Sexual harassment of female physicians by patients

What is to be done?

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OBJECTIVE To determine the responses of female physicians who have been sexually harassed by patients, as a means of answering the question, "What is to be done?"

DESIGN As part of a larger study on the topic, randomly selected participants were mailed a questionnaire requesting information about the nature and extent of sexual harassment by patients and about resulting feelings, actions, and suggestions for prevention.

SETTING Family practices in Ontario.

PARTICIPANTS A random sample of the 1064 female certificants of the College of Family Physicians of Canada in active practice in Ontario during 1992 was selected. A total of 599 were surveyed; 422 (70%) replied.

MAIN OUTCOME MEASURES Responses to survey questions.

RESULTS Of the 422 respondents, 76% reported sexual harassment by patients and their reactions to it. Though most respondents had many suggestions about how to minimize harassment, written comments suggested confusion as to its cause. Many participants wondered whether their behaviour, manner, or dress provoked unwanted responses. The ability to root the cause of the harassment externally as a social rather than a personal problem seemed to decrease immobilization.

CONCLUSIONS There is no single effective response to sexual harassment, but understanding its source as an abuse of the power of gender* (perhaps to overcome the powerlessness felt as a patient) could enable female physicians to act in protective and effective ways.

OBJECTIFS Préciser les réponses des médecins de sexe féminin victimes de harcèlement sexuel de la part des patients afin de mieux répondre à la question «Que faire ?»

CONCEPTION Dans le cadre d'une étude d'une portée plus vaste sur le sujet, un questionnaire a été posté à un échantillonnage aléatoire de participantes leur demandant des précisions sur la nature et la portée du harcèlement sexuel par des patients et de décrire leurs sentiments, les actions posées et leurs suggestions afin de prévenir ce harcèlement.

CONTEXTE Cliniques de médecine familiale de l'Ontario.

PARTICIPANTES Échantillon aléatoire parmi 1 064 certifiées du Collège des médecins de famille du Canada exerçant activement en Ontario en 1992. Un total de 599 ont reçu le questionnaire; 422 (70%) ont répondu.

PRINCIPALES MESURES DES RÉSULTATS Réponses aux questions du questionnaire.

RÉSULTATS Des 422 répondantes, 76% ont rapporté avoir été victimes de harcèlement sexuel de la part des patients et ont décrit leurs réactions. Même si la plupart des répondantes ont offert de nombreuses suggestions afin de réduire le harcèlement, les commentaires écrits ont indiqué que la cause était plutôt confuse. De nombreuses participantes se demandaient si leur comportement, leurs manières ou leurs vêtements avaient provoqué ces réactions non désirées. La capacité d'identifier que la cause du harcèlement était d'origine externe, c'est-à-dire un problème davantage social que personnel, a semblé réduire l'immobilisation.

CONCLUSIONS Il n'existe pas de réponse unique et efficace au harcèlement sexuel, mais en comprenant mieux que sa source est un abus du pouvoir lié au sexe (peut-être pour surmonter le sentiment d'impuissance ressenti lorsqu'on est patient) les médecins de sexe féminin seront peut-être capables de réagir efficacement pour se protéger.

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* *Gender is used throughout this article to denote the sociologic construction of being male or female.*

THOUGH SEXUAL HARASSMENT IN the workplace has been extensively studied over the past two decades, harassment of female physicians by patients has only recently been recognized and documented as a problem.[1] Patient behaviours, such as suggestive exposure of parts of the body, pressure for dates, making inappropriate or

threatening sexual remarks, or, occasionally, stalking, seem to represent an occupational hazard for female physicians. Documentation has given voice to a previously unnamed though remarkably prevalent problem.

Recognizing that they are not alone has probably helped some of those victimized by patients feel less vulnerable or confused. However, quantitative data alone will not answer the question, "What is to be done?"

The previously noted study[1] included a second, more qualitative section, in which the nature of and responses to sexual harassment were examined. This paper presents these findings. The discussion will draw on study results and information from other sources to look at effective strategies and policies for preventing and reacting to sexual harassment of students and practitioners by patients.

