Sexual Misconduct in the Health Services: Tip of the Iceberg

ABSTRACT

Medicine has been long considered a noble profession. Nobility in medicine is not obsolete; the selflessness, courage, self-sacrifice, and altruism on gallant display in the response to COVID-19 reassure that at its core, this ethic of egalitarian service remains intact and deeply established in the DNA of physicians worldwide.[1] However, a rising rate of reported sexual misconduct in the UK NHS is putting both vulnerable patients and learners at risk of long-term physical and mental harm.[2] Sexual misconduct is not only devastating for the victims, but by making the workplace unsafe for women, perpetrators make the workplace unsafe for patients.

Keywords

Sexual harassment, sexual misconduct, professionalism

RP Singh

Consultant Transplant Surgeon, Manchester

Cite as: Singh, R.P. (2024) Sexual misconduct in the health services: the tip of the iceberg. Sushruta J Health Pol vol 16: issue 1: Art 8 DOI 10.38192/16.1.8

Article Information

Submitted Jul23

Revised Feb24

Published Mar24

Introduction

Perpetrators who assault colleagues, and utter sexist or harassing language demonstrate a disregard for patient safety that is often overlooked. [3] According to a survey report in the BMJ, ''90% of women and 81% of men have witnessed some form of sexual misconduct'', and there have been "35,000 cases of sexual misconduct in NHS in five years''.[4] Vulnerable trainees have faced sexual harassment during their training, sometimes at the hands of senior surgeons who were their supervisors, although not exclusively so. According to the report: ''30% of women had been sexually assaulted by a colleague, 11% of women reported forced physical contact related to career opportunities, and at least 11 incidents of rape were reported''. Allegations of sexual assault are fundamentally criminal and need to be investigated by the police. Yet, these figures vastly underestimate the problem because systems for recording are so poor across the NHS. Trusts have wildly varying criteria for when a case is reported.

This article explores the sexual misconduct affecting staff on staff, but it recognises that similar threats can occur between staff and patients and in many situations where patients may be vulnerable from a physical and mental health perspective or incarcerated in health facilities. There is also an intersectional element to sexual assault, harassment and under-reporting which involves both staff and patients from a minority or under-represented groups.[5]

Sexual Misconduct in Healthcare Globally

Although this study was published in the UK, sexual harassment in the hospital setting may be a worldwide problem. Human predatory behaviour transcends geographical and ethnic boundaries. In 2018, the US National Academies of Science, Engineering, and Medicine identified sexual harassment as an important problem in scientific communities and medicine, finding that more than 50% of women faculty and staff and 20% to 50% of women students reportedly have encountered or experienced sexually harassing conduct in academia.[6] In a survey in the US, of the accused faculty, 98% were male, 92% targeted only females, 72% of perpetrators targeted subordinates 19% targeted clinical trainees and over half were in senior academic leadership positions.[7] In Australia, notifications regarding sexual misconduct by health professionals were less than 1% to the regulator and were more frequent for men than women, for middle-aged than younger practitioners, for rural/regional than metropolitan practitioners, and in clinical specialities characterised by longer-term one-to-one treatment relationships.[8]

The American Medical Association's Council on Ethical and Judicial Affairs recently reviewed the ethical implications of sexual or romantic relationships between physicians and patients and concluded that (1) sexual contact or a romantic relationship concurrent with the physician-patient relationship is unethical; (2) sexual contact or a romantic relationship with a former patient may be unethical under certain circumstances; (3) education on the ethical issues involved in sexual misconduct should be included throughout all levels of medical training; and (4) in the case of sexual misconduct, reporting offending colleagues is especially important.[9]

Role of the Government & Regulators

Although all physician licensees accused of sexual misconduct are entitled to the presumption of
innocence and due process, complaints made by patients must be taken seriously and vigorously pursued. [10] Women have enforceable legal rights to gender equality and freedom from sexual harassment in the workplace. An individual perpetrator may be personally liable for criminal offences, and for breaching anti-discrimination legislation, duties owed in civil law, professional standards, and codes of conduct. However, an employer may also be liable for breaching anti-discrimination legislation, workplace safety laws, duties owed in contract law, and a duty of care owed to the employee. [11] In the USA, Courts issued their opinions considering the American Medical Council's opinion about licensure disciplinary action against physicians for sexual contact with patients. In the last 5 years, the NHS spent over £4 million settling sexual misconduct-related claims.

