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- Views & reviews: I was sexually harassed as a junior by senior doctors: it still goes on, and it needs to stop (*BMJ* 2013;347:f6302)
- Editorial: The impact of the workplace on health (*BMJ* 2013;347:f4944)
- Research: Impact of workplace based assessment on doctors' education and performance: a systematic review (*BMJ* 2010;341:c5064)

The middle aged are captive prey to corporate medicine and the drug industry
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Harassment by patients forces doctors to alter practice

GPs should not have to worry about patients behaving inappropriately, says **Lorraine Baker**

A representative survey of 600 female Australian general practitioners (GPs) published in the *Medical Journal of Australia* in 2010 found that more than half (54.5%; 97) of the 180 who responded had experienced sexual harassment during their careers. Of those 97 respondents, nine had experienced harassment more than eight times.[1] Behaviours reported ranged from inappropriate gifts or sexual remarks to requests for inappropriate examination or inappropriate exposure of body parts to touching or grabbing.

The report attracted the attention of a journalist who contacted me through the Australian Medical Association Victoria, of which I am a board member. We were both surprised when the next morning his article was featured on page 2 of both *The Age* (Melbourne) and the *Sydney Morning Herald*, reaching a wide audience in the two largest cities in Australia. This led to three television and seven radio interviews. One of the original researchers, Peter Bratuskins, gave a further 17 interviews. Journalists' questions reflected the shock at learning that sexual harassment by patients could happen. The public's view had been that general practice was a secure place of work for women.

Australian GPs consult in an intimate setting, often with the doctor and patient one to one. Doctors are thought of as being in control and safe. Indeed, during training they are told of their powerful position in relation to patients and taught not to abuse it.

My own experience of sexual harassment by patients has at times been confronting. I have encountered odd behaviour from patients of both sexes. In one case of a sexually harassing patient I insisted on him seeing a male doctor and in another with difficult problems that a male GP visit him at home.

Throughout my career as a GP I have had control of my working environment. I have co-owned and operated my practice with my husband for more than 30 years so I have been able to determine its operation myself and negotiate effective resolutions to problems, including harassment.

Reading about the strategies that some of my female colleagues in this survey had adopted made me aware that many of them saw themselves as powerless to make changes to the operation of the practices in which they were employed. This disempowerment was manifested by the various responses they had made to their experiences.

Some had altered or stopped performing certain examinations or no longer worked after hours or alone. The solution for these doctors was to withdraw from the full scope of general practice, affecting the service they could offer to their patients

Some changed to a more formal consultation style or kept their personal lives more private, and this had little or no impact on their work. But some had altered or stopped performing certain examinations or no longer worked after hours or alone. Those GPs saw their capacity to work inhibited. The solution for these doctors was to withdraw from the full scope of general practice, affecting the service they could offer to their patients, affecting their income earning capacity and perhaps, also, career advancement. Some had changed the way they dressed, like other victims of sexual harassment and abuse, indicating an element of self blame. These women are victims.

Specific services for any harassment of doctors are not available in Australia. Australian Medical Association Victoria offers its members a confidential peer support service through which some of these issues may be addressed for individuals, but judging by the reaction to this research and the interest it has generated, until now there has been no formal understanding of the scale of the problem and how to manage it systematically.

For me and my female and male colleagues many questions arise, including:

How prevalent is sexual harassment by patients of male GPs?

Are there medical settings apart from general practice where this occurs?

What training, support, or counselling is available?

Do doctors allow themselves to adopt the label of victim and seek help?

However, the most important question is this: can practices, now the silence is broken, manage these incidents so that female GPs retain the capacity to work any hours they choose, managing any patients who attend? Only once the answer is yes can all GPs confidently and safely practise with the same freedom from fear that I enjoy.

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FROM THE FRONTLINE **Des Spence**

Middle aged medicine

The greatest joy of youth is the lack of insight. We think we know everything because we have so little life experience we don't know any better.

But life experience isn't optional. We age, uncertainty replaces certainty, confidence is replaced by insecurity, invincibility is replaced by vulnerability, and what was once important is now unimportant. We realise that intellectual vanity is the worst vanity of all, with people intent on a kind of social plastic surgery to pretend they are something they are not. The only things we really want are the very things we can't possess.

