

# MALES NEED NOT APPLY

by Michele G. Curtis, MD, FACOG

**ABSTRACT:** Title VII of the 1964 Civil Rights Act plus its 1991 revisions expressly prohibit employment discrimination based on race, color, religion, sex or national origin. A pervasive bias against male obstetrician\gynecologists exists among potential employers, fellow physicians and patients. Society should realize that workplace gender discrimination in any form whether male or female is legally unconstitutional, morally inexcusable and eventually harms everyone.

## Two Wrongs Don't Make a Right

"Three female Ob/Gyns seeking fourth... All-female specialty group seeking BC/BE Ob/Gyn... Managed care network with practice openings for female Ob/Gyns..." These are typical employment advertisements frequently found in current medical journals and periodicals. Their message is obvious: Males Need Not Apply. The proportion of female obstetrics/gynecology residents has been steadily increasing for several years, from 43% in 1986 to 61% in 1996. More to the point, 65% of 1997's first year residents were female. Meanwhile male senior residents trained in prestigious programs seem to have more difficulty securing desirable employment than their female colleagues.

Insurance carriers, managed care plans, medical practice groups and patients unashamedly express great enthusiasm for this trend while claiming, "Women ob/gyns are more understanding. They share their patients' experiences." Apparently women are preferable to men as obstetrician/gynecologists by mere virtue of their gender. This represents sexism and gender discrimination in its most basic form.

Less than 100 years ago American women were legal chattel and we've only had the vote for 78 years. Gains in women's rights over the last century are obvious but were not realized without bigender support. There is still much to be done but even these advances would have been impossible without men's prominent advocacy.

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**THE PRESIDENTIAL BOX**

**Ray Cestero, President**

Those who attended the Society's Sunday evening membership meeting during the College's recent ACM in Philadelphia were treated to a superb presentation by two

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outstanding attorneys and a DO/JD urologist. The program was full of practical tips and extremely useful information for those of us who from time to time provide medical expert witness testimony for plaintiffs or defendants. Unfortunately the membership meeting always competes with those of numerous alumni associations, other special interest groups and myriad CME activities, possibly preventing many from attending our outstanding, useful discussions. Any suggestions you might have on solving this problem would be welcome.

I previewed this issue's lead article by Michele Curtis on gender discrimination in obstetrics and gynecology with great interest. She addresses a very timely and potentially volatile subject with incredible fairness, and she is right on target. There is no question that during this century much progress has been made in women's rights, but there is much yet to be done while relatively few women currently hold positions as deans or tenured faculty members of prestigious medical institutions. There is still oftentimes a significant difference between incomes of equivalent male and female specialists but the blatant anti-male sexism and gender bias obvious in insurance carriers', managed care plans' and group practices' employment policies, especially their catering to patients' discriminatory physician preferences and refusals, is not the answer. I wholeheartedly agree with Michelle's brilliant analysis of this problem when she warns of the future creating a same-gender medical specialty for women's healthcare. Any comments or criticisms from our membership on this most urgent matter would be appreciated.

In closing I hope that those of you who did attend the ACM had a chance to congratulate our Past President, Ben Harer, now officially installed as ACOG President-Elect. We all look forward to his inauguration as ACOG President at the Y2K ACM in San Francisco. Hope you enjoy this *Newsletter*, and 'til the next one I remain,

Ray

## THE WITNESS BOX

Doug Daniel, Editor

*"My basic principle is that you don't make decisions because they are easy; you don't make them because they are cheap; you don't make them because they're popular; you make them because they're right."*

Theodore Hesburgh, C.S.C  
Former President of University of Notre Dame

The Newsletter's July issue traditionally has been dedicated to a single topic, and this month we look at institutional sexism in obstetrics and gynecology. I first heard and understood the term institutional racism back in the early 70's, never guessing institutionally established and supported discrimination would ever become a concern in my nobly chosen profession of medicine. Especially gender discrimination considering society's overwhelming concern with ensuring equal rights for women. And least of all anti-male discrimination in employment of obstetrician/gynecologists. But here we are. Go figure.

The Newsletter has also been committed from the start to providing its readers as many facets of controversial topics as possible and this issue is no exception. Several viewpoints are remarkable by their absence. Two well-recognized women academic obstetrician/gynecologists who have previously publicly commented on women's issues related to the speciality, the National Organization For Women, and Independent Women's Forum all refused requests to provide commentaries, position statements or articles.

We also inaugurate another new section in this issue, The Hot Box. Its purpose is to alert readers to hidden and unrecognized potential clinical dangers early before patients are injured or harmed unnecessarily. Many years ago when I was but a lad my uncle worked as a fireman on the Southern Railroad. One of his jobs as he sat in the left-hand seat of his steam engine's cab was to occasionally look rearward down the length of the train to spot any "hot boxes". These indicated a car's axle bearing had become dry and unlubricated, subsequently overheating due to friction. If not serviced or repaired the bearing would fail, the axle would break and the train would derail. The bearings were enclosed in journal boxes which protruded about six inches outside the car's body. The journal boxes were stuffed with oily cotton waste rags, and when a dry bearing overheated it was supposed to ignite the cotton waste producing thick, black, acrid smoke which could easily be seen by the train crew from either the engine cab or caboose. Though relatively low-tech, this warning system served railroaders quite well for over a hundred years. Today railroads run on sealed Timkin® roller bearings which never need lubricating and never run dry.

Michele Curtis authors the lead article and sets the stage for our little morality play. Michele is Assistant Professor, Department of Obstetrics and Gynecology and Reproductive Sciences, University of Texas Medical School - Houston. She grew up in Florida, graduating medical school in 1988 from Texas Tech Regional Academic Health Science Center at Lubbock, Texas, completing a medicine internship and obstetrics/gynecology residency at Akron General Medical Center in Akron, Ohio, and maintaining a private practice in San Antonio before joining the faculty department in Houston in 1993. Her areas of special expertise and interest include perimenopausal and menopausal medicine, investigation of amniotic membrane as a potential tissue graft source, development and production of educational medical videos, popular literature, tennis and weight lifting. She is director of her department's menopause clinic, co-director of its Ambulatory Ob/Gyn Clinic, teaches a residents' cadaver course and is director of her hospital's Medical Student Clerkship. Her interest regarding employment discrimination in obstetrics and gynecology was initially based on personal conversations with patients, later honed by her residents' experiences job hunting.

Ray Cestero's column this month praises the cause of gender equality while bemoaning the poor attendance at the Society's ACM membership meetings. As usual, Ray's comments are obviously heartfelt and true.

The possible clinical and medical risks of cardiac valvular disease secondary to weight reduction drugs were previously discussed in the *Newsletter* ("The Fen-Phen Phrenzy", *The Medicolegal Ob/Gyn Newsletter*, Vol. 6, No. 4, October 1998, pp. 32-33). Those warnings were thought by some to perhaps have been unnecessary as no one else picked-up on the issue. Until now, that is. The inaugural Hot Box is by Charles Herzog, currently Director of Hennepin County Medical Center's Cardiac Ultrasound Laboratory and Associate Professor of Medicine at the University of Minnesota, both in Minneapolis. He was one of the authors of an original article on the problem published in the *New England Journal of Medicine* in September 1998.

Charles completed his BS degree in Biology at Yale University in 1974 (graduating Magna Cum Laude), his MD degree in 1978 at the University of Rochester in New York, his Medical Internship at the University of Iowa Hospital in Iowa City, and his Medical Residency followed by a Cardiology Fellowship at the University of Minnesota in Minneapolis. Not surprisingly, he is a member of Phi Beta Kappa and Alpha Omega Alpha. Now, with the benefit of two years' experience and hindsight, he gives us an update. To tell the truth it isn't much better.

Deep Pockets is still *incommunicado* and we can only hope for his future safe return from the dangerous clutches of evil *saboteurs* currently threatening our democracy and its citizens' freedom. Film at eleven.

This issue's Book Box is by Diane Colgan and reviews Walking Out on the Boys by Frances K. Conley, MD, an account of experiences as a female medical student, resident and faculty attending. Diane is a plastic and reconstructive surgeon currently licensed in Maryland, District of Columbia, Virginia and Pennsylvania who practices in Potomac, Maryland. She is a 1967 graduate of the Medical College of Pennsylvania, afterward completing a rotating internship, general surgery residency and plastic surgery residency at National Naval Medical Center, Naval Hospital Bethesda, Bethesda, Maryland. She is a Fellow of the American College of Surgeons, Diplomate of the American Board of Plastic Surgery, member of the American College of Surgeons and American Medical Women's Association. Captain Colgan retired from the United States Navy Reserve in 1990 after having served as Commanding Officer of the Naval Reserve Unit of the Uniformed Services University of Health Sciences and Secretary of the Navy Appointee to represent the US Navy Medical Corps to the National Naval Reserve Policy Board at the Pentagon. We trained at Naval Hospital Bethesda about the same time, she in general surgery and a year ahead of me. She's also a personal friend and one of my favorite surgeons.

Unresolved gender discrimination in almost any workplace sooner or later involves applicant and employee dissatisfaction, verbal complaints, formal complaints and ultimately litigation. Whenever lawyers enter the equation costs skyrocket. Think Mitsubishi. It therefore seemed only prudent to seek the wise counsel of an attorney well-versed in these matters. Actually two attorneys. David Morrison and Vanessa Goddard are both with Steptoe and Johnson's Clarksburg, West Virginia, office. Dave is West Virginia's recognized expert in defending employers sued for alleged gender discrimination in employment and personnel practices plus a regular consultant on their policies and procedures. He is a 1981 graduate of the University of Kentucky School of Law, a partner in his firm and chairman of its Employment Law Department for the past four years. He has also served as an adjunct professor at the West Virginia University College of Law in addition to frequently lecturing on employment and labor law. He is a member of the Employment Law Committee of the West Virginia State Bar and a member of the American Bar Association's Subcommittee on Employee Rights and Responsibilities, Employment Law Committee.

Vanessa is a 1997 graduate of the West Virginia University College of Law and an associate in her firm specializing in labor and employment law. She is also a regular contributor to the West Virginia Employment Law Letter.