METHOD

In May 1992 the College of Family Physicians of Canada provided a randomized selection of 600 of the 1064 female certificants of the College in active practice in Ontario. A questionnaire was mailed to 599 of these. One was excluded because she had participated in pilot testing of the questionnaire. An accompanying letter explained that the purpose of the study was to examine sexual harassment of female physicians by patients. Sexual harassment was defined as "unwelcome sexual advances, requests for sexual favours, and other verbal or physical conduct of a sexual nature."[2]

Respondents were asked about a range of behaviours including suggestive gestures, pressure for dates, inappropriate exposure of body parts, grossly inappropriate touching, and rape.

Physicians were then asked to describe one incident in detail and to include information about whom they had talked with after the incident, how they had felt, and whether they had asked the patient to find another doctor to provide subsequent care. Suggestions as to causes of, protection from, and prevention of sexual harassment were sought.

A more detailed description of the methodology and analysis of data can be found in "Sexual Harassment of Female Doctors by Patients,"[1] the paper documenting the quantitative results of the survey.

Information about sexual harassment in the workplace and in the university was reviewed to determine whether legislation, preventive programs, and guidelines for response could be useful or relevant to students or physicians experiencing sexual harassment by patients.

RESULTS

Of the 422 (70% of 599) respondents, 321 (76%) had been sexually harassed at least once during their careers. Most commonly the harasser was a male patient (92%) known to the physician (56%). Typically, incidents occurred face-to-face in the doctor's office.

Nonrespondents were not analyzed in any way, as the only information available about each was a mailing address.

Physicians' feelings

Physicians' feelings about being harassed ranged from anger (35%) to fear (26%) to amusement (9%). Respondents used words like vulnerable, exploited, manipulated, terrified, uncomfortable, surprised, embarrassed, awkward, disgusted, and violated to describe their responses. Most (81%) of the 279 women who described one example of harassment discussed the harassment with someone and felt supported by that person. Some attempted to go beyond seeking personal support by reporting the incident to the Canadian Medical Protective Association, Bell Canada, staff at other health care facilities (eg, walk-in clinics), the College of Family Physicians of Canada, or recording details on the patient's chart.

Physicians' actions

The women surveyed were asked whether they subsequently refused to see the patient who had harassed them. Only 31% (56 of 180 respondents) did so, while 60% continued to provide care. The other 9% of respondents were willing

to remain doctors to their harassing patients; however, the patients never returned. Several respondents chose to explain their decisions. Some wrote that it would be difficult to refuse to see a patient when his family were also patients and an explanation to them would be required. Others continued to provide limited care, excluding personal counseling.

The women surveyed made many suggestions about prevention and protection. These involved changes to office routine and security and to personal behaviour.

The importance of scheduling that minimizes the opportunity for patients to be alone in the office suite with the physician was repeatedly stressed. Respondents suggested that new patients should not be booked at the end of the day when fewer staff are present in the office. Several physicians made sure that an employee remained in the suite until all patients had left. There were a variety of suggestions about having someone else present in the examining room, particularly for genital examinations, always positioning oneself between the door and the patient, and leaving examining room doors ajar while maintaining patient privacy by drawing a curtain around the examining table.

Many of the women surveyed had bought security systems for their offices, their homes, their cars, and themselves. They cautioned that home addresses and phone numbers must not appear in telephone books, on printed call schedules, via "call display" when calling patients from home, or on the mailing stickers on magazines that end up in the waiting room, and must never be given out by office staff or an answering service to anyone.

For many of the physicians surveyed, protection was costly and involved significant vigilance or upheaval. One physician reported feeling she had to "lock the office door when alone, never give out [her] home phone number or address, install a security system at home, install timers on home lights, buy a car phone, and use a message machine to screen incoming home phone calls." Another had to move and start a new practice. A third physician arranged a self-defence course for herself and her female colleagues.