We strive for our children, intent on being better parents than our own, but our children will blame us for all their failings and give us no credit for their successes. We are all half baked and lame parents because being a "great parent" is not possible or desirable. Those living vicariously through their children be warned! We spin out into middle age, older, fatter (having never lost the weight from the first child), dizzy, confused, unloved, and unthanked. Indeed, the young cannot tell the middle aged apart, even men from women. Middle age can be defined by vulnerability, unhappiness, disappointment, loss, alcohol abuse, inactivity, aches and pains. A slow burning crisis.

The middle aged are captive prey to corporate medicine and the drug industry

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Medicine is intent on seeing all these woes as simple "illness"—diabetes, hypertension, hypercholesterolaemia, hypogonadism, obesity, smoking, addiction, anxiety, and depression. And once modern medicine gets the talons in, computerisation means we are trapped in endless recalls.

Some become health neurotics, anti-drink, suggesting we arrest smokers and ban all salt, blending quinoa and spinach into a "delicious shake." But this is just another type of prescription misery. The middle aged are captive prey to corporate medicine and the drug industry. Indeed, reading research on prevention and treatments leaves me wondering if modern medicine does much good; but I'm absolutely certain it does much harm.[1] Medicine is encouraging passivity, disempowering rather than empowering. Our loss of youth is compounded by the loss of wellbeing.

Perhaps the middle aged need to form a clandestine organisation (suggestions for names gratefully received) against medicine, medication, and medicalisation. Take our chances in the wild and drop off the medical grid. Pop all health circulars straight into the recycling bin, decline all screening tests and recalls. Spurn doctors. Engage in active health through exercise, pet ownership, acceptance, work, continued education, cooking, music, routine, a varied diet, and occasional but liberal alcohol. There is even some evidence to support this anecdotal musing.[2-6]

Life is for living, even if we are middle aged, and we should be free to get on with it.

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BMJ BLOG OF THE WEEK **Tessa Richards**

The rise and reach of expert patients

In the Victorian era, patients who acquired public profiles tended to be doubly disadvantaged. Joseph Merrick, exploited as the "Elephant man," was a notable example. Now patients are becoming well known less for shouldering disease so much as for using their experience to help others. A handful have achieved celebrity status and are run off their feet, responding to calls to give keynote speeches at medical meetings.

It's not hard to see why patients become passionate advocates for others. The insight gained from experiencing prolonged physical and mental ill health motivates you to help fellow patients in a way that nothing else can.

The *BMJ* has just held its first patient partnership workshop, and we were humbled and inspired by the enthusiasm of the many patients and patient advocates who have come forward to help us spur the march towards making patient partnership a reality.

Our strategy will be announced soon. Steps we have already taken include patient peer review of selected papers, and we are inviting patients to join our growing database of patient reviewers to help us do this.

Patients bring an expertise to the table that can't be found in the corridors of academia or the manager's office. Many of those who live with chronic disease slowly and painfully acquire knowledge which over time exceeds that of many of the health professionals they intermittently meet.

If you have a rare disease none of the doctors you are likely to encounter will begin to match the expertise lodged in patient organisations.

Some doctors admit, as Jonathan Richards, a Welsh GP, told me last week, it's the patients not the doctors, who provide the crucial information. "When I got diabetes," he said, "the people I learnt most from were fellow patients."

For patients who assume leading roles as advocates the time and effort they put in by contributing patient perspectives in committee meetings and commenting on reports, guidelines, and information leaflets (the list is long) are poorly recognised.

Some argue that now they are being invited to sit round the table with doctors and managers as equal partners, their expertise should not only be recognised but rewarded too. They are motivated by altruism but feel the demands being put on them verge on exploitation.

Several of the patients who came to talk to us made their own arrangements to travel to BMA House from overseas. All gave us their time for free. How many medical or managerial experts would be happy to do the same?

Tessa Richards is senior editor/patient partnership, *BMJ*

Read this blog in full and other blogs at bmj.com/blogs.