Since this problem is driving some people crazy, it seemed reasonable to seek professional help. Sally Satel is a psychiatrist practicing in the Washington, DC, area. She earned her MD degree from Brown University, interned at Yale University School of Medicine's Hospital of St. Raphael, completed a residency in psychiatry at Yale and has been an Assistant Professor of Psychiatry, currently a Lecturer, at the Yale University School of Medicine. She has contributed articles on women's health and other issues to *The New Republic*, *The Wall Street Journal*, *The New York Times*, *Public Interest*, *City Journal* (of the Manhattan Institute), *SLATE* and *Women's Quarterly*. She is currently writing a book on politically correct healthcare issues and would appreciate any data to support or refute Michele's premise. She can be reached at slsatel@aol.com or 202.216.0855, extension 223.

"Well what about medical schools? Surely to God they must have a handle on this in the ivory towers of medicine!" Glad you asked. We just happened to stumble on a veritable gold mine in Jim Nocon, David Rosenman and Anita Mazdai's recent study of how gender bias influenced their department's faculty and resident evaluation of medical students. To the department's credit, Jim and others have pretty much corrected this particular problem. A more insidious dilemma, the extent of patients' overall bias toward students of the opposite gender, is accurately described but no solution is proposed.

Jim is a 1971 graduate of Thomas Jefferson University's Jefferson Medical College in Philadelphia and a 1987 graduate of Milwaukee's Marquette University School of Law, completing his Internship and Residency at Thomas Jefferson University Hospital. He is currently Clinical Associate Professor and Director, Junior Clerkship in Obstetrics and Gynecology in Indiana University School of Medicine's Department of Obstetrics and Gynecology and maintains a private practice in Milwaukee. Jim reviews articles for *Obstetrics and Gynecology*, *The American Journal of Obstetrics and Gynecology*, and *Academic Medicine* in addition to serving the Indiana Attorney General's office as a consultant on medical licensing issues. He also wrote most of APGO's *Exploring Medical Legal Issues in Obstetrics and Gynecology*. Not surprisingly, Jim is a member of the Wisconsin and Indiana State Bars. One of his most recent achievements was as Head Coach of the undefeated 1998 Elementary School Football Champions of the Washington Township School District.

Anita is now an intern at Indiana University Hospital while David is a fourth-year medical student.

No exposé would be complete without an investigational "60 Minutes" piece by a bulldog reporter from the old school `a la Mike Wallace. Bob Berkowitz is a 1984 graduate of Temple University School of Medicine and completed his internship and residency at Albert Einstein Medical Center, Northern Division, both in Philadelphia. Over the years he has practiced in California, New Jersey, Massachusetts, and Pennsylvania in addition to serving on the faculty of Harvard Medical School and Jefferson Medical College. He is also this year's recipient of the *Newsletter's* "Woodward and Bernstein Award for Excellence in Investigative Reporting", recognizing his unflagging persistence in asking the tough questions when interviewing highly placed sources. Of course I found it impossible to remain silent on such a pithy matter, putting pen to paper (actually fingers to keyboard) in an effort to organize thoughts and reach some sort of reasonable position. While some may argue the result is anything but reasonable, it works for me.

I have good news and bad news; you decide which is which. The ACM Luncheon Conferences in Philly were a qualified success. A total of three attendees showed up for both conferences, not counting a resident attendee Tuesday who came late, sat down at a table set with salads, rolls and beverages for ten but seating only three, and proceeded to enjoy an all-you-can-eat complimentary salad bar. The next day two residents tried the same ploy and were rebuffed by the waitstaff since they didn't have tickets. At least it was a start. While some nay-sayers may have problems finding the silver lining here, this to my knowledge was the first formally-endorsed and supported educational opportunity on impaired physicians at an ACM.

The membership meeting fared better but still fell far short of expectations. We had an excellent program arranged by Tim McGuinness but as usual poorly attended with only five members and three guests present. The Caduceus meeting had another excellent program but only one attendee, a bag lady who wandered in for a cup of

coffee. Total costs not including publicity and personal invitations to area residency training programs via correspondence were \$1678.50, translating to over \$186.73 per attendee including the bag lady. Maybe we need to rethink this.

Current efforts to secure outside financial support are expected to cover most expenses without draining the Society's dues treasury. We have assurances that although attendance may have been less than stellar, ACOG is committed to providing continuing educational activities on physician impairment for all College members plus support activities for recovering members.

Oh, by the way. Ron Chez, one of the Editors of *Primary Care Update For Ob/Gyns* published by the College, wrote requesting submission of an article on impaired physicians. We pulled three of the chapters in our monograph (see below), rewrote them in a more suitable format and sent them off. I expect it to be accepted, with editing of course, and subsequently published within six to twelve months. Keep an eye out.

And don't forget to check-out the ACOG web site. The current issue of the *Newsletter* is posted and past issues are archived. If you see it and approve, call or write Mark Graves at the College's offices and tell him what a great job he's doing.

As usual we encourage submission of letters to the editor, articles and guest editorials for publication consideration. Letters and editorials are subject to editing only for space requirements with articles and editorials typewritten and double-spaced. Free reprints of individual past *Newsletter* articles are available to members at no cost upon submission of a SASE, back issues for \$10.00 each or \$20.00 per volume of four issues. A 44 page monograph entitled "The Impaired Physician" and containing the complete series of articles previously published in the *Newsletter* is available for \$20.00 including tax, shipping and handling, \$15.00 to Society members. A new monograph entitled "The Ninth Commandment: Providing Effective Medical Expert Witness" is available for the same price.

All opinions expressed in *The Medicolegal OB/GYN Newsletter* are strictly those of the bylined authors and do not necessarily represent policies, opinions or recommendations of the American Society of Forensic Obstetricians and Gynecologists, its members, Board of Directors, Editorial Board, etc.

## THE MAIL BOX

15 MAY 1999

Dear Doug,

I would appreciate your advice regarding a recent bizarre experience during a locum tenens assignment. I was filling-in during vacation for the only obstetrician/gynecologist in town. He had successfully graduated from a major university residency program less than a year prior. Several other general practitioners also did obstetrics, some relatively complicated, in the hospital.

I was severely criticized by the nursing and administrative staff for exposing patients breasts and abdomens while doing breast examinations, abdominal palpation for contractions, and Leopold's Maneuvers on patients to be admitted to labor and delivery, in addition to the inference of inappropriate behavior by taking an unusually long time examining patients' breasts. All examinations were done with a nurse chaperone in attendance and according to recognized techniques described by medical textbooks on obstetrics, gynecology and physical diagnosis as I have ever since medical school and residency about 25 years ago.

Should I respond to these criticisms or just let it go?

Alan Smithee, MD, FACOG

1 JUNE 1999

Dear Alan,

Thanks for your letter, I think. Your problem is very troubling though not uncommon. I am making several assumptions. First, you no longer work in that environment. If you do, get out immediately before you're hit with a medical suit, medical board complaint or criminal indictment. Second, you were in an unfamiliar, small, Level I remote rural hospital of about sixty occupied beds or less. Third, you went to a reputable medical school in the sixties and successfully completed an approved residency training program in obstetrics and gynecology no later than the seventies. Fourth, family practitioners had always provided the hospital's obstetrical care until the arrival of the young resident you were temping for. Fifth, the L&D nurses, administrators and patients were relatively inexperienced regarding the practice of obstetrics outside their remote geographic area or in larger hospitals such as where you trained and probably practiced for much of your career.

Under these conditions, I can tell you exactly what happened and perhaps give you some useful advice. I have done considerable locum tenens, independent contractor, quality assurance and medical expert witness work over the years, in addition to practicing in more than a few military and civilian hospitals throughout the U.S. and on Guam. One thing has always impressed me: small rural civilian hospitals have no business delivering babies because they either cannot or will not deliver obstetric care meeting the nationally recognized minimum acceptable standard. General practitioners practicing far below today's national standard have delivered their babies over the years and established outdated, rigid, inadequate local standards of care. This is why every court with perhaps a rare exception now

embraces the concept of a nationally recognized minimum standard of care for medical litigation.

Having said this, the local standard of care was probably to perform inadequate and/or rare breast examinations, no breast examinations on pregnant patients (possibly including prenatal patients), and for physicians to rely primarily on nurse evaluations of L&D patients with a lot of telephone calls until delivery was imminent. Under these circumstances your management of patients, though appropriate and meeting nationally recognized standards, was considerably different from local custom and therefore inappropriate in inexperienced eyes.

If it's any consolation, I personally have always performed a breast examination on all pregnant patients during the prenatal examination and upon any admission to hospital. Since my physical diagnosis instruction was to visually examine and compare both breasts simultaneously in addition to performing a thorough palpation for masses, I expose both breasts for about one to five minutes depending on the level of breast examination and cardiac examination (longer for patients evaluated for a self-found mass or re-evaluated for a previously diagnosed and treated mass, shorter for the routine asymptomatic check-up). I can't imagine properly performing Leopold's maneuvers or palpating uterine contractions, both of which I do routinely and frequently, without exposing the patient's abdomen.

If you hadn't had a hospital employee chaperone present I would have strongly urged you to do so in the future. One of the most troubling aspects of your dilemma is that you did have a chaperone present and still were essentially accused of sexually abusing your patients. In the future I will advise that chaperones not only be employees and of the patient's same sex and gender preference but also familiar with and willing to support the physician's methods of practice. This may seem like a no-brainer but your problem makes it an important issue.

The other thing to remember is that today's medical students and residents don't seem to have as complete an appreciation of the art and science of physical diagnosis as us older guys. These young whippersnappers today wouldn't know where to start with a sick patient if they didn't have serial vaginal probe color Doppler impedance ultrasounds, PET-CAT-MRI scans, SMA 500's with fractionated serum porcelain levels, and sub-specialty consultants to look at fundi, listen to hearts and palpate rectal ampullae.

If written complaints were filed, by all means consult with your attorney and respond to them in the same manner with copies of supporting medical literature and supportive letters from colleagues. Even though you can't force the issue, insist upon proper assessment of both the complaints and your answer with a formal written opinion provided to you. Permanently file it, forget it and move on if it's favorable. If it's adverse call your lawyer, fasten your seat belt, batten down the hatches, load the cannon and prepare for the worst 'cause it may be a bumpy ride.

