HOMOSEXUALITY, HEALTH AND HUMANITY: HLEBOTOMY AND BIASES AGAINST GAYS

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Abstract

During the authors' visit to hospital for a voluntary blood donation, one of them took notice of a problematic question in a survey that would determine whether one is fit to donate blood. This question was "Nakipagtalik ka na ba sa iyong kauri?" which, in English, translates to "Have you ever had sexual relations with your own kind?"

In view of intersubjective agreement, the author who took notice asked the other for verification, specifically if they understood the question in the same manner. The author who took notice is homosexual, while the other is heterosexual, so the latter understood it initially as the probable intended meaning of those who constructed the question, interpreting it as: "Have you ever had sexual relations with the same sex?" When the homosexual author expounded, however, it did not take long for the heterosexual author to see it in the way that the former saw it.
Language is important, with its power to name and define. It facilitates a common understanding that goes beyond syntactic and semantic concerns. For instance, it can clearly define which sectors are dominant, and which are marginalized. A linguistic breakdown of texts, therefore, has never been at its most useful, with movements toward empowerment of marginalized sectors abound.

A critical reading of questionnaires for medical processes, using standpoint theory and queer theory, will be complemented by a survey of homosexual blood donors, to be pooled through snowball sampling, as well as interviews with medical professionals. The study not only aims for a mere revision of how these questions are structured, but more importantly, for the structuring of a program that would raise awareness and sensitivity in the use of language among medical professionals, in view as well of minimizing the stereotype that where there is an abundance of intelligence quotient in medical professionals, there is also a deficiency of emotional quotient.

Keywords: homosexuality, phlebotomy, language, standpoint theory, queer theory, medical profession

Introduction

Two of the authors decided to donate blood, both voluntarily, in a well-known health institution in the Philippines. One has a more practical approach to the whole business of blood donation – should accidents occur, he has a bank from which to get possibly needed blood from; the other, more personal – he had expressed his fear of blood and needles, and had hopes of killing two birds with one stone, overcoming the phobias simultaneously, when he gets it over with. They are united by a mutual second approach – a charitable one.

The practical-approach author, having donated blood multiple times before in the same institution, briefed the personal-approach author about the entire procedure. Before the actual blood-letting, forms had to be filled out. While the latter had had significant experience with bureaucracy so far at that point, it was a fateful day for him as a particular 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 above in English is, "have you had sexual relations with the same sex?" The literal translation, however, was what the personal-approach author found bothersome: "Have you had sex with your kind?" or even "Have you had sex with beings of the same species?"

The loaded question will be the sole question critiqued in the study, to be preceded by a review of standpoint theory, as well as the methodology associated with it and, in effect, used in the study, institutional ethnography. Said critique will be divided into individual narrations and interpretations of each author. It must be noted that the personal-approach author is gay and the practical-approach author is not.

Because phlebotomy is inherently more science than social science, another co-author, a hematologist, lends her insight to the logistics and issues of phlebotomy. The collaboration of three authors of different persuasions is presented to be proof that an interdisciplinary approach may open new vistas to a phenomenon that has long been existing but promptly ignored.

The authors' respective narrations, will endeavor toward a well-represented understanding of a single experience, validating as well one of standpoint theory's main premises, "no two people have exactly the same standpoint" (Applerouth, 2012, p. 561). In turn, the study aims to follow up this validation by carrying out the prescription that standpoints ought to be recognized, reflected upon, and problematized (Applerouth, 2012).

As the review of literature will reveal, standpoint theory is close to the sociological equivalent of extinction in communication theory. The authors, guided by the same literature, aim to conclude if the so-called extinction is in order.

