5

Medical Workplaces

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INTRODUCTION

Medical workplaces help frame a doctor's identity. Where a doctor works operates as shorthand for the type of work they do, the teams they may work in, the types of patients they see and the conditions they treat. Some workplaces represent long-sought career goals, while others are places doctors have been allocated without choice, or have entered through happenstance. Medical workplaces can engender a profound sense of belonging, where workers feel valued and supported to work to their best, and where their personal values are aligned with the institution. Many doctors do sustain over the long term a sense of belonging to their workplace. Sometimes, however, the workplace can function as a trap for doctors. Its physical spaces can be places of physical risk. The emotional affinity many doctors feel towards the workplace may enable them to be exploited, suborned or subverted.

Typically, medical workplaces are characterised by their service mission, the challenges and responsibilities of the work, and the frequent expectation of extended work hours. Although not all workplaces are hierarchical, the institutions in which almost all doctors train, and in which they spend their formative years, are deeply hierarchical. The requirement to be a good fit in the workplace can have a profound impact upon one's expectation of what it is to be a doctor.

HOSPITAL WORKPLACES

A hospital reflects the culture of its community, but it also creates its own culture. It is a total institution in the sense meant by Goffman. (1) A total institution physically separates its residents from the rest of society, imposes a bureaucratic order upon them, and regulates their activities. A defining characteristic is the way junior staff are acculturated to the mores and rules of the total institution. (1) In total institutions some of the power relations in the outside society are heightened and difficult to resist. Junior staff are most likely to be 'batch living' in hospitals, and thus are the most vulnerable to the impacts of the hospital as a total institution.

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Hospitals were constructed historically to provide accessible nursing and doctoring to groups of sick people, and later to concentrate and support specialised functions such as surgery or pathology. The institutions which founded the first hospitals – military and religious organisations – were experienced in human logistics. Nursing became increasingly regimented, reflecting the Nightingale influence, in part to protect the emerging middle-class cohort of nurses from sexual harassment. (2) Nightingale's ambition was to create a decentralised nursing cadre which could function through outreach into people's homes. Hospitals were 'but an intermediate stage of civilisation'. (3) She was concerned to protect her nurses from being 'morally and bodily destroyed' (4, p. 184), a risk she felt was particularly acute when nurses fell under the sole purview of male hospital authorities (4). To prevent this, nurses lived in designated accommodation near hospitals, and were supervised by on-site nursing managers responsible for their workloads and their moral safety.

The traditional hospital workforce thus separated (female) nurses from (male) doctors. Doctors had freedom of movement to move across all hospital spaces and enter different wards; nurses were assigned to, and supervised in, wards or teams. When women in the West started to graduate from medicine in the mid to late nineteenth century, they often found themselves structurally separated in their careers from men. In career surveys of women doctors undertaken in 1881 by the Women's Medical College in Pennsylvania and the New England Hospital in Boston, women doctors described working almost entirely separately from male doctors – in women's hospitals, or in private clinics, women's asylums or schools. (5) English, Australian and Canadian women doctors of this era experienced the same gendered separation, with women unable to find positions in the public hospitals where they had trained. (6–8) After the Flexner report recommended co-education of doctors, the women's medical programmes and women's hospitals went into a decline. (9) In the early twentieth century, women doctors in countries as diverse as the US (5) and China (10) were increasingly employed in male-run hospitals, but usually in 'female' specialities, such as obstetrics and gynaecology.

Women doctors moved into spaces constructed by and for male doctors, and in many respects this has never changed. Women doctors adapt to these environments; the environments rarely change for them. Hospital working schedules may not be adapted to the needs of workers who have other caring responsibilities outside of work. The working structures for doctors are usually based on seniority hierarchies which shape the working cultures of those lower down the hierarchy, and which in turn reflect the historical patriarchal relations of power in hospitals.

