

Physicians and healthcare professionals in the era of #MeToo

ABSTRACT

Gender Based Violence is and has been a pervasive problem in our societies and communities. In recent times, there has been a renewed emphasis on the problem given the #MeToo movement and social activism. In this editorial, we discuss healthcare professions and gender-based violence in light of the #MeToo movement. Also, three major types of exchanges in the healthcare field have been described in relation to gender-based violence. Implications for practice and prevention of gender-based violence in healthcare systems worldwide have been discussed. Healthcare industry is one of the biggest and most prominent enterprises worldwide with lives at stake. Safety of providers and patients and violence free healthcare workplaces can significantly improve health outcomes. The #MeToo movement reminds us of our responsibilities and professional codes of conduct and demands that we always keep at the forefront—the rights of those we serve or interact with.

Keywords: Harassment, healthcare, safety, violence, workplace

Background/Introduction

The last few years have been remarkable as it relates to societal awareness on gender-based violence (GBV), workplace harassment, and sexual violence. No profession and no class of professionals was spared. Accusations involved prominent personalities, media, and film celebrities, lawmakers, and religious leaders; the #MeToo movement heightened our awareness of GBV as a global public health and social issue.^[1] Prominent international organizations have long highlighted the problem of GBV. For example, in early 1990s, the UN General Assembly adopted the *Declaration on the Elimination of Violence against Women*.^[1,2] Despite such declarations and our understanding that GBV undermines the health, dignity, security, and autonomy of its victims and survivors, the problem remained masked in a culture of silence. So, what made the past few years unique? Social activism, lesser stigma, willingness of victims to speak up, involvement of prominent people in the society (victims and accused), legal reforms, and mass media movements such as #MeToo may have renewed our awareness of the pervasive problem of GBV.^[1-4]

GBV, #MeToo, and Healthcare Professions

While no profession and no class of professionals remained immune to the latest movements on GBV, healthcare professions warrant additional attention and dialog. For a number of reasons, healthcare professionals are in unique situations where a lot of good is done, but the opportunity exists to cause harm to vulnerable patients or clients.^[3-6] In addition, healthcare can be a 24/7 business involving a lot of special circumstances. As a result, healthcare professionals need to make deliberate efforts to avoid causing harm. We discuss three major types of interactions that call for greater attention to potential GBV and highlight avenues to improve interpersonal exchanges in the field of healthcare.

First, healthcare workers often function in complex situations surrounded by multifaceted nature of interactions frequently interfacing with issues of life and death. Our professional codes of conduct mandate that we demonstrate cultural competence and gender sensitivity in interactions with our clients/patients/audiences.^[3-5] For example, reports of physician mistrust, disrespect towards patients, engaging in sexual relationships, and poor communication with patients and clients are not infrequent and have long-term implications for the physician-patient relationship, treatment adherence, and overall health outcomes. Physicians and other healthcare workers are in a certain “positions of power” even without conscious awareness.^[5,7,8] Patients and clients are in need, dependent on healthcare professionals for a benefit or service, and often invest a lot in healthcare practitioners emotionally and financially. As a result, they may not believe they have a choice to refuse or question inappropriate behaviors from their providers. We must remain cognizant of our authority and its impact, while allowing a lot of space for shared decision making with respect and sensitivity.^[3-5,7,8] This is particularly true when working with members of vulnerable populations such as women, persons from lower socioeconomic status groups, children and adolescents, and others (eg, victims of domestic violence or sexual abuse, homeless, and disabled individuals). We must hope to carry our responsibilities with the highest standards of professional conduct at all times because our respective fields demand it, the #MeToo movement notwithstanding.

Second, reports of violence against healthcare workers perpetrated by patients and clients are more common now than in the past. However, despite being ubiquitous and persistent, these problems continue to be tolerated. In a review of 101 serious incidents of violence against doctors in China from 2003 to 2013, it was reported that 24 doctors or nurses died as a result of the violence.^[9] Numerous other such studies highlight violence against

practicing physicians, healthcare workers, and trainees from all fields across all continents.^[9-13] Generally, verbal harassment is ranked as the most prevalent form of abuse, followed by sexual and physical violence. The rates of violence against healthcare workers differ by seriousness of incidents, specialty or area of practice of the victim, work setting, education and experience, and age. However, a plethora of studies highlight and confirm that female healthcare workers are disproportionately affected with sexual and physical violence.^[10-12]