Rather than take the risk of going too far out on the proverbial limb and soonafter discovering myself soaring through the air like a rock launched off Stone Mountain, I sent this to Bill Hindle who is our in-house expert on matters pertaining to gynecologists and their patients' breasts,. Here's his response.

Doug

25 JUNE 1999

Dear Doug,

Your detailed response is cogent, pertinent and excellent. I have little to add. I strongly agree with your suggestions to "do nothing" unless a written complaint is filed. If that happens, then go to war via an attorney (preferably licensed in the same state in which this occurred). Thank God for the presence of the nurse chaperone! That is good medical practice and has become required in our current "hypersensitive" social environment.

As you stated, proper breast examination can not be carried out without visualization, inspection and palpation. Those all require that the patient's breasts must be "exposed". There is published evidence that the thoroughness of breast examination as measured by the effectiveness of palpation of the number of masses in breast models is a function of the time spent. That is, the longer the examination takes (with proper technique) the more masses and the smaller the masses identified. Some referenced articles recommend spending five minutes for examination on each side, that would be ten minutes total for the routine "complete clinical breast examination". Small consolation for what must be kept, emotionally distressing attitudes of the local healthcare providers (and administrators) where Dr. Smithee did locum tenens.

Bill Hindle

## THE HOT BOX

### FEN-PHEN REDUX

by Charles A. Herzog, MD

**ABSTRACT:** Undiagnosed cardiac valvular disease is a recognized complication of a limited number of weight reduction drug regimens which enjoyed considerable popularity in the past though no longer available in the United States. Cardiac evaluation of all patients exposed to these drugs and antibiotic prophylaxis to prevent postoperative Subacute Bacterial Endocarditis (SBE) in certain well-defined subgroups has been recommended.

On 8 JULY 1997 a public health advisory was issued by the Food and Drug Administration (FDA) regarding unusual heart valve morphology and regurgitation in 33 women who had taken fenfluramine and phentermine. In August 1997 Connolly and colleagues<sup>1</sup> reported on 24 of these 33 patients and noted that the valvular disease superficially resembled carcinoid heart disease or that seen in patients with ergotamine toxicity, both related to serotonin excess. The FDA subsequently analyzed a series of independent reports linking appetite suppressant agents to cardiac valvular insufficiency and shortly thereafter fenfluramine (Pondimin®) and dexfenfluramine (Redux®) were voluntarily withdrawn from the market.

Appetite suppressants have been available for many years with the FDA approving phentermine in 1959 and fenfluramine in 1973. Both were primarily used as short-term monotherapy for obesity until 1992 when Weintraub published results of his long-term experience with combination therapy<sup>1</sup>, later known as "fen-phen"<sup>2</sup>. (The same Michael Weintraub lectured the author's University of Rochester pharmacology class nearly a quarter of a century ago.)

In 1996 the FDA approved dexfenfluramine which was marketed to a population of younger, predominantly female patients. Appetite suppressants were known to increase the risk of primary pulmonary hypertension and our Pharmacy and Therapeutics Committee chose to restrict prescribing of the agents to two physicians, both conducting institutional review board approved open-label clinical trials of appetite suppressants.

When the early reports of associated valvulopathies appeared Mehmood Kahn, a colleague, proposed a study investigating the prevalence of cardiac valvulopathies in Hennepin County Medical Center's clinical trial patients. A cohort of non-exposed obese subjects matched for age, gender, height and body mass index was recruited. The subsequent study compared the prevalence of valvular insufficiency in the two groups<sup>3</sup> and was reported in the *New England Journal of Medicine* on 10 SEPTEMBER 1998 along with related papers by Jick<sup>4</sup> and Weismann<sup>5</sup>.

A total of 1.3% (3 of 233) of the controls and 22.7% (53 of 233) of the drug-exposed patients had FDA-defined cardiac valvular disease, i.e.  $\geq$  mild aortic regurgitation or  $\geq$  moderate mitral regurgitation. In a regression model the only predictors of valvular insufficiency were age (6% increased risk per year of age) and drug use [dexfenfluramine odds ratio 12.7 (95% Confidence Interval 2.9-56.4), dexfenfluramine + phentermine odds ratio 24.5 (95% Confidence Interval 5.9-102.2) and fenfluramine + phentermine odds ratio 26.3 (95% Confidence Interval 7.9- 87.1)]. Drug exposed patients had approximately a 22-fold risk of significant cardiac valvulopathy.

Eight months have passed since the publication of three articles confirming this associated risk, and more recent preliminary data presented at the November 1998 American Heart Association (AHA) Scientific Sessions in Dallas, Texas, suggested a relationship between **duration** of drug exposure and valvulopathy risk. Any clinical strategy based upon length of exposure remains pure speculation until these data are published, but two informative documents from the AHA addressing valvular heart disease and SBE prophylaxis are currently available and highly recommended.

In the summer of 1997 the AHA's recommendations on prevention of bacterial endocarditis were simultaneously published in both *The Journal of the American Medical Association (JAMA)*<sup>6</sup> and *Circulation*<sup>7</sup>. In the fall of 1998 an executive summary of the American College of Cardiology's (ACC's) and the AHA's joint practice guidelines on management of patients with valvular heart disease was published in *Circulation*<sup>8</sup>. All express expert opinions and attempt to reconcile confusing, controversial data.

It is often difficult to understand research articles or even practice guidelines and then apply them to one's clinical practice. The FDA's quite arbitrary definition of significant valvulopathy was chosen to avoid the confounding presence of low-grade valvular insufficiency in the general population. Mitral Valve Prolapse (MVP) occurs in at least 5% or more women, primarily caused by myxomatous changes in the valve not related to use of appetite suppressants. MVP is a frequent cause of mitral regurgitation since floppy valves naturally leak.

The FDA defined moderate or worse MVP as the threshold for pathologic regurgitation to avoid the relatively high background or baseline prevalence of mild MVP and insufficiency. Aortic regurgitation is much rarer in the general population and is found in only 1-2% of healthy young adults, so a lower threshold was defined for pathologic aortic regurgitation. Unfortunately there is no universally accepted color flow Doppler echocardiography definition of "mild" or "moderate" regurgitation for either valve. Hennepin investigators spent hundreds of hours validating the reproducibility of a qualitative technique to assess valvular insufficiency, and the arbitrary distinction between "trace" and "mild" aortic regurgitation may be difficult to apply to individual patients in routine clinical practice even though it is the threshold for case definition.

What should one do when confronted with these patients? There may be as many as four million patients exposed to these drugs in the U.S. alone. That's a lot of possibly expensive cardiac evaluations. The AHA recommendations for SBE prophylaxis classify acquired valvular heart diseases with significant regurgitation and/or thickened leaflets such as rheumatic heart disease and MVP as predisposing to "moderate" risk of endocarditis. The ACC/AHA practice guidelines on valvular heart disease include a section entitled "Valvular Heart Disease Associated with Anorectic Drugs". Effective cardiac auscultation is difficult in morbidly obese patients, not to mention their frequent complaints of symptoms such as dyspnea and fatigue which may be indicative of valvular heart disease but also may be due to poor physical condition and obesity.

The ACC/AHA guidelines follow a class format as noted below.

- CLASS I: Conditions for which there is evidence and/or general agreement that a given procedure or treatment is useful and effective.
- CLASS II: Conditions for which there is conflicting evidence and/or a divergence of opinion about the usefulness/efficacy of a procedure or treatment.
- IIa: Weight of evidence is in favor of usefulness/efficacy.
- IIb: Usefulness/efficacy is less well-established by evidence/opinion.
- CLASS III: Conditions for which there is evidence and/or general agreement that the procedure/treatment is not useful and in some cases may be harmful.

The following ACC/AHA practice guidelines apply to patients exposed to anorectic agents.

CLASS I:

- Discontinue fenfluramine, dexfenfluramine, fen-phen or dex-phen therapy
- Perform cardiac physical examination
- Perform echocardiography in patients with symptoms, heart murmurs or associated physical findings
- Perform Doppler echocardiography in patients for whom cardiac auscultation cannot be adequately performed due to body habitus.

Class IIa:

- Repeat physical examination in six to eight months for those without murmurs.

CLASS IIb:

- Perform echocardiography in all patients before dental procedures in the absence of symptoms, heart murmurs or associated findings.

CLASS III:

- Perform echocardiography in all patients without heart murmurs.

*From Bonow Ro, Carabello B, De Leon AC Jr., Edmunds LH Jr., Fedderly BJ, Freed MD, Gaasch WH, McKay CR, Nishimura RA, O'Gara PT, O'Rourke RA, Rahimtoola SH. ACC/AHA guidelines for the management of patients with valvular heart disease: executive summary. A report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines (Committee on Management of Patients With Valvular Heart Disease). Circulation. 1998;98:1949-1984.*

Although the AHA SBE prophylaxis guidelines do not directly address anorectic agents, a reasonable interpretation would be to consider appetite suppressant-related valvulopathy a type of acquired valve disease and accordingly classify it with other "moderate risk" conditions until further data become available.

Dozens of unsolicited requests from attorneys for expert medical witness opinions in addition to several subpoenas for release of confidential research project patient data have been received over the past year. Any opinions expressed herein are definitely personal, unofficial and do not necessarily reflect those of any other investigators. They should be taken with a very large grain of salt. Having said that, I try to apply the FDA case definition of valvulopathy and the AHA SBE practice guidelines in my own clinical practice. Interestingly, my patients

meeting the FDA case definition often have surprisingly normal valves. The carcinoid-like cases described by Connolly, et al. may be one end of the disease spectrum but there are probably many others of less severity.

The Newsletter has previously raised an interesting point regarding SBE prophylaxis at vaginal delivery ("The Fen-Phen Phrenzy", *The Medicolegal Ob/Gyn Newsletter*, Vol. 6, No. 4, October 1998, pp. 32-33). AHA recommendations do not include endocarditis prophylaxis for vaginal hysterectomy or delivery, instead making it optional for high-risk patients such as those with prosthetic heart valves, previous endocarditis, complex cyanotic congenital heart disease and surgically constructed conduits or shunts. SBE prophylaxis is also not recommended for sterile induced abortion or uninfected IUD insertion/removal. Prophylaxis for repair of episiotomies and perineal lacerations at vaginal delivery is a questionable area depending on the degree of bacterial contamination and subsequent bacteremia.