Effective prevention requires training across all stages of a career, beginning in clinical school. Yet, there is no standardisation of sexual harassment training across the UK's public medical schools. Many future doctors will not have received relevant education when they assume posts in the NHS.[12] The regulation of health care professionals in the United Kingdom (UK) falls under the authority of one of nine General Councils, each of which has a statutory duty to ensure the fitness to practice of a subdivision of these professionals. Among the matters that may call fitness to practice into question are deviations from published standards of behaviour, which include the maintenance of appropriate sexual boundaries by practitioners. [13] While the protection of the health, safety and well-being of the public may be considered in cases involving sexual misconduct, the need to maintain public and professional confidence in their respective professions is sufficient grounds alone to end the careers of health professionals who engage in sexual misconduct.

Allegations of sexual harassment should be fast-tracked and directly administered by law enforcement bodies, with a redressal cell allowing for anonymous whistleblowing. The best way to guarantee the safety of whistle-blowers is to keep their identity anonymous. Women say they fear reporting incidents will damage their careers and they lack confidence the NHS will act. [14] Unsurprisingly, reports have also shown a lack of confidence in both

the GMC and NHS Trusts about appropriate responses to whistleblowing by women, with figures below 15% for both these authorities.

It has been argued that anonymous reporting of sexual assault holds the risk of false allegations. [15] However, the evidence suggests that it is under-reporting, not false reporting, which poses the largest problem for authorities aiming to reduce sexual assault. Provision of infrastructure and manpower should be ensured to handle the extra workload expected since such investments are well deserved and appropriate. Otherwise, we risk facing a travesty of justice where the lives of learners become permanently scarred. Often the insistence of regulatory bodies for disclosure of the name of a whistle-blower is inappropriate since the safeguard of anonymity can never be ensured. The disclosure of identity carries the inherent risk of alerting the perpetrators who in turn can exercise their influence to avoid punishment, and in surreptitious ways bring retaliatory harm to the whistle-blower. Therefore, this requirement for the victim or whistle-blower to disclose their identity is a flawed mechanism which may indemnify perpetrators.

Barriers to Reporting Sexual Misconduct

In many NHS Trusts, whistle-blowing triggers an extensive inquiry which digs out unrelated information, which ends up harming the reputation of the person reporting the concern. Such cases of 'shooting the messenger' are common since many whistle-blowers may have erred innocuously during their NHS journey, making it easy to build up a retaliatory case against them. The collateral damage may result in damage to the career of the reporting individual, which diverts attention away from the original concern raised. One of the latest glaring examples is the case of Lucy Letby where the warnings by whistle-blowers were ignored by the hospital management.[16] In the scenario of reporting sexual harassment, powerful seniors and trainee supervisors can pass subtle hints to their friendly colleagues who may know what to do next. The fear of one's anonymity being blown, and consequent reprisal serves as a strong disincentive to reporting by the vulnerable from reporting resulting in a culture of silence. It is not very encouraging to note that less than 1% of GMC reports are seriously investigated if reported anonymously.

Vulnerability to Sexual Harassment

Are rates of sexual harassment governed by socio-ethnic factors? Is the proportion of harassment similar between overseas trainees and local graduates? It will be useful to review reports to discover if there are ethnic disparities. In addition to gender, under-represented cohorts, Asian, multiracial, and LGB students seem to bear a disproportionate burden of the mistreatment reported in medical schools.[17,18] Harassment and inequality are mutually reinforcing. Failure to adequately tackle harassment contributes to perpetuating and reproducing inequality. Further, the intersectional nature of inequality has to be acknowledged and acted upon.[19] It is often more difficult for foreign graduates to climb the ladder of success in surgical training. Therefore, it is imperative to gauge whether they are more predisposed to sexual harassment due to this specific vulnerability. Foreign graduates may not be adequately familiar with the British system in their initial period in the UK and may therefore lack awareness about the whistle-blowing protocol in NHS Trusts. They could be at a heightened risk of facing sexual harassment by seniors. Thus staff disciplinary processes need to follow a process more akin to civil justice than criminal justice, thus ensuring that the process accords equal rights to complainants and respondents. [20]

Education to Combat Sexual Harassment

Medical ethics in the medical curriculum must be included not as a normative discipline but as a practical course with its problems and considerations. [21] According to the archives on Sushruta and Charak Samhita, before any medical training was imparted to pupils in ancient India, there was a significant incubation period devoted to teaching ethical and moral principles. A medical competency framework was written and implemented more than two thousand years ago. The framework identified key competencies

including Medical expertise, Communication skills, Scholar, Health Advocacy and Professionalism.[22] These were presented in the form of formal documents incorporated into the framework of training programs. Although the medical faculty of that time in India, as well as other civilisations, was male-dominated, this example highlights the importance of educating medical practitioners about appropriate behaviour with vulnerable patients and trainees under their care.

