

Surface Judgments, Profound Questions: A Homosexual Male's Phlebotomy Experience

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RESEARCH ARTICLE

Abstract

Background and Objectives: Two of the authors, one heterosexual and one homosexual, both voluntarily donated blood to a well-known health institution in the Philippines. As they were filling out the paperwork, one of the authors' attention was called by one of the questions in the form: “*Nakipagtalik ka na ba sa iyong kauri?*,” which can be literally translated as “Have you had sex with your own kind?”. This erroneously phrased question was the sole question interrogated and problematized in the study.

Methodology: Reviews of Standpoint Theory and the methodology associated with it and, in effect, used in the study, formed part of the critique, divided into individual narrations and interpretations by each author. A third co-author, a hematologist, lent her insight on the logistics and issues of phlebotomy. Institutional ethnography was brought to bear on the narratives.

Results and Conclusion: This three-author collaboration is presented as a claim that an interdisciplinary approach may open new vistas to a phenomenon that has long existed but been ignored. Reviews of Standpoint Theory and curriculum planning for health professionals are recommended.

Keywords: *phlebotomy, communication, Standpoint Theory, homosexuality, blood donation, institutional bias*

Introduction

Two of the study's three authors voluntarily decided to donate blood to a tertiary hospital in Quezon City, Philippines. One has a practical approach to the whole business of blood donation – should unfortunate incidents occur, he has a bank from which to get possibly needed blood; the other, a first-time donor, had a personal motive – a fear of blood and needles that he hoped to overcome during or after phlebotomy. They share a charitable motivation for the donation.

The practical-approach author, having donated blood multiple times in the same institution previously, briefed the first-time donor about the procedure. It was a fateful day for the latter, as a question he encountered in the second form led to the conceptualization of this study: “*Nakipagtalik ka na ba sa iyong kauri?*”

The intended meaning of the question is, “Have you had sexual relations with someone of the same sex?” The literal translation, however, bothered the personal-approach author: “Have you had sex with your kind?” or even “Have

you had sex with beings of the same species?” This erroneously worded question was interrogated and problematized in this study. It must be noted that the personal-approach author is gay and the practical-approach author is a heterosexual male. Because phlebotomy is inherently more medical science than social, a third author, a cisgender female hematologist, lent her insight on its logistics and issues.

Hospitals can be looked at as inclusive places that afford treatment and relief to all sectors of society, from people in the most abject of poverty to those most fortunate with money. It is, however, not immune from institutional biases. From state legislatures that impose drug testing on recipients of welfare funds to immigration policy being influenced by an increased number of refugees, it can be seen that decision-makers' biases color outcomes [1,2]. Algorithms, influenced as they are by human decisions, tend to reflect these biases as well. Urban housing in Guangzhou, China and the class system in United Kingdom higher

education are but a few examples of institutional biases in aspects of life thought of as rights rather than privileges [3,4]. As it turns out, even in the matter of charity, specifically in the matter of blood donation, the existence of bias may have to be considered.

This paper is hoped to be a starting point for the improvement of blood donation procedures, in that it may become more inclusive. It attempted to ask profound questions, from how judgments about donors' suitability are made to the challenges in ensuring that no contaminated donor blood enters the hospital system. We wish to point out one person's truth: that in a milieu largely perceived to be neutral or inclusive, one can feel entirely "othered" or oppressed.

Methodology

The paper was anchored on Standpoint Theory. As this theory traces its roots to the social sciences, its applications to communication, specifically doctor-patient communication, may be reasonably inferred. The theory is also a lens with which the views of persons in a given interaction may be examined. The paper used a narrative approach from the three authors that endeavored towards a well-represented understanding of a single experience.

The study provides first-person point-of-view narrations, following the concepts of institutional ethnography, which can be summarized as found in the "microlevel, everyday practices at the level of the individual that collective, hierarchical patterns of social structure are experienced, shaped, and reaffirmed" [5]. Institutional ethnography in this case, can be seen in the relative positions of this study's authors. The first author is an academic who, at the time of initial writing, was a year away from eventual tenure, relatively knowledgeable about phlebotomy but at best a dilettante in matters of medicine. The second author was a university student who had little to no knowledge of phlebotomy. The third author is steeped in the hospital system, as can be expected of someone with an MD and a relevant diplomate. The authors recounted their other experiences that could have led to their respective readings of the situation, to provide context to their respective experiences in the tertiary hospital they donated blood in.