The major issues regarding appetite suppressants and associated cardiac valvulopathy are still unresolved but more definitive guidelines relating risk to drug exposure time are expected in the near future. The larger unresolved issue is the natural history of this unusual drug-induced valvulopathy. Will it disappear over time or like acute rheumatic fever valvular disease cause long-term effects years later? There are no reliable long-term follow-up data addressing this important issue but currently ongoing studies should provide more objective information.

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## THE BOOK BOX

by Diane Colgan

### HELL HATH NO FURY

Walking Out on the Boys  
Frances K. Conley, MD  
Unillustrated. 240 Pages. New York: 1998  
Farrar, Straus and Giroux  
Hardback, \$24.00, Paperback, \$13.00

Until a few years ago there was very little public information about the frequency and effects of gender discrimination and harassment of women physicians by their male colleagues. This book is a detailed, revelatory account of Dr. Frances Conley's struggle to become "one of the boys" in what was then an all-male, elite Neurosurgery Department at the Stanford University School of Medicine.

Dr. Conley briefly takes us through her training at Stanford Medical School where the concept of "women as fair game" was accepted then, as it continues to be in today's world, according to Conley.

Conley relates in her book that women physicians have historically been encouraged to enter a certain few nonsurgical disciplines. If they chose, instead, to enter a surgical speciality, it was made abundantly clear that they would receive little support or encouragement during training to reach their goals.

Despite her insight into these unwritten rules about the training of women physicians, Dr. Conley chose to enter the field of neurosurgery. She believed that if she were committed to becoming the best possible physician, she would not suffer from gender discrimination. But her experiences both during her training and later proved otherwise.

Conley describes her goals: to become a tenured professor of neurosurgery and to become an accepted member of this historically masculine club. While she ultimately met both of her professional goals, Conley describes the heavy price she paid by accepting both harassment and abuse from her colleagues and from her professional superiors. Conley reports that to avoid risking failure to achieve the professional advancement necessary to reach her goals (or worse yet, risk dismissal) she never challenged the sexist behavior she experienced.

Still at Stanford, after having become a tenured professor in neurosurgery, Conley and a fellow neurosurgeon simultaneously became candidates for the position of Chairman of the Department of Neurosurgery. It was then that the mental abuses and harassment by her colleagues accelerated and became completely intolerable.

In her attempt to put a stop to such abuse, Conley presented well-documented evidence of the harassment she was experiencing to both the Dean and President of the Medical School. But neither the Dean nor the President of Stanford University Medical School acknowledged the situation until Dr. Conley "went public" with her story by exposing it in the press.

The public exposure of the harassment Conley experienced at Stanford prompted many other women, both employees and medical students at the Medical School along with other support staff, to publicly describe their own similar experiences of harassment by their male superiors at Stanford.

This eventually led to some Stanford medical staff retirements and promises by Stanford to institute sexual harassment policies designed to end such serious problems of gender discrimination.

A clear demonstration of the pervasive character of gender discrimination in medicine appeared in a 1996 article in *The Journal of Plastic and Reconstructive Surgery*.

In it, Dr. Edward Luce reviewed several studies of gender inequality. In one of them, reported in the *Western Journal of Medicine* in 1991, Baldwin, et al, conducted a survey of ten medical schools on the subjects of harassment and discrimination. Both male and female medical students said they had experienced some sort of harassment and discrimination, but the problems were much more common among women students. Males reported discrimination from colleagues of similar standing. But women's reported harassment from both faculty and residents. This pattern was substantiated in a study by Komaromy, et al, as reported in a 1993 edition of *The New England Journal of Medicine*.

According to Dr. Luce, discrimination is more difficult to identify and document than is harassment. He reports a survey conducted by the Association of Women Surgeons, documenting a disproportionate clustering of women in non-tenured and lower academic ranks, as opposed to those in associate and full professorships. This situation persisted even among women 45 years and older, who seriously lagged behind their male colleagues in achieving appointments to more senior positions.

The weight of these findings is particularly significant because Dr. Luce served as Chairman of the Promotions and Tenure Committee at the University Hospitals of Cleveland. Luce has freely admitted to the "glass ceiling" effect that confronts women in pursuit of tenure and other higher academic positions in medicine.

A more recent study, The Webb Report, in a 1998 issue of the *Archives of Internal Medicine*, reported that more than thirty percent of female physicians say they have been sexually harassed during training and in the workplace. Sadly, the authors of The Webb Report concluded that problems of gender discrimination and harassment might, in fact, be growing.

It is an obvious but unfortunate fact that women in medicine not only must train and work as hard as their male counterparts, they must also endure gender discrimination and harassment.

As more women today are choosing a career in medicine than ever before, the number of women considering surgery as a speciality must concomitantly increase. And if those women physicians believe that their surgical training will involve enduring years of gender discrimination and harassment, such a career choice will be limited to only a few brave souls.

Dr. Conley's book has revealed the gender discrimination and harassment against women that is pervasive in medicine, particularly against those women physicians who would aspire to a surgical career.

Even though Conley's story is one of the very few published accounts of gender inequality in medicine, it typifies the unrecognized struggles of countless women physicians not only in academic medicine, but in medicine generally.

Dr. Conley's warning to the practitioners of academic medicine must be taken seriously. If they don't act to end discouragement, harassment and discrimination, they may well find women physicians engaged in a "collective movement" to empower themselves to insure their career choices in medicine.

**MALES NEED NOT APPLY, Continued From Page 1**

Progress in medicine has been even slower. Membership in the medical practitioner's guild from its inception was almost exclusively restricted to males, yet their relatively recent social and political advocacy created a field of medicine specifically devoted to female healthcare. The first female physician graduated from a US medical school in 1849, but not until 1997 did the number of female applicants accepted by medical schools even begin to approach equality (43%).<sup>1</sup> In business-related occupations women's salaries are only 74% of equivalent male counterparts'.<sup>2</sup> Accepted societal stereotypes and biases still confine the percentage of women in academic and industrial executive positions to single digits despite their recognized and well-demonstrated abilities compared to men.

It's also illegal. Connecticut and Massachusetts had in 1962 existing legislation providing prosecution for prescribing or discussing contraception. Dr. C. Lee Buxton, Chairman of the Department of Obstetrics and Gynecology at Yale University Medical School in New Haven, fitted a patient with a diaphragm and was subsequently arrested, ultimately culminating in *Griswold vs. Connecticut*. In 1965 the all-male United States Supreme Court found the restrictive law unconstitutional. Women do not hold the exclusive right to care for or about women nor be the sole force for feminist political and social change.

Title VII of the 1964 Civil Rights Act and its 1991 revisions expressly prohibit employment discrimination based on race, color, religion, sex or national origin, defining employer as one engaged in an industry affecting commerce who has fifteen or more employees for each working day in each of twenty or more calendar weeks during the current or preceding calendar year. Section 703 clearly states:

"It shall be an unlawful employment practice for an employer to fail or refuse to hire or to discharge any individual, or otherwise to discriminate against any individual with respect to his compensation, terms, conditions, or privileges of employment, because of such individual's race, color, religion, sex, or national origin."

Apparently most of the employers advertising for and hiring female-only obstetrician/gynecologists, even covertly, are engaging in criminal activity.

Undoubtedly women have in the past suffered gender discrimination in a male-dominated United States and still do in many parts of the world, but that does not justify perpetrating the identical injustice on their current or past masters. Two wrongs don't make a right.

**Turnabout is Fair Play**

Now the tide is turning. More and more patients recognize female physicians spend more time talking with their patients, hence the perception they are more empathetic and concerned. Patients have always sought these traits in their physicians. More and more women are demanding to see female obstetrician/gynecologists and they are increasingly being accommodated. A patient certainly has the right to choose a physician she believes shares her philosophies and interests; sharing similar views, backgrounds or experiences strengthens and enhances the therapeutic relationship.

Physician groups and third party payors are also aware that a female obstetrician/gynecologist is an asset in recruiting patients and marketing, thereby increasing profits. They argue that capitalism allows every business to utilize effective marketing strategies. Medicine is now a business; ergo, the obstetrics and gynecology business should not be prevented from utilizing effective marketing strategies. Employers recruiting females-only are simply responding to the demands of their customers. If these demands tend to exclude men, for the first time labeling their gender as undesirable employees, we must realize that women have endured the same for centuries. Turnabout is fair play.

## Women Make Better Ob/Gyns, Don't They?

As a female, practicing obstetrician/gynecologist, administrator, and teacher responsible for medical student and resident education, I have heard all sides of this issue. Numerous patients have confided in conspiratorial tones, "How nice it is to have a woman doctor. You understand what I'm going through." This was before I even had children! Although always vaguely uncomfortable with this attitude, I gave it little thought until entering academics. Then I saw an increasing number of well-qualified men exerting considerable time and effort in attempts to secure suitable employment while equally well-qualified female residents were courted by numerous employer suitors.

Reflection on my discomfort with this pervasive attitude among female patients and women in general produced the realization that it's based on a very ugly word, discrimination. As a woman I am adamant that my reproductive organs not be a factor in the practice of my profession. The presence or absence of ovaries and a uterus is irrelevant to my intelligence, efficiency, dexterity, compassion or ability. If I condone the idea that women make better obstetrician/gynecologists I perpetrate the very gender discrimination I so abhor, in the process becoming a classic hypocrite.

Discrimination based upon color or religion is unacceptable as is gender discrimination against women. If a qualified professional were denied an advertised position, publicly stated to be because they were Black, Yellow, Red, African-American, Chicano, Hispanic, Asian, American Indian, Catholic, Jewish, Moslem and/or Female, the hue and cry would be astounding to say nothing of the settlement or judgment check to include treble plus punitive damages they would shortly receive. They would be swamped with job offers from socially conscious employers flocking to their rescue. Why then is it socially acceptable to discriminate against men on the basis of gender? Is it because society has made discrimination against women, but not men, a punishable offense? Is the victim now allowed revenge against her former assailant?