Standpoint Theory and Institutional Ethnography

Standpoint Theory

Standpoint theory asks "what systematic limitations are imposed by the social location of different classes or collectivities of knowers, and what potential they have for developing an understanding of this structured epistemic partiality" (Wylie, 2003, pp. 31-32). He then added:

> Those who are subject to structures of domination that systematically marginalize and oppress them may, in fact, be epistemically privileged in some crucial respects. They may know different things, or know some things better than those who are comparatively privileged (socially, politically), by virtue of what they typically experience and how they understand the experience. (p. 27)

and that:

> The inversion thesis that underpins most forms of feminist standpoint theory suggests that, when standpoint is taken into account, often the epistemic tables are turned. Those who are economically dispossessed, politically oppressed, socially marginalized and are therefore likely to be discredited as epistemic agents–e.g., as uneducated, uninformed, unreliable – may actually have a capacity, by virtue of their standpoint, to know things that those occupying privileged positions typically do not know, or are invested in not knowing (or, indeed, are invested in systematically ignoring or denying). (p. 32)

Hekman (1997) 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" (p. 344).

Wylie (2003) also said, however, that "Harstock, Collins, Harding, and Smith all object to a recurring tendency to reduce the notion of standpoint to the social location of individuals, a move that is inevitable" (p. 29). Wylie (2003) defined social location as that which "systematically shapes and limits what we know, including tacit, experiential knowledge as well as explicit understanding" (p. 30). Not prioritizing social location in considering standpoint, then, would mitigate the risk, for instance, of assuming that all privileged people do not sympathize with the marginalized sectors just because they are in such position. Instead, Wylie (2003) argued that standpoint theory should instead ask "what features of location and/or standpoint are relevant to specific epistemic projects" (p. 32).

There is much contention among scholars regarding the retention of standpoint theory in the transition from Second Wave Feminism from Third Wave Feminism. Hekman (1997) even noted that the theory as "frequently regarded as a quaint relic of feminism's less sophisticated past" (p. 341). Hekman, however, counters said contention with her own by saying that standpoint theory has much to contribute to contemporary feminist thought. She (1997) said that the "two central understandings: that knowledge is situated and perspectival and that there are multiple standpoints from which knowledge is produced" (p. 342) led her to conclude (1997) that the conclusion that "feminist standpoint theory should be discarded… is premature" (p. 342).

Due to the many contentions against standpoint theory, Wylie (2003) pointed out that several "loose ends" of the theory must be tightened:

> First, standpoint theory must not presuppose an essentialist definition of the social categories or collectivities in terms of which epistemically relevant standpoints are characterized.
>
> Second, it must not be aligned with a thesis of automatic epistemic privilege; standpoint theorists cannot claim that those who occupy particular standpoints (usually

> subdominant, oppressed, marginal standpoints) automatically know more, or know better, by virtue of their social, political location. (p. 28)

Given that "feminist standpoint theory has laid the groundwork for such a politics by initiating the discussion of situated knowledges" (Hekman, 1997, p. 342), it is not a far-fetched idea that it also became 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.

Particular to the study, Applerouth (2012) said that "Smith emphasizes that in modern, Western societies social domination operates through texts (such as medical records, census reports, psychiatric evaluations, employment files) that facilitate social control" (p. 563). 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 by two different genders are also still very in line with standpoint, as "[c]onsiderable epistemic advantage may accrue to those who approach inquiry from an interested standpoint, even a standpoint of overtly political engagement" (Wylie, 2003, p. 33). The possible overtly political engagement of the personal-approach author with the problem of the study is to be balanced by the objectivity, defined by Wylie (2003) 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" (p. 32) of the practical-approach author. Another possible problem that might arise from the usage of standpoint theory – bias to one's standpoint and individual situation – will also be addressed by an overlap of perspectives, which would also aim to achieve intersubjective agreement.

Institutional Ethnography

The study will provide first-person point-of-view narrations of the author of the same experience, following the concepts of institutional ethnography, which Applerouth (2012) defined as

> designed to create an alternate to the objectified subject of knowledge of established social scientific discourse. The latter conforms to and is integrated with what I have come to call the "ruling relations" – the extraordinary yet ordinary complex of relations that are textually mediated, that connect us across space and time and organize our everyday lives – the corporations, government bureaucracies, academic and professional discourses, mass media, and the complex relations that interconnect them. (p. 568)

Applerouth (2012) noted that the strength of institutional ethnography as a methodology lies in the fact that it is in the "microlevel, everyday practices at the level of the individual that collective, hierarchical patterns of social structure are experienced, shaped and reaffirmed" (p. 564). Further, he said that "[t]he institutional ethnographer works from the social in people's experience to discover its presence and organization in their lives to explicate or map that organization beyond the local of the everyday" (p. 568).

