

# Virtual Mentor

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## ON CALL

### Medical Team Responses to a Newborn with Ambiguous Genitalia

Commentary by Kabir Matharu and Ryan C. VanWoerkom

Stuart and Beth awaited the arrival of their first baby with great anticipation. Testing weeks earlier had revealed that the baby would be a girl. Excitedly, the couple prepared their house for Belinda's arrival. The nursery was beautifully adorned with pink walls and yellow flowers and a baby bed handcrafted by Stuart's father.

Beth's pregnancy had been uneventful, and she opted for a natural birth without anesthetics. In the delivery room, Stuart stood by to capture every moment on video.

When the nurse said, "Push harder," Beth made a final effort and sighed with relief when at last her baby arrived. The umbilical cord was cut.

The obstetrician first emphatically and then cautiously exclaimed: "Belinda is such a beautiful...baby." There was whispering among the nursing staff. Exhausted, Beth wondered what was going on.

The doctor took a moment to choose his words: "Congratulations on your new child. We are not exactly sure of the sex at this point, so we'd like to run some tests. One test in particular will look at levels of 17-hydroxyprogesterone, which can be a marker for a condition called congenital adrenal hyperplasia (CAH). This is a common cause of individuals' being born with genitalia that does not aid us in determining their sex."

Stuart stopped the camera's filming as Beth cried.

### Commentary 1

Kabir Matharu

The doctor's reaction to the situation is disappointing, especially given that the process of having a child is stressful even without unexpected surprises. The obstetrician's inappropriate response was probably due to his overt discomfort with the situation. Though the diagnosis, presumably of congenital adrenal hyperplasia (CAH), was unforeseen, health care professionals should not respond to unlikely events with surprise. In all cases, they should be confident and courteous, with no sense of awkwardness. The therapeutic relationship depends upon candor and calmness.

Yet, when I hear of a case like this one, I am not surprised about the responses of the physician and nurses. As a gay Indian medical student, I believe those responses

reflect a wider discomfort some members of the medical profession have with issues of sexuality and gender identity in general. They respond with awkwardness and unease because they are thinking, “Oh, this poor child,” or “How sad for these parents to have a child like this.” If all topics of sexual identity were better understood within the field, physicians would learn to cope more easily with variations in sex characteristics and would realize that this birth is not a tragedy by any means.

Accordingly, I think it is fitting to discuss the visibility of LGBTQI physicians as a way to improve understanding of individual differences, an area where medicine often comes up short. Disclosure of sexual orientation and gender identity by physicians who identify as gay, lesbian, bisexual, and transgender is a recent phenomenon. The trend can be attributed in part to the American Psychiatric Association’s decision to remove homosexuality from its list of “deviant behaviors” in the *Diagnostic and Statistical Manual of Mental Disorders* and in part to greater efforts within the LGBT community for improved awareness of social, cultural, and ethical concerns that affect sexual minorities.

One unique aspect of being in the LGBT community is that, unlike members of other minority groups (ethnic, racial, linguistic, among a myriad of others), LGBT physicians can choose whether to disclose their sexual orientations to others. Heterosexuality (being “straight”) is usually assumed until one states or acts otherwise.

Despite steadily improving social tolerance and increasing visibility of LGBT concerns in mainstream media and through anti-hate laws, LGBT people in medicine still face the conundrum of whether to come out. What are the ramifications of doing so? Will disclosing sexual preference lead to professional consequences? In a 1993 survey of out lesbian physicians, 18 percent reported harassment during graduate medical education, and 18.5 percent reported harassment during medical practice [1].

How patients deal with their physician’s sexuality is another important consideration. Respect for patients dictates that no one should be made to feel uncomfortable at his or her physician’s office. Upon many visits to the physician, a patient usually sees pictures of loved ones, spouses, and children. Should LGBT physicians keep this part of their lives secret so as not to alienate some patients and to protect themselves from discrimination? In one study conducted in an urban area in Canada, 12 percent of 500 randomly selected people said they would refuse to see an LGBT family physician. Their reasons were mainly emotional and based on perceptions that LGBT physicians were “incompetent” and that they would “feel uncomfortable” around their doctor [2].

Though patient comfort remains the mainstay of adequate communication and good clinical outcomes, it is difficult to accept subjective patient attitudes about one’s sexual orientation as a valid reason for not coming to one’s office. Such attitudes and discomfort should be dealt with through patient communication and education.

The questions facing LGBT physicians are not easily answered; they affect both the personal and professional lives of physicians. What can we, as physicians-in-training, do to help? Advocating for increased education and information about LGBT issues, both medical and social, would be one step in the right direction. The continually increasing diversity of our country further facilitates and fosters improved awareness of those who are different from ourselves, thus providing an excellent opportunity to embrace social and cultural minorities.

### References

1. Brogan DJ, Frank E, Elon L, Sivanesan SP, O'Hanlan KA. Harassment of lesbians as medical students and physicians. *JAMA*. 1999;282(13):1290-1292.
2. Druzin P, Shrier I, Yacowar M, Rossignol M. Discrimination against gay, lesbian and bisexual family physicians by patients. *CMAJ*. 1998;158(5):593-597.

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### Commentary 2

Ryan C. VanWoerkom

A medical student's experience in his or her clerkship rotations can be fraught with embarrassing situations, unexpected news, and surprises, by virtue of his or her relative lack of experience. These situations have an upside—they can engender seeds of genuine compassion, empathy, and understanding. It largely depends upon the student's adaptive response to novel situations and circumstances and the time a student makes for reflection.

A critical provision of many oaths in the modern medical field stems from the Latin phrase *primum non nocere*, or first do no harm. "Harm," in this sense, can come from looks of surprises or phrases of exclamation in response to unexpected or emotional information. I have seen many physicians who choose to wear a mask of objectivity or indifference when communicating emotional news with patients. One explanation for this might be the routine nature of delivering unexpected news, but perhaps these physicians think the mask protects them and the patient from the news. A student might choose instead to model his or her professional behavior on a physician who, rather than masking fear, disappointment, or embarrassment replaces that expression with one of kindness, warmth, and understanding. If the medical student in the case under discussion had taken time to get to know the family before the delivery, he might have been able to place his hand on the father's shoulder and say, "You have a beautiful baby," providing some reassurance to the family without making any promises.

Timing is also critical. The physician could have refrained from making statements about testing the infant until the family had time to adjust to the news that there was uncertainty about their baby's sex. Individuals are often drawn to medicine because of their desire to do something to alleviate the suffering of humankind, and this desire can "kick in" automatically in times of distress, shock, and surprise. Hence physicians may be too quick to offer to test and find answers or "fix" the problem. Instead, the remedy may be allowing everyone time to adjust to the new information or situation. When the latter is the case, a medical student, physician, or nurse may allow the family time alone before suggesting treatment or testing options.

Whispering in particular is completely unprofessional. Should information need to be communicated privately between staff, there are polite ways for caregivers to briefly take their leave of patients. I have heard professionals say, "Please excuse us for a minute while we talk shop." This may allow for clarifications and explanations to ensure accuracy. Sometimes the patient or family is invited to hear if they wish to.

Addressing the matter directly and in a timely manner often successfully opens communication between patients and health professionals. When the topic involves unexpected or sensitive material, such as Belinda's ambiguous sex, compassion, empathy and a direct approach, properly timed, are best.

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