Suggestions for changes in personal behaviour were more varied. Many believed that formalizing their relationship with a patient would offer added protection. Each of the following statements was made by a different respondent. "I have increased my 'coldness' with male patients," "I try to dress formally rather than casually, and always wear a lab coat," "I avoid wearing jewellery or makeup," "I remember to wear my wedding rings," "If I detect that a patient is attracted to me, I try to remain more impersonal than usual," "I keep visits very short," "I avoid open-ended questions, like 'What can I do for you?'" (this from a respondent who had once had a patient answer the question with "You can jump into bed with me"), "I wear glasses to look more professional and less appealing," "I ask males to leave their underwear on when undressing, and sometimes refer them to a urologist for a genital exam," "I do not do routine genital exams. I know this is controversial and the issue of awkwardness is not considered in the controversy. If a genital exam is specifically requested, I become extremely formal and make a show of putting on examining gloves."

A smaller group responded to patient harassment with increased willingness to confront, decreased willingness to condone, and greater confidence to act. "I changed my internal mindset to permit myself to confront a patient more quickly who insisted on stepping over *my* line in the doctor-patient relationship," "I listen to my instincts," "I give explicit instructions re undressing, draping, and the purpose of the physical exam, and leave the room while the patient is disrobing. I will not examine patients who make advances, and discharge them from the practice."

The women surveyed had the option of returning a separate card on which they could indicate an interest in participating in groups organized to discuss the problem further. Of the 137 physicians whose cards were received, 53% (n = 72) wished to be involved in such discussion groups.

Effect of study on participants

Recalling and describing sexual harassment can be upsetting and distressing. None of the respondents sought support offered by the researchers around

issues arising from the study. However, two women wrote that completing the questionnaire had brought back memories of childhood sexual abuse.

Some respondents commented that, in working through the survey, they had reconsidered their behaviour and would feel able to act sooner to protect themselves in the future. Some recalled their frustration and vulnerability. "I contacted the police about my phone calls but felt little support from the male [officers] I dealt with." Many expressed interest in participating in groups to further discuss the issue and relief that a hidden problem was being brought out into the open. "I suspect we are a quiet yet very frightened group of women. Perhaps this study will be our voice and allow us to be heard."

DISCUSSION

Definitions of sexual harassment generally describe both behaviour (such as sexual advances, requests for favours) and perceptions of that behaviour by the victim (unwelcome, offensive, objectionable). It is not the behaviour itself, but the context in which it occurs that defines whether a particular act constitutes harassment. The Ontario Human Rights Code further describes sexual harassment as "sexual advances or invitations made by a person who is in a position to grant or deny a benefit to another; and threats or reprisals against a person who rejected the sexual advance."[3]

Power relationships

Within the doctor-patient relationship, it is the doctor who holds the power. Despite this fact, most female physicians surveyed had been sexually harassed by (male) patients. It would appear that the power conferred by the title "doctor" is negated by the vulnerability of gender. Male physicians might be disturbed by seductive comments or behaviour of some patients; however, it is the sense of being threatened that differentiates seduction from harassment.

Sexual harassment in the workplace can present itself in two distinct ways. The more familiar scenario involves the abuse of power by one employee, or by the employer, to demand sexual favours of another employee. More difficult to define is the concept of the "poisoned environment." In 1986 the US Supreme Court ruled that employees have the right to work in an environment free from discrimination, intimidation, ridicule, and insult.[4] Despite protective legislation in both the United States and in Canada, proving that a threatening environment exists is the responsibility of the accuser. Accusations are often met with admonishments to "lighten up" and to "have a sense of humour."

Employees are protected from sexual harassment both by legislation, such as human rights codes, and by union contracts in some cases. In reality this protection is often more theoretical than real. Studies done in the United States have shown that few women who are sexually harassed at work actually file formal complaints.[5,6] Often victims are instead silenced by fear of retaliation and fear of loss of privacy.[6]

The position of the female physician confronted by sexual harassment from a patient is the complete reverse of the female employee's situation. Physicians lack legal protection from sexual harassment by patients. The physician is generally not an employee and has no relevant contractual agreement with her patient. Though harassment by patients certainly can poison the work environment, there is no legal recourse available to the doctor-victim. If the harassment is criminal in nature, the physician has the option of involving the police, who may charge the patient. None of the women physicians in this survey had chosen to press charges. Perhaps they, like their counterparts in other settings, were immobilized by awareness of the difficulty of proving anything and by the fear of loss of privacy. Physicians, unlike women in many other workplaces, hold professional power. As employers they usually have some control within the workplace. They can alter work hours, arrangements, and settings. Ultimately they have the power to refuse to see particular patients, to tell offenders to seek care elsewhere.