I'm not quite cynical enough to believe this, but instead feel the initial strides necessary to secure women's rights were so difficult they justified a certain single-mindedness of purpose. True gender equality has yet to be realized, but it's close enough to obligate broadening our focus and addressing gender discrimination issues from other than purely feminist positions. It's time we took the next step, realizing that all gender discrimination is wrong and eventually harms everyone.

As practitioners of a medical specialty devoted to women's healthcare we hold a truly unique position for advancing the cause of gender equality, and its obvious presence among our members lends credibility to our interests, goals, and objectives. If we become predominately or exclusively female we will lose social and political credibility, ultimately being viewed as an organization of feminist extremists.

No one to my knowledge currently discourages male medical students from applying for residencies in obstetrics and gynecology. A recent survey found no evidence of gender discrimination in a private hospital residency training program.<sup>3</sup> At least for now we recruit and train residents recognizing their ability and intelligence. But gender discrimination may still occur if a patient refuses to allow a male resident or attending physician to participate in her care. When privately practicing physicians' patients refuse care by male trainees or attendings it's justified by "I can't afford to lose a patient over this."

I personally cannot in good conscience accept short-term financial gain for allowing perpetuation of a social evil. When patients raise this issue I point out that one doesn't have to have an MI to be a competent and compassionate cardiologist, nor is a diagnosis of cancer prerequisite to the practice of oncology. Physician compassion and competence are not dependent upon the presence of Barr bodies, cyclically fluctuating estrogen and progesterone levels or the ability to conceive and bear children. They are personality traits carefully and continually

cultivated by parents, teachers and preceptors, later honed by years of medical training and experience.

I understand that there is a current market advantage favoring female obstetricians/gynecologists and that some women wish to be treated by other women, but catering to these prejudices and allowing biased gender stereotypes to continue is wrong. I do however support attempts to accommodate women who demand female physicians based upon the tenets or dogma of conservative religions such as Islam. Enforcing a "when in Rome" policy will most likely result in these women foregoing all medical care, while at the same time doing nothing to help them or their families accommodate to typical American culture. Teaching hospitals and clinics must be aware of the changing demographics of their service areas, the cultural impact of these changing demographics, and the adaptations they may require. Most Americans' mores, beliefs and lifestyles are Judeo-Christian based and therefore not subject to these considerations.

I believe the American College of Obstetricians and Gynecologists has an obligation to publicly state it will no longer condone, support or endorse any form of discrimination by its members or their patients, regardless of the genders involved. How can a medical specialty advocating equal recognition of women as human beings with health problems both common and unique promote or even accept the concept that by accident of birth male physicians are incapable of adequately treating these same women? How can we overtly or covertly promote gender discrimination against men in employment matters or the legitimate practice of their profession? If we allow the creation of a predominately single-gender medical specialty, enforcing the erroneous public perception that women are uniquely and solely qualified to care for women, we are not only right-wing political bigots advocating discrimination, segregation, or whatever but ultimately will be responsible for destroying our profession's integrity and credibility.

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# CAUGHT IN THE CROSSFIRE: DISCRIMINATION V. PRIVACY

by C. David Morrison, Esq.  
Vanessa L. Goddard, Esq.

The plight of male obstetrician/gynecologists seeking employment raises some novel gender discrimination issues that have not yet been specifically addressed in a legal forum. While discrimination on the basis of an individual's gender, race, national origin or other immutable personal characteristic may be morally reprehensible, it does not follow that all discrimination is therefore illegal. In the case at hand the right of male obstetrician/gynecologists to seek gainful employment without fear of their gender counting against them clashes with the bodily privacy interests of patients, leaving medical employers caught in the crossfire. Until this issue is addressed and resolved in the courtroom medical employers face a legal Catch-22 between gender discrimination claims from male obstetrician/gynecologists who are told they "need not apply" for posted job opportunities versus privacy claims from female patients who are treated by male physicians not of their choosing and contrary to their wishes.

## LEGAL DISCRIMINATION?

Title VII of the Civil Rights Act makes it unlawful for an employer "to fail or refuse to hire...any individual, or otherwise discriminate against any individual with respect to his compensation, terms, conditions, or privileges of employment, because of such individual's...sex[.]"<sup>1</sup> In certain circumstances employers may take into consideration an individual's gender: "it shall not be an unlawful employment practice for an employer to hire and employ employees...on the basis of...sex...in those certain instances where...sex...is a bona fide occupational qualification reasonably necessary to the normal operation of that particular business or enterprise[.]"<sup>2</sup>

The Bona Fide Occupational Qualification (BFOQ) exception to Title VII is a very narrow exception. A BFOQ cannot be based on stereotyped characteristics of the sexes. In the present context, the assertion that a female is more sympathetic and understanding than a male obstetrician/gynecologist reflects a stereotypical sentiment that courts would probably not find to be covered by the BFOQ exception. Gender may only be a BFOQ by virtue of the gender itself and not due to a characteristic or trait associated with a particular gender.

A BFOQ also cannot be based on customer preferences. The Equal Employment Opportunity Commission (EEOC) has issued guidelines stating that the BFOQ exception is not applicable to "refusal[s] to hire an individual because of the preferences of coworkers, the employer, clients or customers[.]"<sup>3</sup> To permit an employer to cater to customer preferences without regard for the impact of those preferences would essentially eviscerate anti-discrimination laws. Suppose the law had not intervened in the infancy of Title VII when restaurants refused to serve African-Americans because their Caucasian customers disapproved. Obviously the customer preference exclusion is a very important anti-discrimination tool.

It would appear from this statement of the law that the matter could be easily resolved. Surely a female patient's preference for a female obstetrician/gynecologist is not a legally acceptable excuse to refuse hiring male obstetrician/gynecologists. As you may have surmised, it is not that simple. The law delights in creating exceptions to the exception to the exception to the rule. In this instance a BFOQ for what is essentially a customer preference may exist when the bodily privacy interests of an individual are implicated.<sup>4</sup>

## PRIVACY INTERESTS

The problems facing male obstetrician/gynecologists are similar to those that have been adjudicated on behalf of male labor and delivery nurses. Several male nurses have brought gender discrimination claims against hospitals which, asserting that such positions must be filled by females, refused to hire them as labor and delivery nurses.<sup>5</sup> The hospitals argued that being a female is a BFOQ for a labor and delivery nurse by virtue of the duties inherent in the position. These duties require contact with the genitalia of female patients and many female patients object to such contact by members of the opposite sex.

For an employer to successfully assert a BFOQ defense in these situations it must show that:

A factual basis existed for believing that hiring a particular sex would undermine the business of the employer;

A legally protected privacy interest is involved; and

No alternatives were available that would have avoided the privacy violation.

Medical employers generally have had little difficulty meeting the first element in cases involving male labor and delivery nurses. They must show that the gender requirement goes to the essence of their business and not merely some ancillary part. Take for example the commercial airlines whose business is transportation. The argument that female gender is a BFOQ for flight attendants because females attract more business and more effectively calm passengers than males must fail as that is not the essence of an airline's business. On the other hand the business of a labor and delivery suite is caring for laboring mothers and safely delivering their infants, and there is no lack of female patients who will testify they would not want a male nurse caring for them in labor. The requirement for a factual basis is thereby met.

With regard to the second element, privacy in one's body has been overwhelmingly recognized as an important privacy right. As one court has stated, "We cannot conceive of a more basic subject of privacy than the naked body. The desire to shield one's unclothed figure from view of strangers, and particularly strangers of the opposite sex, is impelled by elementary self-respect and personal dignity"<sup>6</sup> Courts have specifically noted that labor and delivery patients cannot choose their nurses, who are therefore often strangers to them. The second element is thereby met.

As to the third element, medical employers have been able to show that the job responsibilities of the male nurse cannot be adjusted to avoid the privacy violation. Ideally both nurses and physicians should be chaperoned by another employee when in the presence of an unclothed or partially unclothed patient, regardless of the genders involved. When other considerations such as sexual preference, differing gender, or trepidation on the part of either party become issues it is vitally important that an employee chaperone of the same sex or preference as the patient be present. Obviously this is rarely convenient and seldom observed. But due to our society's perceived obligation to protect womanhood a male labor and delivery nurse would have to have a female chaperone in almost constant attendance, doubling the cost of care and wasting resources. Thus courts have recognized a privacy exception to the BFOQ defense and have upheld employer decisions to hire only female labor and delivery nurses.

Where do male obstetrician/gynecologists fall on this spectrum? The above noted restaurants refused to serve African-American customers, claiming that if they did they would lose their Caucasian customers and ultimately their businesses. This is the essence of the customer preference exclusion from the BFOQ defense, i.e. an employer saying "I don't discriminate but my customers do, so you shouldn't hold me responsible. I'm just trying to make a living." Courts have rejected this argument resoundingly.

Today restaurants are firing HIV-positive employees, claiming that if they don't they will lose their non-infected customers and ultimately their business because patrons fear they are at risk for contracting AIDS if they eat food prepared or served by HIV-positive food handlers. As with the lunch counter cases of the

60s, courts are rejecting these arguments as the epitome of catering to customer preferences at the expense of the law. Employers cannot base their decisions on the unfounded fears of the public, but instead must educate the public by upholding the law. Lady Justice is not the most zealous defender of profit. The theory is that the laws apply equally to all competitors and any differences should even out in the long run.

Is the plight of the male obstetrician/gynecologist more akin to the lunch counter and HIV cases than to those involving male labor and delivery nurses? Patients are rarely treated by physicians not of their choosing and chaperones do not double costs. Wouldn't it simply be a matter of profits and customer preference to hire only female obstetrician/gynecologists if that's what patients prefer? The privacy interests are the same under both scenarios so it appears that only the "bottom line" changes. While appealing, this argument probably will not win many cases.