Third and finally, the nature and extent of GBV and harassment among healthcare workers is well known.^[3,4,6,13-15] However, there needs to be a careful classification of implicit and explicit instances of GBV among healthcare workers. Females, younger, trainee healthcare workers, or non-physician professionals are more likely to suffer emotional abuse and sexual harassment. Again, the prevalence and type of GBV among healthcare workers may depend upon work setting, education and experience, and specialty. For example, nurses and professionals in emergency departments are more likely to report verbal and emotional abuse. Implicit bias and gender-based discrimination may be subtly visible against women in healthcare professions and biomedical science in the form of fewer promotions and career advancement opportunities, lower levels of research funding and scientific credit offered, fewer workplace benefits, and lower likelihood of receiving positions of authority. There are well known examples of such bias and discrimination across all continents with fewer women in many specialty areas, but these examples are not classified as traditional forms of abuse or harassment (e.g., sexual and physical) and thus, they remain hard to address in several healthcare professions (e.g., research and administration). Gender representation disparity in medicine continues to be a pervasive problem.^[3,4,6,12,14,15]

Implications of GBV and #MeToo in Healthcare

The multifaceted nature of interactions in healthcare professions among patients, our clients, and healthcare professionals warrants more caution, cultural competence, and gender sensitivity.^[4-6] We listed above three types of interactions that can be compromised by unethical and inappropriate behaviors tantamount to or becoming a cause for GBV. First, we discussed above the mistreatment of clients or patients by healthcare professionals.^[7,8] Unfortunately, there have been continued reports of extreme behaviors: either healthcare workers continue to abuse patients without facing consequences. More recently, there are instances where healthcare workers do not want to touch, resuscitate, or help when a client is in real need due to hesitancy and fear of being accused especially in light of the #MeToo movement. Female clients and patients are more likely to be affected by such behaviors and continue to bear the major brunt of GBV acts of omission or commission by healthcare workers (ranging from neglect to abuse of all types such as physical, sexual, and emotional).^[7,8,13,16] Second, violence against healthcare workers may not only pose a risk to life, but can also lead to

greater turnover, burnout, reduced job satisfaction, and poor work performance by healthcare workers.^[9-13] Finally, violence among healthcare workers is associated with a broad range of health and professional risks such as depression, anxiety, suicidal ideation, binge drinking, poor general health, lower job satisfaction, and greater turnover. While all three interactions listed above directly affect victims and perpetrators, there are indirect effects and ramifications for patient care, healthcare quality, and performance of healthcare workers to the highest standards and with maximum efficiency.^[6,12,14,15]

Beyond the healthcare and safety risks for patients and physicians, instances of GBV and the #MeToo movement have greater implications for the work and service of healthcare professionals. A few special circumstances and examples should be considered given the aforementioned three major areas of interactions in regard to gender and culture sensitivity. Male physicians are now opting for obstetrics and gynecology as specialty area of practice and female physicians are opting for urology, is the training across the medical curriculum sensitive and appropriate enough for cross-gender interactions in reproductive healthcare?^[16,17] Worldwide, youth and adolescents comprise a major chunk of the global population and this group is often seeking sexual health services (e.g., abortion and birth control) and sexuality education are pediatricians irrespective of their gender, attuned to the best practices and proficient in interactions with youth and minors (i.e., providing services that are accessible, acceptable, equitable, appropriate, and effective).^[5,16,18] Larry Nasser, a former American gymnastics national team doctor was recently convicted for molesting more than 200 girls and young women with aspirations to become athletes—a classic example of unabated and prolonged sexual and emotional abuse by a person in position of power. Healthcare workers worldwide have been prescribed professional codes of conduct that could be dated and framed in context of the twentieth century. Are we prepared for a respectful interaction with peers and patients who belong to the LGBT community? How confident are we in providing reproductive and sexual healthcare to sexual minorities?^[4,5,19,20] It is noteworthy that in general, sexual minorities suffer from worse health outcomes and more discrimination in healthcare systems than the general population. Another special example is of mentally ill patients and mental health professionals.^[9-12] Mentally ill patients (especially females) are significantly more likely to be victims of abuse, domestic violence, fraud, sexual assault, and rape. Similarly, mental health professionals such as psychiatrists are more likely to be abused by patients compared to physicians in other specialty areas (e.g., sexual advances from patients). In both situations in mental healthcare, such violations of dignity, respect, and professionalism have been long neglected and ignored. Are we sensitive enough to the mentally ill and adequately aware of their rights? Can mental health professionals avoid non-delegable duties or should they continue with their duties considering abusive patients as a “part of the job” because psychiatric patients can be more aggressive and may have abnormal behaviors? These implications of GBV and #MeToo movement urge us to reconsider with renewed

emphasis the clinical, scientific, and ethical standards under which we perform.^[11,14,19,20]

Given the aforementioned concerns, the #MeToo movement, and heightened sensitivity towards GBV, will healthcare practices change around the world? Clearly, there needs to be reconsideration of: professional codes of conduct; physician behaviors and community standards; mentor and mentee relationships in healthcare; impact of digitalization and telemedicine; professional socialization and conflicts of interest; social media, virtual relationships, and privacy; legal implications and disciplinary actions; ethics and confidentiality; consent and decision making; and self-care, wellness, and safety of physicians and healthcare workers while maintaining the highest standards of care for patients and clients.^[3-10,12-19] In addition to these issues and given the #MeToo movement, we must also remain cognizant of the potential for gender-based neglect, backlash against certain groups, and categorizing a certain gender into one group (i.e. gendered assumptions for victims or perpetrators). In healthcare professions, frequent interactions with people can provide ample opportunities for misjudging and labeling.^[1,5,12,13,15,19,20]

