."

And I followed him out.

My Ethical Questions

The attending doctor and I never ended up seeing that patient, the one whose "other" notes puzzled me. Nor, to my knowledge, was she ever involved in an emergency that day. Nevertheless, I could not stop thinking about her. I was left wondering many questions:

--What are the ethical obligations of a hospital, medical institution, clinic, or practice to provide and ensure access for patients, upon request, to physicians and other medical professionals with a certain gender or sex?

--What are the boundaries for patients authorizing who can and cannot enter their hospital rooms?

--If an emergency did occur and one of the male physicians in this situation entered the room against the patient or family's wishes, would the physician be at fault or be seen as having committed an ethical breach? Or would he be cleared and be viewed instead as a hero, having saved the life of a woman and her baby?

--Conversely, how might the physician be seen if he did not enter the room?

Potential Areas to Explore

It is easy to fall into a trap of "black-and-white," dichotomous thinking when considering matters of ethics—"Was the physician wrong or right?" "Should the patient just change his or her mind?" etc. But, perhaps we need not limit ourselves this way.

Communication makes for good caretaking. In an optimal situation, a clinician would be able to talk to a patient about her views or concerns, but in this specific

circumstance, communicating directly with the patient was off-limits. Scenarios like this, although initially frustrating, call for creative, out-of-the-box thinking. Fortunately, narrative medicine and social justice work can help us cultivate and exercise alternative approaches towards collaborative solutions for ethical dilemmas. For example:

1. Could there have been a female ob-gyn on call in case an emergency situation occurred?
2. If there was an emergency, and depending on the specific emergency, could a female medical professional, such as a nurse, have gone in and communicated with one of the male physicians via phone, Skype, video, etc?

One could argue that in order to best treat the patient, the doctors should get to the bottom of why she didn't want men treating her and understand her viewpoint. It would obviously be nice for this to happen, but it's not realistic. We can't always understand others' views or opinions, despite our best intentions. But that doesn't mean we shouldn't respect their personhood and decision-making. Do you *have* to get to the bottom of something or truly understand a viewpoint in order to honor another's decisions and give them the comprehensive care that they desire? I would say no, you don't, the same way that clinicians who are personally pro-life can still help their clients seek resources and care for abortions even if they don't understand their viewpoints.

Clearly, the attending, and the patient and her family, approached the patient's care with various beliefs. It can be worthwhile to argue and debate different sides, trying to figure out who was "more correct," but for clinicians, this shouldn't be the main focus, and certainly not in an urgent situation when the stakes are high. Instead, it is more fruitful to have backup plans in place, and be ready to respond to any kind of emergency or curveball.

Conclusion

I recognize that there may not be simple answers to ethical questions that could satisfy all parties; nevertheless, I believe it is vital to pose them for consideration. Furthermore, it is critical to utilize creative, out-of-the-box thinking to create a space where we can consider alternate pathways, and at the same time, respect one another's viewpoints. It is in contemplating ethical dilemmas, such as the one described above, that we continue asking the challenging and unequivocally necessary questions of a healthcare and medical system that (one hopes) is drawing closer to becoming more self-aware and conscientious.