One of the ways women doctors in hospitals demonstrate their capability is by asking to be treated no differently to men. We can see this most radically in the ways that women doctors in hospitals negotiate their own embodied experience as menstruants. Women medical students and doctors are often loath to publicly discuss their own menstruation. (11) Yet menstruation is part of the regular

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experience of most women doctors. Hiding menstruation is a denial of the facts of women's bodies in the workplace. Women surgeons have recounted the difficulties of managing the pain and fear of flooding due to menstruation through long operations. (12) Despite women constituting the majority of operating theatre staff, they tend to have less changeroom and toilet space allocated to them than men. (12; 13) Leaving the operating theatre to change a menstrual product or to take analgesics involves holding up the procedure and having to scrub in afresh, all while publicly acknowledging what may be seen to be a female vulnerability. (14) Women doctors going through menopause also describe not asking for consideration of its impacts, again citing concerns about appearing frail. (15)

Being silent about menstruation and menopause reinforces women's shame about their bodies. In a ground-breaking study, Schooler et al. (16) demonstrated the links between menstrual shame, bodily shame, and sexual decision-making. Women who are ashamed, and distanced, from their bodies are more likely to be less assertive, more vulnerable and less assured in situations of sexual decision-making. Women doctors in training in hospital thus face a trifecta of vulnerabilities. They work in a hierarchical structure usually under male authority; they are taught to think of their bodies as things to be silenced; and their work brings them into contact with multiple places of risk.

Early career doctors even now are 'itinerant workers, moving from ward to ward'. (17) The spaces a doctor traverses are often the hidden parts of hospital: the underground corridors linking different wards, the unmonitored service lifts, the fire-escapes linking different floors. Rostered overnight, they may doss down in makeshift places such as tea-rooms, spare hospital rooms, or cordoned-off beds in the emergency department.

The association between shiftwork and sexual harassment is difficult to assess, as sexual harassment is often obscured in surveys which use the analytical categories of 'non-physical' or 'physical' violence. Shiftwork does not confer an added risk of sexual violence to women doctors in Serbian emergency departments (18) and Chinese hospitals. (19) This is in contrast to studies in Pakistan, (20; 21) Egypt (22) and Sudan (23) where the already high rates of sexual violence towards female physicians are increased on overnight shifts. The perpetrators in all these studies are most likely to be fellow or more senior physicians. When the site of assault is recorded, closed spaces are frequently mentioned, such as examination rooms, (22–24) operating theatres, (23–25) and doctor's offices (23; 25; 26).

Hospitals can also create risk through sexualising working spaces, through unofficial actions for which the institution may disavow responsibility. (27) A senior doctor who regularly invites health workers to his office to watch pornographic videos (25) may be presented as the one bad egg of the institution. The practice of group sexual bantering may be rationalised as team-building. (27) In their collection of accounts of sexual harassment in the NHS, Cox, Jewitt and MacIver (26) include many stories of groping and frottage by senior doctors of more junior doctors in public places like

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ward rounds, or operating theatres, which indicate that even in surveilled spaces molestation can happen. (26) As noted in chapter 8, clinicians often find it difficult to counter these instances of molestation by more senior doctors in patient-facing spaces in real time.

At other times, institutional actions may be read as direct endorsement of sexual harassment. Liang, Doman and Nestel (28) cite the case of a picture of sexual positions displayed on a wall in a shared staff-in-training office. An example from my own experience: I once worked as a junior doctor in a hospital which had a lease arrangement with a cable company whose range of options included pay-to-view soft pornography. For a small fee, a patient could watch grainy porn on the television fixed to the wall in front of their bed. Other patients or hospital orderlies would saunter over to watch. Behind the scenes, colleagues were amused by the female staff members' concerns about negotiating such an environment to examine the patient. The hospital administrators were probably unaware that pornography was one of the cable company's television options. Nevertheless, neither the administration nor senior colleagues thought that disabling the pornography option on the in-hospital televisions was a priority. For the women doctors and nurses, this decision created a sexualised environment which, not surprisingly, set the scene for sexual harassment from patients.