Prevention and Practice Guidelines

Despite the highlighting of GBV and the #MeToo movement affecting healthcare professions, there are no easy and simple solutions. In part, this is because healthcare professions are a special entity compared to many other work settings. Based on published literature, existing and new codes of conduct for healthcare professionals, and our practice experience, we propose the use of the traditional public health prevention paradigm to address GBV and harassment in healthcare

professions [Figure 1].^[3-21] Essentially, just like we address public health problems, a range of interventions and activities can be used at various stages of prevention of GBV and harassment in healthcare professions. In primary prevention, the efforts are to delay or prevent the onset of a problem (i.e. GBV and harassment in this case). In secondary prevention, the effort is to constantly screen for a problem to prevent greater damage or reduce the impact of a bad workplace climate in healthcare by identifying a problem early. Tertiary prevention aims to treat a problem and reduce the impact of damage done. In the case of GBV and harassment at workplace in healthcare prevention, this level of prevention may include disciplinary actions against perpetrators and rehabilitation and support for victims. In general, primary prevention is most cost effective and efficient.^[21] In our model, we describe these levels of prevention as they relate to GBV and harassment in healthcare settings and also depict costs and outcomes progression for each level. Specific processes and structures that are employed to prevent and address GBV and harassment in healthcare worksites are tied to specific outcomes. Leaders in healthcare industry, employers, and human resources professionals have clear choices to make (i.e. creating safe and inclusive workplaces; promoting transparency and professionalism; ensuring accountability and responsibility; protecting victims and whistleblowers; addressing inequity and discrimination; implementing zero tolerance policies and ensuring that stakeholders are aware of policies and procedures).^[3-21] Prevention is always better than cure, especially when our job is to save lives, prevent and treat disease, and promote health and safety of others.

Medical and allied healthcare professions are among the most complex, interdisciplinary, hierarchical, and cross-sectoral occupations and work settings with a lot of demanding situations

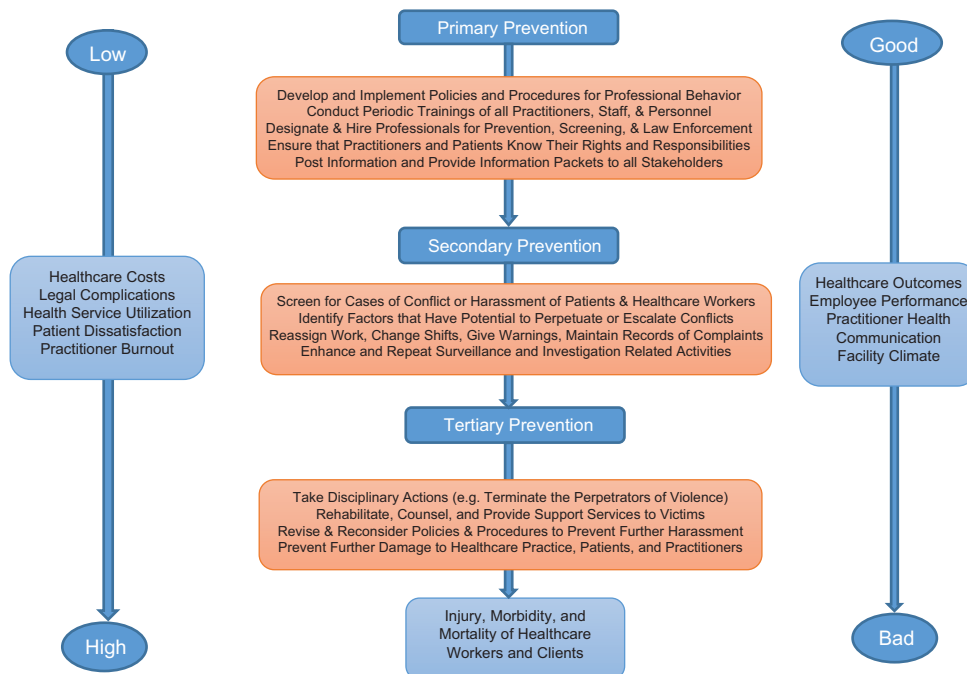


Figure 1: Prevention of GBV and Harassment in Healthcare Worksites

and interactions. Through long years of training, education and practice, professionals in healthcare industries might be well-equipped to deal with patient issues, but must renew our resolve to also pay attention to social circumstances with respect to gender interaction and cultural competency and maintaining professional codes of conduct.

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