A clash of values

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On a recent evening a patient, whom I shall call Mrs. Kahn (not her real name), walked into our labor suite wearing a *shalwar kameez* and *hijab*, the traditional dress and head-covering of a Pakistani Muslim woman. Her gravid belly, her worried facial demeanor, her stooped gait, and the protective manner with which her husband accompanied her down the hallway to the reception desk told much about her. She was pregnant, in the ninth month, she was scared, and she was in labor. And, she might insist upon being cared for only by a female care provider.

By the time the nurse's intake assessment was complete, it was apparent that Mrs. Khan was indeed in labor, she was indeed frightened, and she did indeed insist upon a female care provider. The problem? I was the attending physician on-call and in that capacity was ultimately responsible for her care.

Though our residency training program is more than 80 percent female, the two residents on duty were both men. No midwife was in the hospital, and our nurses, all women, had not been trained to perform deliveries. The only other available resource with which to satisfy the patient's wishes was the female medical student, a person whose practical experience in obstetrics consisted of assisting with one delivery.

What to do?

Actually, this is not an unusual circumstance. Signs posted in the outpatient clinic declare that we do not, and cannot, accommodate expectations regarding the gender of hospital staff. Despite these signs, and despite reiterated oral reminders, somehow patients arrive in Labor and Delivery entertaining precisely that expectation.

Respect for autonomy and cultural sensitivity demand that we attempt to comply with patient wishes. However, such requests are in direct conflict with the exigencies of managing a complicated call schedule, and with our own values. We shouldn't engage in gender bias, regardless of the gender being targeted.

Obstetrics has evolved over the years into a specialty practiced predominantly by women. To a certain extent this trend is driven by patients. In one survey of 125 post-operative and postpartum women in an American university hospital, 53 percent preferred a female physician, 10 percent preferred a male physician, and 37 percent stated no gender preference.[1] Twenty-five percent of the subjects considered gender to be one of the three most important factors in the selection of a physician.

These figures are far from neutral. Instead of having no bias, nearly two-thirds of female patients have a gender-based provider preference, and among these, 84 percent prefer a female obstetrician/gynecologist.

These preferences affect medical education. In an anonymous survey published in 2010 of medical students completing their third-year Ob/Gyn rotation at a large urban medical school,[2] men were far more likely than women to experience patients refusing to allow them to participate in a clinical interview (61% versus 17%, $p < 0.0001$), and physical examination (82% versus 37%, $p < 0.0001$). It is a completely predictable outcome of these and other realities that the proportion of men in obstetrics and gynecology residency programs dropped to less than 19 percent by 2010.[3]

I believe that, on average, there is no inherent difference between male and female physicians in any of the many elements that determine quality—caring, skill, knowledge, experience, effective communication, and judgment. In the patient survey cited above, when asked whether gender was more important than competence, only 0.8 percent of subjects responded in the affirmative. Thus, it appears that for a significant proportion of women, physician gender rises to the level of a determining factor only after all other qualifications are considered equal. When this theoretical principle is applied in the real world, where patients have access to a plethora of doctors who meet their minimum qualifications, they are at liberty to use gender to make their selection.

However, Mrs. Khan was in labor, and we had run out

of time to prepare for an inpatient experience in which her choice might have been honored.

What to do?

With the help of a medical interpreter, I explained to Mr. and Mrs. Khan that I could not surrender my duties to the member of our crew with the least training and experience—the medical student. Mrs. Khan kept her eyes averted and allowed her husband to speak on her behalf. He gave me a brief lesson in Islamic law, according to which the necessary treatment of women may be delivered by providers in the following order of preference: female Muslim, female non-Muslim, male Muslim, and finally male non-Muslim. Thus, if there were no other providers in the unit, a male non-Muslim obstetrician would serve with no compromise of religious laws of modesty. And yet, this did not seem to satisfy Mrs. Khan, who was visibly uncomfortable receiving care from a male doctor.

When I asked for her opinion she demurred, stating that she wished for her husband to make decisions for both of them. I remember being struck by the irony of the fact that my obligation toward Mrs. Khan's autonomy (a value of the highest order in our Western ethical construct) extended to honoring her right to surrender that autonomy to her husband (a value of equal importance in her culture).

Eventually, we arrived at a compromise: both the student and I would scrub in on the delivery, and I would try as much as I could to have the student do all the touching.

Mrs. Khan was clearly uneasy with my presence in the room while she was uncovered, and I was sorry to be an encumbrance to her ability to focus only on her labor. I tried as much as I could to be unobtrusive, but of course, in the end, that was not possible.

The student was excited to assume the role of primary accoucheur, and with guidance executed that role with great enthusiasm and sensitivity. I was able to guide her through a beautiful normal delivery, and the parents (and student) were ecstatic with the outcome.

Looking into my eyes while wiping the tears from her own, Mrs. Khan whispered, "Thank you," and I replied that she was most welcome.

Physicians frequently deal with collisions between a patient's right to autonomy and the doctor's obligation to do no harm. Our complicated task is to minimize the damage such collisions can inflict on patients, on ourselves, and on medical systems. Perhaps we should work harder to ensure that we always have a qualified female provider on call, but somehow that seems like a capitulation to gender discrimination.

Must we ensure that we have providers of all races, ethnicities and religious backgrounds available to appease any and all patient requests? How do we differentiate preferences that are valid from those that are discriminatory?

To me, the important distinction may lie in the focus of the request. For my patient, the restriction was directed inwardly—she was bound by a standard of modesty she applied to herself. Often, in cases we find objectionable, the bias tends to be directed outward.

And, if a patient has a right to certain discriminatory requests, there is still the question of how we fulfill those requests in the real world. Does their right apply to an emergency care unit like labor and delivery? Does it apply only if we happen to have the resources to satisfy it a given time?

Perhaps there are no good answers to these questions. One is tempted to declare that physical care of the patient must take precedence over a secondary consideration such as gender preference. Yet, this is done at the risk of disregarding emotional aspects of well-being, which, like the body, fall under our obligation of beneficence.

And what of our own sense of justice, which prohibits prejudice? Part of the difficulty lies in the fact that this fundamental value of justice, called to action every day in the modern American labor and delivery unit, clashes with another, quintessential American value—respect for personal freedom.

And so, the best course of action is not always clear. We're still working on it.

References

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