A common practice today is for several obstetrician/gynecologists to form a collective group practice. Assume this group employs at least fifteen people and is therefore an "employer" under Title VII. One advantage is that the physicians can cover each other for vacations, emergencies or other similar situations that may arise. Thus it is theoretically possible that a patient may not be delivered by the obstetrician she prefers, and if one obstetrician in the group is male the privacy interests of an objecting patient may become invoked. No problem - this simply bolsters the argument that the exclusionary practice is legal discrimination, right? Wrong! In this situation the third prong of the BFOQ defense would kick in and the feasibility of coverage would be explored. If another female obstetrician/gynecologist in the group could substitute as attendant to the labor of an objecting patient, the exclusion of a male from the group could be illegal gender discrimination.

The theory that the inequities of the anti-discrimination laws will all come out in the wash is even less convincing. Many small groups will be able to avoid these restrictions and therefore cater to their patients' wishes, but as we said, the law is no great protector of profit. The large medical employer's bottom line will be sacrificed for the greater good of preserving the more important anti-discrimination laws.

## CONCLUSION

One has to sympathize with all the players caught in this legal crossfire. Some male obstetrician/gynecologists are denied jobs for which they are qualified while those female patients who in the interest of bodily privacy wish to select a physician of their own gender are made the bad guys. And all healthcare employers are faced with potential lost customers and shrunken profits if they hire without regard to patient preference, or a long and costly trial as the defendant in a federal employment discrimination suit if they don't. A balance must be struck, and it will probably weigh in favor of gender-neutral employment practices. Unfortunately this crossfire will probably not cease until war has been waged in the courtroom.

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## CHOICE OR IMPOSITION?

by Sally L. Satel, MD

Dr. Curtis in her essay rightly decries the perception that only women physicians are capable of treating women patients. But whose perception is it? This is the heart of the issue: If women truly prefer female obstetrician/gynecologists then the market has simply followed their lead by preferentially hiring females. There is no systematic evidence that women physicians are better for women patients, but patients should certainly have the freedom to choose their physicians even if competent males are deprived employment. It would however be front-page news if female physicians became the object of differential hiring practices, and expect the National Organization for Women to file lawsuits and organize marches.

But what if the trend toward hiring women over men does not reflect patient choice? If potential employers simply think women *do* or even *should* prefer female physicians, then feminism has won another Pyrrhic victory. Under the banner of women's health issues feminists have been disseminating misinformation intended to convince females they are a beleaguered patient minority. That women have only recently begun to be used as medical research subjects has been presented as established fact, as has the contention that National Institutes of Health funding is being preferentially allocated to research men's diseases. Both are false. As for truly outlandish claims, some post-modernists have expressed that male obstetrician/gynecologists "devalue women's bodies as defective machines" and their "authoritative knowledge...is a way of organizing power relations...over the patient". If you want still more, see Childbirth and Authoritative Knowledge: Cross-cultural Perspectives, edited by Robbie E. Davis-Floyd and Carolyn F. Sargent, published by the University of California press, 1997.

Pitting men against women is absurd, yet the American College of Women's Health Physicians advocates recognition of women's health as a medical speciality, holding that this will "empower" women. If adopted, it will probably promote the ghettoization they think they are fighting while creating a dumbed-down pseudospecialty full of kinder, gentler docs, homeopaths and guided imagery experts. All this is even more ridiculous when you consider that women constitute approximately 50% of the overall population and the majority of the patient population, not exactly subspecialty material.

We need sound data to determine whether there is a systematic rejection of males as obstetrician/gynecologists. If there is, we need to then separate the issues of women's choice of physicians from healthcare managers' exclusion of male physicians.

# GENDER DISCRIMINATION IN MEDICAL SCHOOLS

by James J. Nocon, MD  
David Rosenman, BA, MS  
Anita K. Mazdai, MD

**ABSTRACT:** At Indiana University School of Medicine Students at are graded as Honors, High Pass, Pass or Fail by department faculty and residents. Clinical evaluations and the students' scores on a written examination determine their final grade. Our study evaluated the possible influence of gender bias in these clinical evaluations.

During a recent meeting in our department many female third year medical students complained that female faculty members and residents were much "harder" on them than on male students, especially in awarding Honors grades. Male students however questioned this alleged gender bias by noting that female students actually received more Honors grades from female faculty members than male students.

At Indiana University School of Medicine each student's clinical evaluations used to be based on the seven factors noted below, scaled from 5 (Outstanding) to 1 (Fail).

1. Adequacy of patient communication
2. Degree of educational initiative and scholarship
3. Quality of history and physical examinations
4. Expertise in oral case presentation
5. Adequacy of medical and surgical techniques
6. Extent of medical knowledge base
7. Degree of patient care responsibility assumed

Students are graded as Honors, High Pass, Pass or Fail by department faculty and residents. These clinical evaluations and the students' scores on a written examination, equally weighted, determine their final grades. Our study evaluated the possible influence of gender bias on the clinical evaluations and was divided into the following six parts.

## I: RETROSPECTIVE ANALYSIS OF CLINICAL EVALUATIONS

Two hundred and seventy two students' clinical evaluations for academic year 1997-1998 were reviewed. Three different sites were utilized with 56 students going to each of two hospitals off campus and 160 students assigned to University Hospital. Clinical grades were determined at one off campus site by exclusively male faculty members and at the other by exclusively female faculty members. There was no significant difference in the distribution of clinical grades at either of these sites. There was also no significant difference in students' mean examination scores between all three sites.

In the Department of Obstetrics and Gynecology eleven female faculty, fourteen male faculty, twenty-two female residents and ten male residents did 703 clinical evaluations of 63 female and 97 male medical students. Clinical evaluations generated by female faculty were significant for granting more Honors grades to

female than male students (Table 1). Male residents' clinical evaluations were significant for granting more Honors grades to male than female students (Table 2). Male faculty and female residents also granted more Honors grades to their respective genders but the results were not significant (Table 1).

**Table 1: Distribution of Clinical Grades by Faculty Gender at University Hospital**

Students (160)	Female Faculty (11)	Male Faculty (14)
Females (63)	11 Honors 22% 26 High Pass 52% 13 Pass 26% <hr/> 50 100%	14 Honors 18% 43 High Pass 55% 21 Pass 27% <hr/> 78 100%
Males (97)	12 Honors 15% 42 High Pass 52% 27 Pass 33% <hr/> 81 100%	23 Honors 24% 48 High Pass 49% 26 Pass 27% <hr/> 97 100%

**Table 2: Distribution of Clinical Grades by Resident Gender at University Hospital**

Students (160)	Female Residents (11)	Male Residents (14)
Females (63)	51 Honors 40% 43 High Pass 33% 35 Pass 27% <hr/> 129 100%	7 Honors 21% 19 High Pass 56% 8 Pass 23% <hr/> 34 100%
Males (97)	51 Honors 31% 74 High Pass 44% 42 Pass 25% <hr/> 167 100%	28 Honors 42% 27 High Pass 40% 12 Pass 18% <hr/> 67 100%

**II: PROSPECTIVE ANALYSIS OF CLINICAL EXPERIENCE**

In the prospective arm of this study two rotations of students were required to keep delivery logs identifying faculty and resident supervising staff. Data was submitted for 194 uncomplicated student-attended deliveries including 145 (75%) deliveries by students themselves under direct supervision. The percentage of male and female student deliveries with male or female supervision were equal (Table 3).

**Table 3: Clinical Experience in the Delivery Room by Supervisor's Gender**

Students (48)	Female Supervision (97)	Male Supervision (48)
Females 27% (13)	30 deliveries 31%	15 deliveries 31%
Males 73% (35)	67 deliveries 69%	33 deliveries 69%

### III: ANALYSIS OF STUDENTS' SELF-EVALUATIONS

Male and female students were given the same student evaluation forms as supervisors and asked to grade themselves. Responses were almost identical to their supervisors' regardless of gender. In these self-evaluations 31% of both males (11 of 35) and females (4 of 13) gave themselves Honors, 66% of males (23 of 35) and 62% of females (8 of 13) gave themselves a High Pass, and only one student in each group gave themselves a Pass.

### IV: ANALYSIS OF FACULTY QUESTIONNAIRE

The standard clinical evaluation form was expanded from seven general categories to include an additional 20 factors assessing clinical performance (Page 30). Male and female supervisors were asked to fill out questionnaires ranking each factor on a scale of 5 (most important) to 1 (least important) in awarding Honors grades. The data was analyzed by gender and ranking with no significant differences noted except that male residents ranked proper performance of breast examinations (mean rank 2.3) lower than the rest of the faculty (female residents 3.3, male faculty 3.5, female faculty 3.28).

### V: ANALYSIS OF WRITTEN EXAMINATION GRADES

The written obstetrics and gynecology final examination consisted of 200 questions, 150 "best single answer" multiple choice and 50 matching. Females generally scored higher than males (mean scores 75.3 and 73.1) and female students with an Honors grade scored higher than similar male students (mean scores 81.4 and 80.2) but the differences were not significant.

There was a strong correlation between written final examination scores and clinical evaluations. Approximately 80% of students who scored above the 80<sup>th</sup> percentile on their written final examination received a clinical Honors grade, but when these scores and clinical evaluation grades were combined 23.4% of females received a final Honors grade compared to 15.7% of males.

### VI: GENDER DISCRIMINATION BY PATIENTS

All of fifteen male and fourteen of twenty (70%) female students reported that at least once during the academic year a patient had refused consent for student participation in their healthcare. During a six week obstetrics and gynecology rotation twelve of fifteen male (80%) and five of twenty (25%) female students had a patient refuse consent for student participation in their pelvic examination.

Reported student experiences during other clinical rotations reflected similar gender bias by patients and even nurses. During their one month urology rotation one of fifteen (7%) male and seventeen of twenty (85%) female students had a patient refuse consent for student participation in their testicle examination. During their six week family practice rotation thirteen of fifteen (87%) male and three of twenty (15%) female students had a patient refuse consent for student participation in their pelvic examination. Male students rotating through one family practice teaching program even complained that a nurse there informed all her female

patients, "You don't have to have a male student present during your pelvic examination." All patients so informed subsequently told the examiner they did not want a male student present during their pelvic examination. While it is obvious that gender discrimination by patients exists, this preliminary data suggests that healthcare providers are also a major contributing factor.

## DISCUSSION

Our general findings are consistent with Kreuger's that female students academically surpass their male peers during obstetrics and gynecology rotations, suggesting supervisor bias as a possible explanation.<sup>1</sup> While there is no other discernible reason for the difference, our study confirmed that gender bias is a factor in supervisors' clinical evaluation of medical students.

