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Sexual harassment of women doctors

THE general practitioner fulfils many roles: diagnostician, clinician, counsellor, social worker, teacher. Female doctors are traditionally seen as being ideally suited for general practice because of their 'nurturing qualities'. Certainly, most female general practitioners see their fair share or more of patients needing counselling or suffering from the after-effects of traumatic experiences.

It has become increasingly clear in recent years that general practitioners are better at counselling others on how to look after themselves than they are at taking their own advice. This inability to take appropriate steps to protect our psychological welfare is highlighted in this Canadian study.

A questionnaire on experiences of sexual harassment by patients, ranging from suggestive gestures to rape, was sent to 600 female physicians in Ontario. Seventy per cent responded and more than three-quarters reported at least one episode of sexual harassment.

The study examined the physicians' response to these episodes and the reasons why only 31% of doctors subsequently refused to see the patients who had harassed them. The balance of power within the doctor/patient relationship is discussed, as were the similarities and differences between such cases and traditional sexual harassment in the workplace. It is clear that, while a female physician is in a stronger position than a female employee in some respects, she has a professional status and responsibility which may make her more, rather than less, vulnerable. The study also examined what options and strategies were, and should be, adopted to minimize the risk of sexual harassment. There are recommendations for changes in the medical curriculum and in attitudes within the profession which would reduce both the risk and the psychological consequences of sexual harassment.

This study is a timely reminder that the nature of general practice is changing, not least as the proportion of female practitioners continues to rise. It addresses a subject which most people prefer not to acknowledge and emphasizes that only by facing the issue directly can it be eradicated.

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General practitioner, London

Source: Phillips S. Sexual harassment of female physicians by patients. *Can Fam Physician* 1996; **42:** 73-78.

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Clinical pharmacists and general practitioners

THE Audit Commission Report, 'A Prescription for Improvement' (1994) has highlighted deficiencies in the prescribing behaviour of general practitioners in the UK and made several recommendations for improvement, including more effective use of repeat prescribing systems. Two thirds of general practitioner prescribing can be generated through repeat prescribing, and the methods of follow-up of patients and audit of this activity can vary greatly.

This study in Michigan in the USA in 1994 demonstrated the potential for reducing costs and simplifying the medication regimes of patients in a primary care setting by employing a clinical pharmacist. Patients attending a family practice residency were selected according to the presence of two or more 'risk' factors relating to their illness and/or medication; for example, five or more long-term medications, or three or more chronic diseases. Twenty-seven patients were randomly assigned to an intervention group (control group 29), where a clinical pharmacist with a Postgraduate Degree would evaluate their drug regime for interactions, and aim to simplify the regime and improve its effectiveness. The findings were discussed with the primary care physician, and changes to the regime were explained to the patient. The patients were followed-up 1 and 6 months after the intervention by means of a telephone questionnaire.

Significant reductions between the intervention and control groups were shown for the number of drugs prescribed (1.1, $P = 0.004$), the number of doses (2.15 per day, $P = 0.007$) and cost of medication ($293 over 6 months, $P = 0.008$). Reductions in side-effects and improvements in compliance occurred, but were not significant. The authors concluded that this intervention led to a simplified and less expensive medication regime which they feel can be generalized to other primary care settings.

The conclusions of this paper do indeed have potential for extrapolation to the primary care setting in the UK. However, the numbers of patients involved were small. They were not 'blinded' to their physician, raising the possibility of subsequent Hawthorne effects. Also, patients may revert to less appropriate prescribing beyond the 6-month study period.

It would be useful to address these concerns before extrapolating these results to practises in the UK. Care would be need to protect the profession from medico-legal implications, and consideration should be given to the funding and availability of clinical pharmacists. If these issues can be addressed, this model could prove useful, not only for the development of the extended primary health care team, but also for improving the quality of repeat prescribing, developing the skills of clinical pharmacists, and relieving some of the burden for general practitioners.

JAMES NR BASHFORD
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Source: Jameson J, Van Noord G, Vanderwould K. The impact of a pharmacotherapy consultation on the cost and outcome of medical therapy. *J Fam Pract* 1995; **41:** 469-472.

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Certification and competence

IN specialist medicine, the possession of higher qualifications is widely accepted, but it has never been entirely clear whether these qualifications are, or are not, associated with improved care of patients. The introduction in different countries of assessments of general practice/family medicine has made it possible to consider this issue since there are now groups of general practitioners who have and have not been specifically trained for general practice, and who have and have not been specifically examined by their academic bodies.

In 1978, Brendan Stuart in Ontario, Canada, showed that postgraduates spent longer with their patients and were more likely to work with a nurse if they had passed the Canadian examination in family medicine. Subsequently, in the late 1980s, other evidence emerged suggesting that there might be significant differences both in Canada and in the UK.

James McSherry's review comprehensively covers the Canadian evidence, but is does not, for example, pick up the reviews from Scotland where Stuart Murray's team shows that the educational behaviour of doctors with the MRCGP differs form doctors who do not hold it.