The strength of this study's one-experience, three-perspective approach is that it demonstrates how one experience can be interpreted in different ways, depending on what place the individuals occupy in society. Future studies can attempt a large-scale interview of homosexuals

who have donated blood, so possible recurring themes or experiences may be described and understood better.

Narratives and Discussion

The Practical Dilettante

I do not fear the needle; in fact, I am aroused by it. When other people look away as their blood is drawn, whether as part of a routine physical examination or a blood donation, I do look, and I look hard. I stare rapt, looking at my blood, red approaching black, coming out of my body through a cannula that will manage to leave so small a mark on me six and a half minutes later.

I have always been concerned with illness and death. I have seen too many times people I held dear taken away. Death is inexorable, but most of us would exhaust all means possible to delay it. One of the considerations though is that some people have more means with which to delay illness and death than others. I would like to believe that I am one of those who have more means to delay illness and death. There lies my charity; because I believe that I can afford more means, I have no issues about donating blood. Thus, I began the habit of donating blood every three months. My stand on the matter was that some people may find use for my O+ blood sooner than I will have use for someone else's blood. If and when it is my time to need someone else's blood, I have more than four liters in the bank, as it were.

I was struck by the invasiveness of the questions and the manner with which these questions were propounded to donors. Apart from the question that stirred my co-author's indignation, there is a question about whether a prospective donor has had sex with people in prostitution. Whether this question is answered in the positive or negative, the interviewer will ask the questions again, with the facial expression ranging from practiced skepticism to a leery, almost creepy, smile.

I, a married man, am asked repeatedly if indeed I did not have sex with a person in prostitution, and I answer that I have not. The medical professional responds that he asks the question because marriage is no guarantee of non-promiscuity; that is fair enough, I think. At the back of my mind though, I ask myself, what if, even if indeed I had not had sex with a person in prostitution, I answer with a gleeful "Yes, I did have sex with a hooker," just to vex the said medical professional. I imagine that he will no longer let me

donate. When that happens, some poor person will have lost the chance to get my blood, which was disease-free with and continues to be disease-free until now.

I understand enough about public health to know that homosexual men make up a group that is of a higher risk of transmitting diseases than other groups, say, homosexual women. However, I began to wonder if, by the asking of these questions, the Philippine public health system is turning its back on a possible source of usable blood. I began to wonder if, by the asking of these questions, the Philippine public health system is reinforcing an unpleasant and probably inane stereotype, that of homosexual men being carriers of disease.

If a homosexual woman attempts to donate blood, I daresay that there will be no such skepticism or glee in the manner with which the questions are asked. After all, the penetrative powers of lesbians are not perceived to be helpful in the transmission of disease.

On that day, I saw just how discomfited my co-author was with the manner with which he was asked the usual questions. Just the same, I surmise that he must have found enough courage, or perhaps spite, to go on with the phlebotomy. He went on to finish the entire process in 25 minutes, almost four times the usual that it takes for me to let go of 450cc of my blood. I wondered then what thoughts were running through his mind. Our phlebotomist remarked that not everyone had my constitution, *i.e.*, the usual person does take from 20 to 25 minutes to donate blood. What went unnoticed was his questioning stance. It did appear to both of us that a surface judgment on his suitability as a donor was made, and that this surface judgment was premised on observable characteristics such as his manner of speech and dress, both of which do not fit the usual expectations for heterosexual males.

As it is, getting people to donate blood is difficult enough. I surmise that this is the reason why public health institutions and non-government organizations alike set up blood donation drives, even to the extent of going to military camps to obtain a reserve of that precious red fluid. I try to run figures in my head: just how many homosexual men who have HIV or similar diseases attempt to donate blood? How many are they as a percentage of total blood donors?

I am convinced that there is a better way to handle the pre-donation procedures, at least a way that does not make obvious any biases against any group or cohort of donors.