Why, then, did most of the women surveyed continue to serve as their harassers' doctors rather than to use this power to terminate the relationship?

Female physicians have been socialized both as doctors, but more particularly as women, to be polite, to put others first, and to question their own behaviour. In this study the responses to harassment reflect this socialization, and are similar to the self-blaming often observed among victims of harassment and abuse. Concerns about provocative dress, being too attractive, familiarity and formality within the doctor-patient relationship, and protecting the harasser's family from the truth reflect the mind-set of the victim more than the true causes of the victimization. Dismissing the harassment as an indication of psychiatric illness, wondering whether the behaviour experienced had been accidental rather than intentional, and hoping for protection from husbands and co-workers could be effective strategies to minimize the psychological effects on oneself. They are also beliefs that locate the cause of harassment at an individual rather than a social level.

What is to be done?

Individual strategies. There is a wealth of literature about sexual harassment and abuse identifying abuse of power by the perpetrator, rather than provocation by the victim as the underlying problem.[7,8] Reading some of these books or articles and discussing them with others can help individual women to look beyond themselves for explanations of the problem. If "I" am somehow behaving in ways that invite harassment, then "I" will feel confused (what did I do and what can I do differently?), embarrassed, and immobilized by that harassment. If "I" view the roots of sexual harassment as social, rather than individual, "I" then have the confidence to name the problem, to talk about it, and to act.

There will not be one set of ideal actions for all situations. Having the confidence and courage to leave the examining room, even if it means walking out without offering any explanation for one's departure, could be adequate action. Refusing to provide ongoing care, notifying appropriate agencies (such as regulatory bodies) or groups (female physicians whose practices are open) might be necessary. The ability to determine how to respond and to act will flow from the mind-set that recognizes the causes of harassment as external to oneself.

Several physicians in the study looked to their power as doctors for protection. By wearing lab coats, snapping gloves, being "more businesslike" and controlling, they hoped to prevent harassment. Such behaviour might be effective. If, however, male harassers are using the power of their sex to overcome the vulnerability they feel as patients, increasing the power differential between doctor and patient could increase the risk of harassment.

Medical education. University and hospital policies that allow students and employees to remove themselves from dangerous or abusive situations could offer some protection to trainees. Despite this protection, students and house staff remain vulnerable. Their fear of how such action will be perceived and will affect future evaluations mitigates against action.

Faculty must incorporate both discussion of the problem of sexual harassment and support for self-protection into training. Such support goes beyond language to action. One of the respondents commented, "My residency in family medicine was the most unsafe position I have ever been put in. We were expected to do housecalls in a rough area of town. The staff person would say he [or] she was available but never wanted to come [with us]."

It is important that sexual harassment of physicians by patients be presented not as a disclaimer for sexual abuse of patients by physicians, but as a manifestation of the same underlying problem: that is, the abuse of power.

Systemic solutions. Catherine MacKinnon has noted, "Trivialization of sexual harassment has been a major means through which its invisibility

has been enforced."[9] Stephanie Riger has identified attitudinal changes: "Sexual harassment... is the most recent form of victimization of women to be redefined as a social rather than a personal problem, following rape and wife abuse."[10]

Individuals often find ways of protecting themselves, of recognizing that sexual harassment is not a response to provocation, and could, as a result, minimize its negative effects. It is, however, only through examining and challenging the social structures, images, stereotypes, and beliefs that reinforce power imbalances and victimization that true prevention will occur. Both medical pedagogy and practice present opportunities for positive change.

Medical teaching and curriculum should incorporate some of the wealth of information available about sex roles, sexual harassment, and violence. In their relationships with both students and patients, faculty can and should model behaviour that is supportive and collegial rather than harassing and hierarchical. Medical students, particularly those who are female, must be told that practising medicine in North America could mean facing sexual harassment from patients. Creating opportunities for students to discuss this reality can only be beneficial.

Perhaps the women in the study who wished to gather together and seek collective solutions through discussion and support have identified the most effective next step in the process of identifying and naming a problem, examining its causes, and searching for answers. ■

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