Preface

Louise Stone

In 2014, I looked after a young intern who was sexually assaulted by her supervising consultant while on the way to the car park after a night shift. As a General Practitioner with a long-standing interest in mental health, I had seen hundreds of survivors of sexual trauma in my clinic, but this consultation felt profoundly different. The therapeutic relationship felt fragile, trust was hard won and the shame in the room was deep. In retrospect, these difficulties were unsurprising. After all, the intern was a doctor, the consultant was a doctor, and I was a doctor, so there were complexities in the therapeutic relationship. I was part of a community that had been complicit in the abuse.

At the time, there was little in the literature to help doctors who were survivors of sexual trauma in the medical workplace. However, we did know a little about harassment and discrimination in medical training. An international meta-analysis by Fnais et al. (1) made it clear that thirty-three per cent of medical trainees experienced sexual harassment. Still, despite the fact that I talked to a number of senior GPs who had cared for junior doctors who were victims of sexual abuse, little was known about the prevalence of abuse in the junior doctor community, or their lived experience.

We knew that the medical workplace was toxic, and despite considerable efforts within and outside of the profession, occupational trauma remained high. Medical workplaces are hierarchical, and junior doctors depend on their seniors for career progression, making them particularly vulnerable to abuse. There are high rates of depression and alcohol use among doctors, and high levels of vicarious trauma. Doctors are reluctant to seek help, and tend to believe that mental illness is a sign of weakness. Racism and sexism are common. Suicide risk is high, particularly among junior doctors.

Although we knew that stepping into this deeply challenging area was going to be methodologically and ethically challenging, Kirsty Douglas, Christine Phillips and I decided to undertake a qualitative study to better understand the lived experience

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of young doctors who had survived sexual abuse within the medical profession. (2) We found that the experience of abuse and its management was complex, and the resultant trauma caused long-lasting harm. In keeping with the existing research around workplace sexual harassment and abuse, we found that the culture of bullying and harassment within medicine made junior doctors vulnerable to more serious sexual trauma. Women doctors described performing 'niceness', walking a tightrope balancing the need to be strong and make decisions and being a 'good girl who is approachable and nice to the nursing staff'. Some participants had already experienced abuse at school or at home, and had learned not to speak up. They questioned whether they had been complicit in the abuse. 'Maybe I need to be more professional' said one female doctor 'and not smile as much'.

We hadn't realised how traumatic it was to wait for the investigations to finish. Some women were still working in teams with the perpetrators, but were under confidentiality agreements with their hospitals, or the courts. This led to months of silence and isolation. At some point, their names became known in their workplace, in the courts or in the media. Feelings of betrayal were common, and loss of anonymity and gossip were painful. Rape culture meant these women were often demonised in the press. There was an article about a survivor who won her case in court. 'Clearly, the surgical training system which has served Australians so well must be destroyed to advance the causes of gender feminism', wrote the journalist, 'just pray you don't get a brain tumour'. (3) For these women, the exposure was a second assault, and sometimes the women they expected to support them caused the worst of the betrayal.

In the aftermath, these women still struggled to make sense of their own experience. They all had difficulties re-establishing their careers and sense of self. Their worlds were broken, and would never be the same.

In disseminating this research internationally, we found an unexpected community. Researchers in multiple countries came to share their experiences, and discuss the frustrations of managing such a complex problem within their own sociocultural and organisational contexts. We began to realise that around the world, people were trialling simple solutions to this complex problem. Unsurprisingly, we all shared the frustration of realising that these isolated solutions, like mandatory education programmes for senior staff, or policy change within institutions, were not enough to manage a problem that was deeply rooted in gendered sociocultural expectations. We realised that this problem involved multiple dilemmas across multiple actors.

Such a complex community problem needs a complex community solution. We needed to bring together the expertise and experience from law, medical regulation, management, human rights, gender theory and therapy. We needed to bring the lived experience and reflections from multiple sociocultural contexts across the world to understand how systems adapt. We also needed to understand the hidden culture, hidden curriculum and hidden behaviour that characterise the dark side of

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medicine as a profession, understanding systems of power and privilege that enable abuse to occur in the cold, hard light of day of large health care institutions.

This book was created to bring these diverse approaches into one text. We wanted to bring the insights of multiple disciplines and multiple contexts into one space so those of us involved in the complex problem of sexual abuse in medicine could examine the problem from multiple perspectives. We do not claim to provide answers to this problem, but we do provide honest and open analysis. We sincerely believe that it is only by engaging with the complexity of the problem that contextually appropriate solutions can be found across the world.

One-third of our junior doctors have experienced sexual harassment. Many of those doctors have survived deep psychological trauma from senior colleagues. We have a responsibility as a profession to enact primary, secondary, tertiary and quaternary prevention strategies: to protect the whole profession from harm, to identify and support those at risk, to provide a restorative justice framework for those who have already experienced harm and to manage the harm of the investigative process.

As a profession dedicated to healing and health promotion, we have a responsibility to our colleagues, as well as our patients. We trust this book will provide a way to understand and address this trauma in our own unique contexts, and ensure future doctors can thrive in a safe and secure medical community.

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