After all, no matter our respective sexual orientations are, our blood is made up of the same components, and the recipients of our blood will perhaps not even care to ask if the blood came from a homosexual or a straight man.

The First-Time Donor

I may not have had a closet phase as far as my gender is concerned, but a deep immersion in a conservative culture, perhaps, had a lot to do with my being a late bloomer, ideology-wise. I grew up well taken care of, with my parents, especially my mother, doing all they could to send my two sisters and me to good schools and to provide for all our needs and the occasional wants. I was taught to ask questions whenever I need or want to know something – a trait that has undergone as much development as I had. My mother is among the earliest strong-woman role models that I had; I internalized that role model as “being feminine is not only okay, it is empowering”. I had no qualms with being called a girl, lady, or woman, for as long as I did not perceive the labeling to be condescending. I had no such qualms, because I decided I would be unabashedly feminine, and that I would reclaim my power by inverting every stereotype flung my way or associated with it.

This decision carried over to my day-to-day activities. I play video games, but I always go for female characters. I am a comic book fan and I would always be Rogue, Storm, or Poison Ivy in games of pretend with my straight male friends in grade school. I was never bullied in high school supposedly because people around me considered me intelligent. In hindsight, this may have been considered as compensation for being gay more than as an independent, individual quality. I did not question back then how it is somehow the gay person's fault if he is not intelligent enough or good-looking enough for society. I breezed through life virtually emotionally unscathed.

College was a different story. It was every bit the melting pot of cultures it was made out to be, and more. It was a safe space. A person whose ideologies differ from yours would argue with you, but only for intellectual purposes instead of antagonizing you into silence. It was there that I found a feminist voice that I could call my own. I took a course on women's studies, buried myself in the works of de Beauvoir and Butler, among others, and chose gender – gender expression in the workplace in particular – as my undergraduate thesis topic.

I now ask questions not just because I was personally interested or I was paranoid about it, but because I saw oppression everywhere, because more likely than not, the

oppressed may not see it for themselves. I now ask questions always thinking that I ask them on behalf of my community.

During one of our meetings, I shared with one of my co-authors that I have phobia of blood and needles. Ever the pragmatist, he told me that it was merely an irrational fear. He invited me to donate blood with him on his next schedule, to which I acquiesced. The day had come, and I found myself more excited than nervous. I had read about the many benefits of blood donation, and it was another way in which I can explore my charitable side. I had been prepared to fill out forms as he had told me what to expect in the standard process. What I had not prepared for were the questions I encountered, specifically the section on sexual activity. The form also asked if I have ever had sexual relations with the same sex, phrased as "*Nakipagtalik ka na ba sa iyong kauri?*"

I was sure that it was not the intention of the health institution, but the question read as demeaning. While I have read enough to acknowledge that meaning could be lost in translation, I still cannot fathom how a health institution could insinuate an archaic view of sexual relations with the same sex as equivalent to that of bestiality. The question asks, translated word-for-word into and adjusted for the syntax of English, "Have you had sex with your kind?" The worst possible translation of that would be, "Have you had sex with beings of the same species?"

It did not stop there; because it could be easily perceived that I am gay, despite answering the form truthfully and in the negative, the medical professional who assessed my questionnaire sought assurance that my answer in the item is true. Because my nerves had crept up on me again and because I understand that lives of others are at stake so they could not risk taking the blood of a person with HIV or AIDS, I just brushed it off at the time.

It is also of note that a Tagalog word for biological sex and gender exists, *kasarian*. It is more baffling, therefore, that the question had not used the direct translation instead. "*Nakipagtalik ka na ba sa kapareho mo ng kasarian?*" ("Have you had sexual relations with the same sex/gender?") would not only be more politically correct but also be much less uncomfortable to read and answer.

For me, not only does the question have derogatory undertones, but it also takes away the power of language – naming, in particular – from the LGBTQ community, to which the question was clearly intended, therefore furthering – whether intentionally or unintentionally – oppression.