Several myths have been exposed. Female faculty and residents were not "harder" on female students. Male and female supervisors clearly rated students of their own gender higher than students of the opposite gender. There has also been substantial evidence reported that interactions between physicians and patients of the same sex have more effective communication and stronger rapport than those between opposite sex dyads,<sup>2</sup> and it would be fair to assume the same in interactions between teachers and students. Herein lies another explanation for the apparent gender bias.

Another myth exposed is that female students score higher on examinations and therefore would be expected to receive more Honors grades. Our data indicated however that the minimal gender difference in final written examination scores did not warrant such a conclusion. Clinical experience of male and female students was exactly the same whether supervised by males or females, so neither did volume of clinical experience explain gender variation in grading. It should be noted though that volume of clinical experience does not correlate well with objective structured clinical examinations (OSCE) scores.<sup>3</sup>

Some might argue that male and female supervisors view attributes deserving an Honors grade differently, but our study clearly demonstrated no difference in either supervisor or student perception of factors used to grade clinical evaluations. Female students nonetheless received more Honors grades than males even though clinical experience was similar, differences in final written examination grades were not significant, male and female faculty had similar notions regarding what merited an Honors grade, and student self-evaluations coincided with those by the faculty. It appears that gender bias indeed shaded clinical evaluation of medical students, and since our study contained more female evaluators it would logically follow that females would have received more Honors grades.

Bias comes in many forms and it would be fair to say that most if not all of us have both received and written biased evaluations in the past. Increasing awareness of gender bias in both the teaching and practice of medicine is the first step, and a more specific clinical evaluation form (Page 30) has been designed on the premise that with greater specificity comes greater objectivity. Initial use of this form has resulted in virtual elimination of gender differences between students' clinical evaluation grades and final overall grades.

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## HELP WANTED

by Robert P. Berkowitz, MD, FACOG

About two years ago I read an article regarding a sexual discrimination lawsuit against HOOTERS. For those unfamiliar with more refined dining establishments it is a nationwide chain of restaurants famous, as its name implies, for stunningly buxom young women in revealing attire who serve average fare to almost exclusively male patrons. The company has built its reputation on these appropriately named "HOOTERS Girls" who are employed as waitresses, hostesses and bartenders.

A number of young men applied for waitstaff positions at various HOOTERS restaurants and (Surprise, Surprise!) were turned down. They then did what any responsible, red-blooded American would do; they filed a federal class-action civil suit against HOOTERS claiming sexual discrimination in employment. They also filed a complaint with the Equal Employment Opportunity Commission (EEOC) which had already begun an investigation of HOOTERS's allegedly discriminatory hiring practices. The EEOC decided HOOTERS's policy of hiring only female waitstaff did indeed amount to sexual discrimination and recommended that males be hired for some of these positions, \$22,000,000 in lost wages be paid to those who had been unfairly denied employment and employee sensitivity training on gender discrimination be instituted.<sup>1</sup>

HOOTERS contended that federal law had allowed gender discrimination in PLAYBOY CLUBS hiring only female bunnies as waitstaff since they were its core business concept. This argument used the Civil Rights Act of 1964, which permits hiring preferences based on sex or ethnicity (but not race) when it is "reasonably necessary to the normal operation of the particular business or enterprise"<sup>2</sup>, as the basis for hiring only female waitstaff. But according to the EEOC the distinction between PLAYBOY CLUBS and HOOTERS was that PLAYBOY CLUBS was in the business of selling sex while HOOTERS was in the business of selling food.<sup>1</sup>

The suit, which the EEOC decided not to join, was settled in favor of - Are you ready for this? - THE PLAINTIFFS! They received \$2,000,000 and the lawyers \$1,750,000 for a total settlement of \$3,750,000. The guys won! HOOTERS had to create a new class of employment called gender-neutral positions, jobs that did not involve direct interaction with the customers such as bussing tables and bar support. The good news? They could continue their policy of hiring only females as HOOTERS Girls.

About this time I began to notice a trend in advertising for obstetrician/gynecologist positions with gender-specific classified ads that expressed or implied a specific preference for female applicants. Sensing a similarity between these gender-based ads and the recently settled HOOTERS lawsuit, and not being one to overlook a potentially financially rewarding class-action lawsuit investment opportunity, I decided to monitor the classified sections of several medical publications.

The September 15, 1997, issue of *Ob.Gyn.News* contained 56 advertisements for professional opportunities and 9 of them, 16%, made reference to gender. I spoke with a representative from *Ob.Gyn.News* and voiced my concern that many of their ads either specified the gender of the physicians being recruited or announced that those doing the recruiting were female, implying that only females need apply. I even sent a letter to the editor but it was never printed. *OBG Management* decided to publish the same letter in its December 1997 issue.

"A recent issue of another publication serving OB/Gyns lists 56 'professional opportunities' in its classified section. One ad touts a flexible surgical schedule in the Midwest, with the added enticement: 'ideal for working mother!' Another mentions that 'a young, female OB seeks another OB for her busy practice.' A third encourages specialists

to 'join B/C female Ob/Gyn in gynecological practice.' Out West, a 'busy solo BC female Ob/Gyn seeks BE/BC Ob/Gyn.'

"If you want to 'flourish in a progressive all female Ob/Gyn practice,' send your C.V. to the Carolinas. Elsewhere, 'two female BC Ob/Gyns seek third.' A California group wants a 'BC/BE female' to join its OBG practice. And two ads offer positions for 'female/male' physicians. (I'm assuming these practices are looking for doctors who are one or the other - not a combination.)

"All told, nine of the 56 advertisements, or 16 percent, make a reference to gender. If the ads do not specify the gender of the physicians being sought, they announce that the doctors doing the recruiting are female, implying - unwittingly or not - that only females need apply. But what makes a situation more ideal for a working mother than for a working father? And would the practices seeking female applicants automatically reject equally or more qualified male applicants?

"These ads are troubling (perhaps especially the two for female/male doctors) because they indicate that the simple word 'physician' no longer conveys very much unless it is accompanied by a gender marker. Furthermore, the ads seeking only females strike me as discriminatory. Isn't there some kind of law against that?"

I received a number of responses from around the country, 90% from men. All were in agreement that such ads were sexually discriminatory and should not be published. Some voiced rather strong opinions about the matter so I decided to conduct my own informal poll, asking the same number of male and female obstetrician/gynecologist friends their opinion regarding gender-specific classifieds. Ninety percent of the women were opposed and the other ten percent either favored it or had no opinion. The men were 100% opposed.

I continued my self-appointed vigil for gender-specific advertising and this is what I found.

*Contemporary OB/GYN* is a repeat offender. The January 1999 edition contained five such examples including the following: "WANTED - OB/GYN doctor to join a two-group practice. Prefer BC/BE female." Another such ad was seen in the November 1998 edition. It read: "ALL FEMALE, GROUP PRACTICE in Columbia, South Carolina seeks BC/BE female OB/GYN physician."

*OBG Management*, the very publication that printed my letter, is also a repeat offender. Ironically, the same issue (December 1997) that carried my letter titled "Gender-specific classifieds: A troubling trend?" also ran the following classified: "PART-TIME OB/GYN FOR ALL-WOMEN GROUP." I guess the trend wasn't all that troubling to *OBG Management* since its January 1999 issue advertised for "BC/BE associate sought for established female practice."

*Ob.Gyn.News* is one of the worst offenders, with such ads accounting for approximately 10% of each issue's classifieds.

*The Female Patient* only prints a few ads each month and appears not to be an offender.

The *Journal of the AAGL*, *Journal of Reproductive Medicine* and *Obstetrical and Gynecological Survey* tend not to have classified sections.

*Primary Care Update For Ob/Gyns* is a repeat offender. It's published in cooperation with the American College of Obstetricians and Gynecologists (ACOG) and is chock-full of ads for professional opportunities. The November/December 1998 issue ran one ad declaring that the employer was "one lovely female physician." Another ad in the same issue stated "All female OB/GYN group has an excellent opportunity for a BE/BC OB/GYN." Surprisingly, this

"All female" group also billed itself as an "Equal Opportunity Employer."

I'm sorry to say *Obstetrics and Gynecology*, our prestigious "Green Journal", is also a repeat offender. One recent ad for an "All female OB/GYN group" ran in the April, May, June, November and December 1998 issues. The same ad was printed in *Primary Care Update For Ob/Gyns* with the tag "Equal Opportunity Employer." I guess it was an equal opportunity for ACOG to employ it in both of its publications.

It seems there is now little difference between the professional employment classifieds in medical publications and the personal ads found in the *National Inquirer* or *The Village Voice*.

I finally investigated how the College screened ads for its publications by interviewing the responsible executives. Pharmaceutical Media, Inc., (PMI) is an advertising sales office that sells ad space for ACOG's publications. All the pharmaceutical ads are sent directly from PMI to Dr. Roy Pitkin, the editor of *Obstetrics and Gynecology*, for approval. The classifieds are screened by PMI. The publisher, Elsevier Science Inc., reviews and approves questionable classifieds. Dr. Pitkin has the final say regarding all advertising, but he does not routinely review the classifieds.

It is the general opinion of Mr. Stan Scherer (President of PMI), Ms. Paula Gantz (Associate Publisher for Elsevier Science Inc.), Dr. Ralph Hale (Executive Vice President of ACOG) and Dr. Pitkin that the classifieds should not specify the particular gender being recruited, but none objects to identifying the recruiting physician's gender. In addition, Ms. Gantz's and Dr. Pitkin's attorneys have advised them that this type of advertising is indeed legal. Curiously, neither Mr. Scherer, Ms. Gantz, Dr. Pitkin nor Dr. Hale feels that the ad specifying "All female group" implies a bias for female applicants. According to Ms. Gantz, ads that do specify gender must also include the phrase "Equal Opportunity Employer." This disclaimer is rarely used in other publications' similar ads.