AMBULATORY CARE WORKPLACES

Hospitals function in similar ways the world over. Ambulatory care workplaces are different. They are a diverse set of small enterprises that range from small private businesses to corporatised entities or government-owned multidisciplinary polyclinics. Stuck for a descriptor, an Australian government website warned readers 'You can't stay overnight in a clinic'. In other words, a clinic is the opposite of a total institution; no one is rostered around the clock, and the patients come and go, generally of their own volition and wearing their own clothes.

These features reflect heightened agency for all people in the workplace, and create a complicated landscape for sexual harassment and assault. In hospitals, sexual abuse of doctors is perpetrated most frequently by other doctors. In ambulatory care, the landscape of sexual harm navigated by doctors also includes sexual misconduct by doctors towards patients, and sexual harassment by patients towards doctors. For female doctors, the primary care setting is colonised by sexual risk, (29) even if the personal risks of experiencing or witnessing these forms are not always high, and are moderated by the spatial and organisational structure of the workplace.

In the ambulatory sector, the overall level of sexual abuse and harassment perpetrated by doctors on doctors, and doctors on nurses, appears to be lower than in hospitals. (27) This is not to say that doctor-on-doctor sexual harassment does not exist. In *Surviving in Scrubs*, (30) a collection of accounts by women doctors of sexual harassment, there are multiple accounts of doctors being sexually harassed by

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other doctors in primary care, usually doctors in more senior positions. The authors point out this sector's workplace organisational systems may be insufficient to respond to reports of sexual abuse made by one staff member about another staff member. Most primary care services are small businesses with limited HR capacity. (26) Sexual harassment by doctors of health workers may be underestimated in the primary care sector as it is underreported by those who experience it.

The second type of sexual harm that can occur in the ambulatory sector is by doctors to patients. Sexual abuse of a patient is considered an offence which should be notified to the regulatory authorities, and so it has a public accounting trail. Although reports of sexual misconduct towards patients are rare, family physicians and psychiatrists are over-represented in national registry data. (31–33) Both these disciplines tend to have longitudinal treatment relationships and consult on a one-to-one basis – a set of circumstances in which patient–doctor boundaries may be violated and patients' vulnerabilities exploited. In Australia, general practitioners constitute 23% of the profession, but 45% of the notifications to the national regulator for sexual misconduct with patients, while psychiatrists constitute 3.2% of the medical workforce but 8.7% of notifications for sexual misconduct. (33) The doctor-perpetrators of sexual assault against patients in notification data are almost all men, and the victims women. (32; 33)

Is there a relationship between sexual harming of patients and sexual harming of other doctors? It is sometimes posited that since both relate to enactments of power, a doctor who victimises a patient is more likely to victimise a vulnerable doctor. Such a suggestion emphasises the psychological characteristics of the abuser doctor. Using the workplace as lens, we propose that the workplace environment may modulate the risk of abuse of doctors by doctors in ambulatory clinics. Most primary care clinics have relatively flat organisational structures, and do not have the level of power asymmetry that occurs in hospitals between senior and junior doctors. The most frequent site of sexual misconduct by doctors with patients in community clinics are the consulting rooms. (27; 33) These consulting rooms are sites of solo practice. Doctors interact with other health workers in communal spaces like tea-rooms or waiting rooms. Thus, the material spaces which may be exploited for sexual harming of patients by doctors do not have the same affordances for sexual harming of other health workers.