This is not a matter of blowing things out of proportion – another rationalization by the dominant classes whenever a marginalized sector points out something wrong about the hierarchy and its existence; for instance, if an empowered African-American woman speaks out, she is written off as an "angry black woman" – it is a matter of questioning the system. It is through questioning the system that Philippine mainstream media has stopped positioning a murdered transgender Filipina's chosen name of Jennifer as an alias, placing it in quotation marks. It is also through questioning the system that same-sex marriage (albeit part and parcel of the LGBTQ struggle) has been legalized in the entire United States of America. It is perhaps high time to question the health care system on textual and sociological aspects to achieve the same clarity in the first two cases.

The Professional Insider

Despite all the resources available to a physician these days, there are still medical conditions where the transfusion of blood is the only solution. Blood transfusion, no matter how fleeting the duration, is a form of organ transplantation. Therefore, to donate blood is to save a life. As a medical student, I find this fascinating since I am blood donor myself. As a practicing physician, that same concept can be frustrating. Coming from a subspecialty where blood would literally be needed to sustain a treatment plan, I have experienced firsthand how delays in blood transfusion have spelled disastrous outcomes for patients.

The reason for delays in blood transfusion inevitably stems from the unavailability of blood that is safe to transfuse. At the core of this problem is the question of how to get more blood donors. Logically, the easy answers are the expansion of infrastructure, training of more personnel, and the facilitation of the screening process for blood donors. The complexity here lies in the aspect of safety and public health. How can one guarantee (1) minimal public cost; (2) that no harm will come to the donor; and (3) that the blood product that we will get is safe for transfusion? Even as there is always the option to spend on numerous screening laboratory tests, this does not only add on cost but can potentially lead to more medical, legal, and ethical problems, the least of which would involve getting more blood from a donor.

The most basic of history taking and physical examination has always been the cornerstone of medicine and it is no surprise that this will be used as a premise for safety in blood donation. By asking a few questions, health personnel can readily screen blood donors for conditions that may cause

harm when giving blood. For example, a person who has recently undergone major surgery would have lost a significant amount of blood and might be harmed if more blood is taken from him. A person who recently had a tattoo or travelled to an area with an endemic disease may be incubating an illness and hence should not donate blood. These questions help cut down on spending on screening laboratory tests or unnecessary treatment brought about by taking blood from someone unqualified to do so. These are the easy questions, however. What happens when we get to the more sensitive questions?

Health personnel must ask questions on high-risk behavior as part of screening for illnesses. This can range anywhere from possible substance abuse to sexual practices. There lies the problem. Health professionals themselves bring their own biases to the table when asking such questions. As hard as they try to be objective, there is no amount of preparation that can help individual health professionals scrub out every single bias they have. This will inevitably lead to different moods, attitudes, or stances during the screening process, all of which can affect the whole blood donation experience.

I once took comfort in the thought that these questions were based on epidemiologic studies. There is that solid background that dictates the need to ask these endlessly probing questions to help ensure safety on both donor and recipient sides. I only must stick to the script since these questions have been revised numerous times to keep up with the scientific evidence that the medical community has on illnesses. Even so, I have come to realize and even slowly accept that it still reflects the biases of the time and place of conceptualization. The most glaring of these are the questions screening for sexually transmitted illnesses. There was a time when homosexual practices played a larger role in the transmission of such illnesses. I wonder if that data still hold true in these times. HIV/AIDS advocates, in particular, say that this seemingly is untrue today; pending an updated solid set of data, it would be hard to dissuade people from the institutionalized set of notions.

Add to this the fact that these topics are not usually keenly discussed, and we have a formula for more problems. Training in such areas especially on how to ask or approach the question is very minimal to say the least. Not only are we queasy about asking these questions and want to get it over with quickly, but our general attitude is to avoid asking altogether. Having gone through the mandated training, I can say that there is still a big void in this area, the result being that when deployed in the actual field, there is no

standard way of doing the interview. There may be some guidelines, but an actual check if health personnel may be construed as crossing a line has yet to be set up.

Now wrap all these biases and lack of training together with a system that needs updating, and it can be seen why there are so many cracks in the process. We are taking steps to improve the handling of blood donations. This, however, has been consigned to the back burner, in favor of more pressing issues such as funding for vaccines or how to handle communicable diseases spreading rapidly. It does not help either that we live in a country where blood donation, a process that arguably inspires fear, is not a norm. Health professionals, I included, recognize that the current system needs a lot of improvement. The alternative of stopping altogether and doing nothing about it is unacceptable. Change comes slowly for those who want it; meanwhile, we make do with what we have.

