Correspondence

Male Nurses in Delivery Rooms

Dear Editors:

In the article, *Delivery Rooms: For Women Only?* which appeared in the December 1981 issue of *Law, Medicine & Health Care*, Jane Greenlaw discusses the hospital's argument in *Backus v. Baptist Memorial Medical Center* that "in order to assign male nurses to the labor and delivery section, the hospital would have to schedule extra female nurses who would chaperone the male nurses during all intimate contact with patients." The argument further states, according to Ms. Greenlaw, that "this is in keeping with hospital policy designed to protect the health care professional from a charge of impropriety."

Ms. Greenlaw disagrees with this, and contends that "in modern obstetrical practice, nearly all patients are accompanied by a spouse, family member, or friend who remains throughout virtually all phases of labor and delivery." Those who accompany the patient, submits Ms. Greenlaw, "undoubtedly have the patient's best interests at heart," and this should eliminate the need to chaperone male nurses. Moreover, Ms. Greenlaw argues that "surely the policy of providing a chaperone is at least as much to ease the patient's discomfort as to protect the professional from fabricated claims of impropriety."

It has been my experience as a nurse that hospitals have required, and will continue to require, female personnel to be in attendance whenever a male physician has intimate contact with a female patient, *precisely* to avoid charges of impropriety. It seems to me that the same policy which serves to protect the hospital and/or physicians from charges of alleged impropriety would also apply to male nurses. Thus, hospitals could indeed be economically burdened by having to assign chaperones to male nurses.

As to hospitals not providing chaperones for male nurses because family and/or friends present will have the patient's best interest at heart — Ms. Greenlaw, we should not be that naive, especially in this day of a litigious public. I would agree, of course, that a spouse, other family member, and/or friend undoubtedly does have the patient's best interest at heart, but this "best interest" is all too often the reason hospitals end up defending themselves in courtrooms.

Janice Rader, R.N.
Risk Manager
St. Luke's Hospital
Bethlehem, Pennsylvania

Ms. Greenlaw replies:

Ms. Rader responds to one narrow issue in my argument that male nurses should be allowed to work in delivery rooms.

The policy of requiring a chaperone is one of the few policies that hospitals are honest in justifying. Generally, if any explanation of a policy is given, it is that it "allows us to give better patient care" — even if it inconveniences patients and bears no obvious relation to patient care. In this case, though, we are told the truth. This outdated policy is based on mistrust: it protects the hospital (and physician or nurse) from "litigious" patients and their family members and friends who would otherwise maliciously assert false claims of impropriety. Obviously, the hospital cannot claim that the policy is to protect the patient, because this would imply that the physician or nurse might actually do something improper.

My position is that when the patient is accompanied by a spouse, family member, or friend there is no need for a chaperone, whether the examiner is a male physician or male nurse. I do not believe that patients and families who are in the hospital for the purpose of giving birth are in any way thinking about finding a way to sue someone. Quite to the contrary, they are interested in having a positive birthing experience that produces a normal healthy child. Moreover, I have been unable to find any statistics to support the claim that patients will fabricate claims of impropriety.

Patients' Rights: Informed Consent

Dear Editors:

I share both the concerns and the convictions expressed by George Annas in *The Emerging Stowaway: Patients' Rights in the 1980s* (February

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1982 issue). A major right, that of patients to the information they desire, remains of particular concern to those of us who work with patients. An important obstacle to fulfillment of that right — the well-documented failure of the informed consent system — led us to investigate the problem further so that remediation might be attempted.

Numerous studies have shown that patients fail to remember most of what they are told during the consent process. Prior to taking the usual first step of castigating the system and demanding additional safeguards for patients' rights, we felt it useful to learn *why* the consent process fails to work. We adopted the admittedly unusual position that patients, not physicians, bioethicists or lawyers, could best explain why they recall so little from written and verbal consent explanations. We therefore mounted a survey of patients to determine their perceptions of and attitudes toward the consent process.[1] We found that patients believed consent information to be important and worthwhile, but that only 40 percent admitted to having read their consent forms carefully. Perhaps the finding that best illustrates the dilemma intrinsic to patients' rights was that patients were offended by the legalistic connotations of the consent procedure, connotations that they felt inappropriate in a doctor-patient relationship based on trust. It appears that it was the legalistic *qua* adversarial implications of consent forms that led to cursory reading and to inadequate recall. This study concluded with a reaffirmation of the importance of ensuring informed decisions on the part of the patient, and with a call for removing barriers to that goal such as overly complicated and adversarial-appearing consent documents.

In light of the published goals and results of our study, it was with some surprise that we found it used as an example of an "attack on patients' rights" in *The Emerging Stowaway* article. In fact, our study actually supports, not opposes, the thrust of Mr. Annas' otherwise fine report.

Barrie R. Cassileth, Ph.D.
Director, Division of Human Resources Research
University of Pennsylvania Cancer Center
Philadelphia, Pennsylvania

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