The third type of sexual harassment in this sector is sexual harassment by patients, particularly of younger female doctors. While sexual harassment by patients and their families is reported in hospital settings, it seems to be more frequent in ambulatory care. This may be related to patient characteristics. Clinics with a high patient throughput and more patients with substance abuse and mental illness have higher rates of reported patient-on-doctor sexual harassment. (34) Sexual harassment of doctors by patients may also be related to spatial and organisational factors. The practice of one-to-one consultation, or home visits, provides more opportunities for sexual harassment. (35; 36)

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Rural and remote clinics for underserved populations pose their own challenges. In countries with inadequately resourced rural populations, doctors are often posted to a rural community service for at least a year. Many countries issue specific visas to doctors on the requirement that they are bonded to serve in rural towns. Indeed, immigrant doctors have become the mainstay of rural medical care in Australia, Canada and the US. (37; 38) Despite this, there is a dearth of research on the experiences of female immigrant rural doctors. Many of the oral histories focus on fish-out-of-water accounts of women overcoming racism, though there have been layered accounts indicating that these women also faced gender discrimination. (39, 40)

The practice of rural bonding of doctors who may come from a different background raises the possibility of intersectional harassment. In one rural clinic in the US, for example, the female clinicians who belonged to minority groups described gender and racial harassment by their male co-workers. (41) Many felt they had little recourse but to leave the community. Such incidents pose a risk to sustainable service delivery in underserved populations.

TEMPORARY WORKPLACES

This category includes locum (or fly-in/fly-out) arrangements and mobile medical units. These are challenging workplaces. By their very nature they are not sustainable, and workplace supports are fragile.

In locum employment, clinicians work for themselves, usually contracting their labour through a medical recruitment agency. These arrangements are instituted because the workplace has been unable to secure the workforce it needs, or because the workplace is so challenging that it can only be undertaken on short visits. For the doctors themselves, local arrangements have the advantage of self-employment and the ability to make decisions about their own workload and workplace. However, locum doctors in a health service are often treated with disengagement by hospital management and depersonalised as the stopgap solution. In their interviews with locums in the NHS, Ferguson et al. (42) noted that locums were subject to repeated questioning of their legitimacy as doctors, both excluded from professional development activities, such as training and case presentations, and cast as a clinical governance risk. In 2010, the *British Medical Journal* reinforced this everyday discrimination against locums when it ran a front cover headlined 'Misfits: the problem with locums' for a simple story on the difficulties of recruiting locums. Being on the outer edge of the medical workforce in a hospital places junior locums at risk of harassment, and reduces their ability to protest about it through the hospital's formal channels. For more senior locum doctors, sitting outside the governance arrangements of a hospital can provide a cover for sexual harassment of other staff. (43; 44)

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If fly-in/fly-out arrangements are used for an entire workforce, as they are in the mining industry, they can be associated with a marked risk of sexual harassment for women, reflecting the itinerant workforce, the lack of oversight, and a macho culture. (45) Mobile medical units or teams have been touted as a way to improve service delivery in underserved rural and under-resourced urban populations.

In richer countries, many mobile clinics are funded through philanthropy or faith-based organisations, and run with a volunteer workforce of clinicians. (46; 47) In other settings, they usually operate through vertical staffing where staff are brought in from another facility. (48) These models are expensive and frequently rely upon external funders such as universities or philanthropists for funding.

There has been little evaluation of the staffing, safety and sustainability of mobile clinics. Mobile clinics can operate outside of formal governance structures or oversight, as in the case of US-based anti-abortion pregnancy support clinics. (49) In one of the few studies of a mobile medical unit programme in a fragile humanitarian setting, senior doctors were reported to be moving the arduous responsibility onto younger doctors, with women being underrepresented. (50) The respondents also noted the emotional and financial investment of donors into this model, when a transition to place-based care might be preferable. The literature on mobile clinics often emphasises the moral worth of their project, othering the population being served and elevating the mission of the clinic. The management model for mobile clinics is generally fairly flat, and there seem to be few recourses for complaint for workplace bullying and harassment. A harassed person may be more likely to simply take themselves off the volunteer work roster than to make a formal complaint about workplace safety.

PRECARIOUS WORKPLACES

Some years ago I taught a course to humanitarian medical aid workers. The students had spontaneously divided themselves into constituencies: the inexperienced workers who viewed the course as an entrée to global humanitarian work, and a heckling claque of old hands who sat at the back of the class often deflating the enthusiasm of the novices with their accounts from the field, which were literally war stories.