Standpoint Theory and Institutional Ethnography

Standpoint theory questions the systematic limitations imposed by the social location of different classes or collectivities of knowers [5]. Social location is defined as that which systematically shapes or limits what we know. Following this definition, it is claimed that no two people have the same standpoints [6]. A further claim is made: those who are marginalized or oppressed may have a certain advantage over the oppressor, an epistemic privilege as it were. The marginalized or oppressed may know different things or some things better than those who are more socially or politically privileged. While an academic belonging to the middle class may be able to pontificate about poverty, it is the truly poor person exposed to such a reality who is the true pontiff.

The so-called uneducated, uninformed, and unreliable, who we can more kindly call the economically dispossessed, politically oppressed, and socially marginalized, are likely to know things that those who have more privileged positions are unaware of. It can be noted as well that people in more privileged positions are invested in not knowing or denying that such knowledge or interpretation exists. Hekman helped emphasize this premise in saying that "All knowledge is necessarily from perspective; we must speak from somewhere and that somewhere is constitutive of our knowledge" [7].

This study carries out the prescription that standpoints ought to be recognized, reflected upon, and problematized. Standpoint Theory has had its applications in social work and gender studies [4, 5]. This high degree of locus of utility has also led to issues and objections, such as the objection

to a recurring tendency to reduce standpoints to individuals' social locations [5]. As such, there exists a primary impetus to delve into intersectionality, or the consideration of other realities of an individual – for instance, class, religion, or race – in view of the individual's gender. Both standpoint and intersectionality aim toward a common result – a precise picture of the individual's experience [7].

To the study, Applerouth posits that social domination operates through texts that facilitate social control, such as medical records, census reports, psychiatric evaluations, and employment files [5]. The aptness of Standpoint Theory in the study is reinforced as the subject of critique – the question – is textual. It also operates within an institution – the health care system – that could potentially and possibly be a power structure and/or a site of struggle.

The narrations of persons of different genders are also still very in line with standpoint, as “considerable epistemic advantage may accrue to those who approach inquiry from an interested standpoint, even a standpoint of overtly political engagement” [6]. The possibly overtly political engagement of one author with the problem of the study is to be balanced by the objectivity of the cisgender and medical professional authors. “Objectivity”, in this case, is defined by Wylie as “also standardly used to refer to conventionally desirable properties of epistemic agents: that they are neutral and dispassionate with regard to a particular subject of inquiry or research project” [6].

The question, especially because of it being singled out in the study, is but part of the story of the health care system. While the study cannot conclude if the health care system is politically incorrect, it can, however, conclude that there is a possibility that the question critiqued in the study is not the sole problematic aspect of the health care system on the sociological level.

Two main recommendations are made. The first recommendation is guided by research on inclusive strategies specific to sexual orientation and gender identity for health professions education [8]. Discrimination, harassment, and denial of care by healthcare professionals are possible outcomes for members of the LGBT community, with homophobia not only decreasing the quality of care for LGBT patients but also marginalizing health professionals who are in the LGBT community. There is, thus, the need to teach sexual orientation and gender identity across several courses, as opposed to one specific course [9]. One-time exposure may result in cursory understanding and

perfunctory performance, whereas exposure that is spread out through time may help ensure that lessons and applications are allowed to set in, as it were. Key course content may include (1) non-heteronormative identities; (2) case studies involving LGBT patients; (3) patient-provider communication exercises; and (4) history-taking, specifically the use of gender-neutral language and attention to sexual histories, among others.

The second recommendation is directed towards Standpoint Theory itself, with much of its focus having been trained on feminism [10]. With this study and increased awareness of LGBTQ issues in mind, we proffer the claim that there is no better time than now for the development of a queer standpoint – an organized body of knowledge that would shed light on the LGBTQ experience outside of the context of heteronormative and patriarchal cultures, an institutional ethnography of different communities within the LGBTQ community at large.

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