This is a useful article and can be recommended for its value in summarizing academic evidence. However, the world has moved on and four of the 12 provinces in Canada now require

membership of the Canadian College of Family Physicians for entry to practice, and in the UK, the Joint Committee on Postgraduate Training for General Practice has, after widespread consultation, decided to introduce professionally led summative assessment for all doctors completing vocational training in September 1996. Furthermore, the Medical Act 1995 places a new emphasis on performance rather than examinations for competence, and the RCGP's new Fellowship by Assessment system is the leading quality assurance programme in the UK. It is now certain that there will be much more research and interest in the relationship between passing examinations and subsequent performance.

DENIS PEREIRA GRAY
Chairman, Joint Committee on Postgraduate Training for General Practice

Source: McSherry J. If family medicine certification is the answer, what is the question? *Can Fam Physician* 1995; **41:** 2060-2065.

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Smoking in pregnancy

THIS paper builds on previous work by Hilary Graham and others, concerned with obstacles to smoking cessation in pregnancy.

The paper reports a retrospective survey of a sample of over 5 000 women in Norway, asking about their smoking before and during pregnancy. As shown in many previous studies, smoking prevalence was highest in low socio-economic groups. Likelihood of stopping smoking during pregnancy was also lowest in these groups. Failure to stop smoking was also associated with being overburdened with work (especially housework) and with having young children. Having extra help with housework during pregnancy improved the likelihood of stopping smoking, as did (somewhat paradoxically) having full-time paid work. However, confounding these factors with measures of socio-economic status and biases in reporting smoking status make precise interpretation of the findings difficult. Nevertheless, the findings are consistent with the view that stopping smoking in pregnancy is not simply a matter of motivation but also relates to the ability to cope with work pressures.

GODFREY FOWLER
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Source: Wergeland E, Strand K, Bjerkedal T. Smoking in pregnancy: a way to cope with excessive workload? *Scand J Prim Health Care* 1996; **14:** 21-28.

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Weaning: lessons from overseas

THE median age for weaning in the mobile population of suburban areas of Bissau, the capital of Guinea, is 22.6 months. This interesting paper sets out to show that mothers' reasons for weaning babies from the breast, such as pregnancy or illness, are more important factors than independent socio-economic variables, and themselves need to be considered as affecting the impact of weaning.

Questions are raised by the articles as well as answered, despite its stringent statistical methodology. For example, how far *can* we assume that the mother retains the right to choose when to terminate breastfeeding?

Any consideration of breastfeeding in a different setting which takes personal and cultural meanings affecting breastfeeding style seriously provides a useful stimulus to extend the examination of motivations for the abandonment of breastfeeding in the UK, preferably with a more qualitative methodology which allows for an exploration of ambiguities. For example, the mothers in this study were only allowed to state one reason, in retrospect, for weaning. The main reason given for weaning, that the baby is now 'old enough' or 'healthy', as the researchers themselves point out, may mean that he or she has always been well or that weaning is taking place after a period of illness.

What relevance is there for practice here? The discussion suggests that breastfeeding campaigns should be based on what really affects weaning, not on correlations with socio-economic factors, which are less reliable as predictors, and stresses that if mother or child is ill, help is needed to continue breastfeeding.

MARY SMALE
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Source: Jakobsen MS, Sodemann M, Mølbak K, Aaby P. Reason for termination of breastfeeding and the length of breastfeeding. *Int J Epidemiol* 1996; **25:** 115-121.

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Health and exercise: not so simple!

THIS descriptive paper is intended as a 'kit bag' guide to exercise prescription for family doctors in the USA.

Translated into a model for general practice in the UK, it falls at the first hurdle. The initial stumbling block, the authors acknowledge, is the need to win the commitment of doctors, which is unlikely to be achieved by this paper. Within the framework, the 'practical strategy' ignores the workload implications and 'structural' components required before any major change can occur at practice level in the UK. The methodologies are inconsistent with current British practice, particularly in relation to needs assessment, identification of priority groups and goal setting.

Technically, the paper is flawed. Sections lack cohesion, clarity is lost by an imprecise use of 'physical activity' and 'exercise' interchangeably, and enthusiastic statements about effectiveness are unreferenced. Strangely absent from the 'readiness to change' model is the 'action stage'! Also, the paper's recommendations are unclear. While the old 'three times 20 minutes' regimen is advocated, the authors reference the *Journal of the American Medical Association's* 1995 recommendation of accumulated physical activity. Furthermore, 'heavy exercise', normally ill advised for sedentary people, is recommended.

The impacts of their interventions are unevaluated. To sceptical GPs still rejoicing in the wake of 'banding's' demise defining 'core' services and preaching 'evidence-based' medicine, the framework is mere fodder. The integration of physical activity into primary care is not 'simple', culturally or organizationally. It requires a strategic framework based on scientific evaluation and the best use of scarce resources. From this perspective, this paper is a nonrunner.

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Source: Will PM, Demico TM, George DL. Prescribing exercise for health: a simple framework for primary care. *Amer Fam Physician* 1996; **53:** 579-585.

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