After an unappreciated discussion on international guidelines, a novice asked the experienced hands, 'What do you think we *should* learn about?'

'Sex at work', replied an experienced health worker. 'The things no one tells you about until you're in the field.'

In 2018, the humanitarian sector had its #MeToo moment. Oxfam was accused of covering up sexual abuse and harassment by its staff in Haiti after the 2010 earthquake. In the wake of the scandal, Médecins Sans Frontières (MSF), one of the world's largest medical aid agencies, announced that it had concluded an investigation into sexual harassment and abuse by its staff and had fired twenty people. (51) Since then, it has become clear that sexual harassment is common among many

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international humanitarian aid organisations. (52) In a large, representative survey, 6% of men and 17% of women had experienced sexual harassment while on their previous assignment, (53) almost entirely from their peers.

Humanitarian aid is a precarious workplace. The work setting is complex and fragile, and clearly distinct from the person's home. Workers are often encouraged to separate themselves from the local people, and to socialise only with other aid workers. Workers are driven by the mores and buy into the mission of the humanitarian aid organisation. It is common for missions to be led by older males, with younger females working the entry-level roles. (54) Added to this combustible mix is the desperate and chaotic crisis of humanitarian aid work, the weak rule of law in these settings, and the hyper-masculinity that characterises much of the humanitarian aid work. (55)

Since MSF began publicly reporting incidents of unacceptable behaviour by its staff, there has been a steady increase in the number of local staff reporting bullying and sexual harassment by international aid workers. (56) This increase suggests growing comfort in the organisation with reporting and responding to abuse. It also points to intersectional power plays. While early career women aid workers are at higher risk of sexual abuse in humanitarian organisations, lower-paid local women face the highest risk of sexual abuse.

VIRTUAL WORKPLACES

Telehealth, a virtual workplace, provides the clinician with freedom from some of the constraints of ambulatory care or hospital workplaces. However, the emerging literature suggests that sexual harassment by patients remains an uncomfortable possibility. (57) This phenomenon has already been described in call centres. In a survey of a German call centre, three quarters of the women respondents had been sexually harassed by telephone in the course of their work. Being subjected to sexual harassment over the telephone was a more stressful experience if the call operator worked from home. (58)

Telehealth usually involves the use of a video-link, which expands the possibilities for sexual harassment. The extent of sexual harassment by telehealth of doctors is unknown. The *Times of India* (59) reported concerted sexual harassment by patients of doctors on twenty-four-hour telehealth sites – from genital exposure to sexual soliciting – noting that systems to prevent and ban patients who harassed doctors were not robust. This kind of sexual harassment in the workplace is criminalised in most countries, but prosecuting may be difficult if the patients are not in the country or have given false identities.

The virtual workplace should be a safe workplace. Management approaches need to be proactive and responsive, and have firm mechanisms to prevent e-consultation harassment, to respond to it if it occurs, and to support the clinician who has experienced this kind of harassment.

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CONCLUSION

Different medical workplaces create different conditions of possibility for sexual harassment and abuse. Of all the workplaces discussed in this chapter, hospitals are the most cited as places of risk for sexual harassment of doctors, usually by peers or more senior doctors. In hospitals, the hierarchy of the workforce, the long hours on premises, and the structure of the building itself poses a particular risk for sexual harassment. Ambulatory care workplaces overall are less likely to be sites of sexual harassment, but the forms of sexual harassment that may occur in these settings are manifold, including peer harassment and harassment by and of patients. Temporary workplaces, such as those occupied by locum clinicians, intensify some of the vulnerabilities of clinicians in hospitals, while simultaneously providing less oversight and support for clinicians. Workplaces such as international humanitarian aid settings are considered precarious in that their settings are fragile, and the workplaces are temporary, intense, and remote from the home life of the aid worker. The virtual world of the telehealth worker requires forward planning and response by businesses and managers to prevent online sexual harassment.

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