The authors chose this particular methodology as it is, after all, that which led to the ideation of the theoretical framework in the study, and it is also "a method of inquiry that works from the

actualities of people's everyday lives and experience to discover the social as it extends beyond experience" (Applerouth, 2012, p. 568). The authors will therefore extend beyond their experience in the health institution they donated blood in and will recount other experiences that could have led to their respective readings of the situation.

It's Personal: Paul

I have recently just come to terms with the fact that I am, indeed, a feminist. 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 me and my two sisters 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, all aspects considered. My mother is among the earliest strong-woman role models that I had, and my impressionable self internalized that as "being feminine is not only okay, it is empowering". I had no qualms with being called a girl or a lady or a woman, as long as it is not condescending, because I decided I would be unabashedly feminine, and that I will reclaim my power by inverting every stereotype associated with it and/or flung my way.

Naturally, it carried over to my day-to-day activities. I play video games, but I always go for female characters. I am a huge comic book fan, but I would always be Rogue or Storm or Poison Ivy in games of pretend with my straight male friends back in grade school. I was never bullied in high school because people around me considered me intelligent and, in hindsight, I think they considered that 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, however. It was every bit the melting pot of cultures, especially the university I attended, it was made out to be, and more. It was a safe place to be who you truly are. 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 asked questions not just/only because I was personally interested, but because I saw oppression everywhere, also not just/only because of paranoia, but because more likely than not, the oppressed do 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 had shared with Chadwick that I had a phobia of blood and needles. Ever the pragmatist, he told me that, exactly, it was merely an *irrational* fear. He invited me to donate blood with him on his next schedule, to which I expressed a hesitant acceptance. The day had come and I found myself more excited than nervous. I had read about the many benefits of blood-letting, and it was another way in which I can explore my charitable side. I had

been prepared to fill out forms as Chadwick had told me what to expect in the standard process. What I had not prepared for was 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 particular 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. For the time being, that was.

It is also of note that a Tagalog word for biological sex and gender actually exists, *kasarian*. It is all the 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.

I also think that 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 all of the states of the U.S. It is perhaps high time to question the health care system on the textual and sociological level to achieve the same clarity in the first two cases.

It's Practical: Chadwick

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 ten minutes later.

I have always been concerned by 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 almost three liters in the bank, as it were.

Among the things that I found striking about the whole donation process were the invasiveness of the questions and the manner with which these questions were propounded to donors. Apart from the question that stirred Paul's indignation, there are questions about whether a prospective donor has had sex with people in prostitution and whether a prospective donor has had received compensation for any sexual activity. Whether these questions are answered in the positive or negative, the medical professional will ask those questions again. When he does, the facial expression ranges from practiced skepticism to a leery, almost creepy, smile.

Even I, as a married man, am asked repeatedly if indeed I did not have sex with a person in prostitution. I have not had such a pleasure, and so, I answer that I have not. The medical professional will respond that he asks the question because marriage is no guarantee of non-promiscuity. Understood and perfectly logical, I said. 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 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 to begin 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 dare guess that there will be no such virulence 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 Paul was with the manner with which he was asked the usual barrage of 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, more than twice the usual amount of time 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 the donor Paul's questioning stance.

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. As an amateur statistician, I 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? Could it be that the breeding of so much distrust may be the reason for the perennial deficit in blood stores?

I am convinced that there has to be a better way to handle the pre-donation procedures, at least a way that does not make obvious any biases against any particular 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.

It Is What It Is: Teresita

Despite all the resources available to a physician these days, there are still medical conditions where 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 found this fascinating, especially since I was a 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, it is easy enough to answer that there is a need to build more infrastructure, train more personnel, and make the screening process easier 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? Sure, there is always the option to spend on numerous screening laboratory tests. However, 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 or potentially give unsafe 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. Or 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 set of questions help cut down on spending on screening laboratory tests or unnecessary treatment brought about by taking blood from someone who is not qualified to do so. But these are the easy questions. What happens when we get to the more sensitive questions?