*Obstetrics and Gynecology* promotes itself as the official publication of the American College of Obstetricians and Gynecologists. As a professional society representing nearly 40,000 physicians ACOG has an obligation to assume moral and ethical responsibility for all its publications' advertisements. Dr. Curtis's article challenges the College not to "condone, support or endorse any form of discrimination." Gender-specific classifieds supporting sexually discriminatory employment practices should be an embarrassment to the College. Even though legal, such ads certainly appear unethical. They are at least in poor taste and have no place in professional medical journals. The College would do well to again set the example for others to follow by refusing such ads.

It was just a few years ago that the EEOC investigated HOOTERS for its discriminatory hiring practices, eventually spawning a \$3,750,000 class-action suit. George Santayana gave the College some excellent advice when he said, "Those who cannot remember the past are condemned to repeat it."

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# IT'S ONLY ABOUT SEX, ISN'T IT?

by Doug Daniel

I once had a conversation with a lawyer friend regarding how we American citizens enjoy equal protection of the law under our Constitution. My position in the affirmative seemed reasonably strong but he quickly and easily won the debate by quoting what I later found to be the most important maxim in the study, practice and application of the law: "*It depends on whose ox is gored.*" While some of us get overheated about this, it appears lawyers embrace it as necessary to maintaining order and comity within modern society. This has most recently been confirmed by L'Affaire Clinton and Jones v. Clinton. It applies in spades to the argument at hand.

There's no excuse or reason why gender should enter into any employment or deployment decision unless the physiology of one's sex prevents discharging the required task. Obviously no male could be considered for employment as a surrogate mother for an infertile couple seeking a child; it is physiologically impossible. And just as obviously no female could be considered for employment as a sperm donor. Excepting such cases (I don't think the Americans with Disabilities Act can be invoked here), there is no sustainable argument for discrimination by gender.

Let's talk about male labor and delivery nurses or nurse midwives. I've never met a male nurse midwife but there have been anecdotal reports of qualified males applying to midwifery programs and being denied acceptance solely on gender. Obstetrics and gynecology residency training programs apparently are next if current trends continue.

I was however privileged to work with a male labor and delivery nurse while stationed on Guam with the U.S. Navy. Carl had a wife, a couple of kids, an RN degree and a commission as a Lieutenant in the United States Navy Nurse Corps. When I first met him he was running the enlisted med/surg ward, but shortly thereafter asked to be transferred to L&D. Even if he had never worked on L&D or postpartum before, he had a definite talent for it because in a short time he became very proficient. Actually Carl was one of the best L&D nurses I've ever worked with. He was unusually intelligent, caring and responsible, remaining calm and competent when things started turning brown and runny as they so often do in any L&D suite. And there were never any patient complaints! They recognized his ability and appreciated his being there for them. Carl would have made a great midwife but for one minor genetic flaw: he no Barr bodies and so never even had a chance.

Now let's talk about prejudice. I grew up in the rural South during the 40s and 50s. I saw and heard firsthand the fruits of racial bias and discrimination. Toilets signed "White Only". Help Wanted ads advising "Colored Need Not Apply". And it was all supported by biblical scripture and arguments as to the irreparable harm integration and equal opportunity would bring to the helpless, innocent white children and white women. Every white male had a God-given and Constitutionally guaranteed right not to have to sit next to a \_\_\_\_\_ (insert your preferred racial epithet) while trying to eat his lunch or drink his coffee. And anyway, the benevolent white folks had provided just as good schools, houses, jobs, colleges, theaters, bus seating, etc. for the black folks so why were they complaining anyway? Give'em an inch and they'll take a mile. Worst of all, for over a century the United States government through its judiciary had said it was all legal under the Constitution. If you've forgotten your high school American History, go the library and look up our Supreme Court's decisions in *Dred Scott* (1857), *Plessy v. Ferguson* (1896), and *Sweatt v. Painter* (1950).

But everything changed in a decade once the Supreme Court, the Presidency and the Citizenry found their individual and collective consciences. In 1955 a young black woman named Rosa Parks was commuting from her job as a household domestic in a white upper-class home when, upon being ordered to move to the back of the bus by the driver, she refused to give up her seat to a white man. This act of courageous solitary defiance produced the Montgomery Bus Boycott and catapulted Martin Luther

King, Jr.'s, movement of passive resistance and civil disobedience against racial segregation to the world's attention. At age 86 Ms. Parks was finally recognized for her role in the war against discrimination by receiving the United States Congressional Gold Medal on 15 JUNE 1999.

The last Sunday evening in January 1960 a freshman at Greensboro's all-black North Carolina Agricultural and Technical College named Joseph McNeill went downtown to the bus station lunch counter, the only restaurant open at that hour, to get a sandwich and cup of coffee. He was refused service by reason of his race and told to leave, all legally in accordance with a local city ordinance. Upon returning to his dormitory he and several fellow students determined to enter the local Woolworth's the next morning and sit passively at the lunch counter until they were served. They were ignored for two and one-half hours, finally leaving. Over the next several days students sat at Woolworth's and other lunch counters until of necessity the city's racial barrier dissolved. The remainder of the year saw similar lunch counter sit-ins by black college students throughout the South, and though ultimately successful there was intense, sometimes violent, opposition. Such passive and courageous acts of individual defiance and resistance were the match that lit the flames of change.

Well what about those women whose religion forbids revealing themselves to men, such as the more fundamentalist Mormon, Jewish and Islamic sects? We have to respect peoples' religion, don't we?. Of course we do, but only to the extent it doesn't infringe on or violate more important rights of others. The religious argument for segregation was fervent and heartfelt, but it was wrong. Various religious or quasi-religious groups have claimed exceptions to our laws and public policies which almost always have been denied. I remember a tribe of Amerinds out West who petitioned the federal government to allow them to legally smoke peyote during their religious rites. It was a long-standing and revered tradition in their culture but the feds said no way. Others have wanted to smoke everything from lead to marijuana for purportedly religious purposes but it's always been held an illegal activity. Every state except mine has laws on the books banning the use of venomous reptiles in religious rites, yet every state in Appalachia or the deep South has congregations in remote rural areas who bring out the rattlers and copperheads on Saturday and Sunday night. Our laws are selectively enforced.

Unless we want to go back to the ancient Chinese and Japanese custom of physicians using a fully clothed doll for females to point to where it hurts and describe what it feels like without examining the patient, we need to realize that physicians of either gender should not be considered by their patients as strangers in the conventional sense. There was even a critically acclaimed novel about physicians called Not as a Stranger. No one seems to be concerned about men's reluctance to be examined by female physicians, and God knows there have been infinite occasions when female nurses have performed care on male patients similar to that in question here. You may not have seen it in civilian medicine but it has been the case in military medicine since Florence Nightingale first bathed and bandaged a wounded soldier during the Crimean War.

Now let's talk about the future of our speciality. I can remember about 30 years ago when the rare practicing female obstetrician/gynecologist was assumed to be a lesbian and emasculating feminist until proven otherwise. It really doesn't matter, but in retrospect some of the few I encountered would probably have met that definition. My first contact with a female medical student on an elective obstetrics rotation was as a senior resident in 1974, and two years later she was a resident in the same program. Over the past years more and more female residents were seen in training programs although the last time I checked they were slightly fewer than the male residents.

Recently the College mailed a publication entitled "Issues in Women's Health Media Kit - 1999" which was chock-a-block with statistics. All were interesting but some of the ones on female obstetrician/gynecologists were a shock. To wit:

1. In 1970 (30 years ago) women composed 7.1% of all obstetrician/gynecologists, about the same percentage as all medical specialties. In 1996 women composed 30.9% all obstetrician/

gynecologists compared to 21.3% of all medical specialties. No surprises here.

2. In 1977 women composed 15.7% of ACOG membership, in 1998 33.5%. See above.
3. In 1976 (20 years ago) women composed 15.7% of all obstetrics/gynecology residents and 19.4% of first year residents. Same as above.
4. In 1998 women composed 64.5% of all obstetrics/gynecology residents and 68.4% of first year residents. WOW!

Michelle is right on target with her comments about males being frozen out of women's healthcare. The numbers don't lie. I'm opposed to quotas and affirmative action programs but it is obvious that every effort must be made to insure equal opportunity for qualified applicants both male and female, from nursing and medical students to CNMs and Board Diplomates, to become professionals in women's healthcare delivery. Most important of all, this has to start with the students in examining rooms and L&D suites getting adequate hands-on experience under supervision. Back in the old days charity hospitals provided this clinical experience, but now since everybody is covered by welfare or private third party payors and expects to be treated as a private patient there are no "teaching cases". Therefore every patient in every medical education institution should be prepared to be a "teaching case".

Of course patients will always have the ultimate decision in who their physicians will be. Private patients will schedule their appointments with physicians of their choice. Unassigned welfare and managed care patients will always have the option of simply leaving the clinic and rescheduling their appointment if presented with physicians whom, for personal reasons, they prefer not to see. As far as emergency situations involving possible disability or loss of life, and I consider labor such a situation, we long ago recognized every competent patient's right to refuse anything and walk out if physically capable. Otherwise there is no realistic choice but to accept the care offered.

I've mentioned before there's a federal civil rights case pending in Florida regarding a forced Caesarean section in which the patient presented to hospital and was told she would have a repeat Cesarean section by court order if necessary. She then literally jumped out the window to escape the hospital but was later taken into custody at her home by county sheriff's deputies who forcibly returned her to the hospital where she was delivered by Caesarean section. I expect the case to be decided in favor of the plaintiff patient. I was also advised by an attorney years ago that the simple act of a patient voluntarily presenting herself in labor to the hospital implied her consent for whatever was necessary to safely deliver her baby. There's no excuse for institutional gender discrimination.

Let's get a grip here folks. The fact is that if any politically organized group such as females, blacks, asians, hispanics, gays, lesbians, welfare recipients, martians, etc. was being subjected to this blatantly discriminatory treatment there would be torchlight parades in the streets, demonstrations on the grounds of the Washington Monument, and marches on state and federal legislatures demanding relief. As it is almost no one cares and it's politically incorrect to rock the boat over this issue. But saddest of all is the ultimate realization that such discrimination will persist regardless of how Help Wanted ads are written. At least if the bias is open and blatant from the start it saves unnecessarily applying for a job you'll never get. One can only hope that come the Revolution, ...