Health personnel have to ask questions on high-risk behavior as part of screening for illnesses. This can range anywhere from possible substance abuse to sexual practices. There in itself 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 which dictates for us the need to ask these endlessly probing questions to help ensure safety on both donor and recipient side. I only have to 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. But I have come to realize and even slowly accept that it still reflects the biases of the time or place from when or where it was conceptualized. 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 transmission of such illnesses but I wonder if that data would still hold true in these times. HIV/AIDS advocates in particular will tell you that this seemingly is not true 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 doing the 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 actually be construed as crossing a line is yet to be set up.

Now wrap all of these biases and lack of training neatly together with a system that is in need of updating and it is impossible not to see why there are so many cracks in the process. There have been moves from several groups and we are taking steps to improve handling of blood donations. This however is getting a back seat to the more pressing issues such as funding for vaccines or how to handle communicable diseases spreading rapidly. It also does not help that we live in a country where blood donation is not a norm and the process inspires fear. Health professionals, myself included, recognize that the current system needs a lot of improvement. But the alternative which is to stop all together and do nothing about it is unacceptable. Change comes slowly for those who want it and in the meantime we have to make do with what we have.

Conclusion

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 and within the feminist standpoint.

There are also two main recommendations derived from this preliminary study. The first recommendation is guided by research on inclusive strategies, specific to sexual orientation and gender identity, for health professions education, conducted by Müller (2015). She proposed the inclusion of sexual orientation and gender identity on the basis of findings on the attitude and behavior of “lesbian, gay, bisexual, transgender and intersex (LGBTI) people” (Müller, 2015, p. 4) toward a health care system that would be perceived as non gender-sensitive. She goes on to note that “LGBTI people continually experience discrimination, harassment, and even denial of care by healthcare professionals” (p.4) and asserted that homophobia “not only decreases the

quality of care for LGBTI patients, but also marginalizes LGBTI health professionals" (p. 4). Awareness would only be the beginning as Müller (2015) concluded that:

> [s]exual orientation and gender identity cannot and should not be taught in one specific course, but rather be spiraled through the curriculum to enable students to challenge their own attitudes, and learn about specific LGBTI health issues and the psychosocial well-being of LGBTI people." (p. 4)

Of the courses with "potential LGBTI content" (Müller, 2015) suggested, the course on patient-provider interaction training is of interest to the authors. The proposed course contents are as follows:

> Discuss professional behavior and non-judgmental care with regard to sexual orientation and gender identity
>
> Address students' attitudes towards non-heteronormative identities
>
> Include LGBTI patients, or patients with same-sex partners in case studies and patient-provider communication exercises
>
> Include LGBTI patients, or patients with same-sex partners in case studies and patient-provider communication exercises
>
> History-taking: Teach gender-neutral language ('partner' instead of 'wife/husband', etc.)
>
> Taking sexual histories: Include information about sexual orientation, gender identity and non-heteronormative sexual practices (Müller, 2015, p. 5)

This specific course would be helpful in keeping any perceived hostilities during assessment of answers to questionnaires, for instance.

We are all in agreement with the literature supporting the retention of standpoint theory in contemporary feminist thought. It is a framework that not a lot of sociological theories can match the particularity of in the importance of the micro in understanding the macro. It is also worth a revisit from the current cadre of feminists, as much of feminism today, in our observation, at least, is derived from mainstream media; therefore, more likely than not, simplified iterations and glossed-over generalizations. While it is with a sigh of relief that we also observe that feminism today does not perpetuate the myth/harmful stereotype that feminists are man-hating lesbians, there is much to be discussed about how it is not exclusively for women, and how there is no one absolute way of being a feminist.

Another way in which standpoint theory merits revisiting is in how, during its heyday, so to speak, much focus had been trained on the female standpoint. With this article specifically in mind and the continuing increase in awareness of LGBTQ issues, we also believe that there is no other place and 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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