Therefore, medical education programs must incorporate such curriculum which includes a didactic portion consisting of lectures on the definitions, causes and consequences of physician-patient sexual misconduct and teacher-learner mistreatment and harassment and role-play of scenarios and reporting processes. [23]

Conclusion

Strong regulation, strengthening of professionalism, preventative education, awareness of factors of intersectionality, power imbalance and reinforcement of civil standards for providing protection, a degree of anonymity and early involvement of law enforcement agencies would help tackle the scourge of sexual misconduct in the medical profession. There is value in deriving strength from both ancient and modern ethical principles.

1. Yancy, C. W. Academic Medicine and Black Lives Matter: Time for Deep Listening. *JAMA* **324**, 435–436 (2020).
2. Luepker, E. T. Effects of Practitioners' Sexual Misconduct: A Follow-Up Study. *J Am Acad Psychiatry Law* **27**, (1999).
3. Bagenal, J. & Baxter, N. Sexual misconduct in medicine must end. *The Lancet* **399**, 1030–1032 (2022).
4. Torjesen, I. & Waters, A. Medical colleges and unions call for inquiry over "shocking" levels of sexual assault in the NHS. *BMJ* **381**, p1105 (2023).
5. Ali, N., Butt, J. & Phillips, M. Improving responses to the sexual abuse of Black, Asian and minority ethnic children.
6. King, P. A., Chaudhry, H. J. & Staz, M. L. State Medical Board Recommendations for Stronger Approaches to Sexual Misconduct by Physicians. *JAMA* **325**, 1609–1610 (2021).
7. Espinoza, M. & Hsiehchen, D. Characteristics of Faculty Accused of Academic Sexual Misconduct in the Biomedical and Health Sciences. *JAMA* **323**, 1503–1505 (2020).
8. Bismark, M. M. *et al.* Sexual misconduct by health professionals in Australia, 2011–2016: a retrospective analysis of notifications to health regulators. *Med. J. Aust.* **213**, 218–224 (2020).
9. McMurray, R. J. *et al.* Sexual Misconduct in the Practice of Medicine. *JAMA* **266**, 2741–2745 (1991).
10. Sindhu, K. K., Schaffer, A. C., Cohen, I. G., Allensworth, R. H. & Adashi, E. Y. Honoring the public trust: curbing the bane of physician sexual misconduct. *J. Law Biosci.* **9**, lsac007 (2022).
11. Mathews, B. & Bismark, M. M. Sexual harassment in the medical profession: legal and ethical responsibilities. *Med. J. Aust.* **203**, 189–192 (2015).
12. Dowling, T. & Steele, S. Is sexual misconduct training sufficient in the UK's medical schools: Results of a cross-sectional survey and opportunities for improvement. *JRSM Open* **14**, 20542704231198732 (2023).
13. Gallagher, C. T. *et al.* Disciplinary Action Against UK Health Professionals for Sexual Misconduct: A Matter of Reputational Damage or Public Safety? *J. Med. Regul.* **107**, 7–16 (2022).
14. Wolfe, S., Worth, M., Dreyfus, S. & Brown, A. J. *Breaking the Silence: Strengths and Weaknesses in G20 Whistleblower Protection Laws*. https://apo.org.au/node/41246 (2014).
15. Providing anonymity to those accused of rape: An assessment of evidence.
16. Whistleblowing In The Lucy Letby Case | Hatton James Legal. https://www.hattonjameslegal.co.uk/whistleblowing-in-the-lucy-letby-case/ (2023).
17. Hill, K. A. *et al.* Assessment of the Prevalence of Medical Student Mistreatment by Sex, Race/Ethnicity, and Sexual Orientation. *JAMA Intern. Med.* **180**, 653–665 (2020).
18. McClain, T., Kammer-Kerwick, M., Wood, L., Temple, J. R. & Busch-Armendariz, N.

Sexual Harassment Among Medical Students: Prevalence, Prediction, and Correlated Outcomes. *Workplace Health Saf.* **69**, 257–267 (2021).
19. Täuber, S., Loyens, K., Oertelt-Prigione, S. & Kubbe, I. Harassment as a consequence and cause of inequality in academia: A narrative review. *eClinicalMedicine* **49**, (2022).
20. Bull, A., Calvert-Lee, G. & Page, T. Discrimination in the complaints process: introducing the sector guidance to address staff sexual misconduct in UK higher education. *Perspect. Policy Pract. High. Educ.* **25**, 72–77 (2021).
21. Charaka, A. Rashmi Tiwari & Nitesh Gupta: Ancient Medical Ethics And Present Scenario. **4**, (2016).
22. Choudhary, A. The fully equipped physician: An ancient Indian competency framework. *J. Fam. Med. Prim. Care* **12**, 4–9 (2023).
23. Robinson, G. E. & Stewart, D. E. A curriculum on physician-patient sexual misconduct and teacher-learner mistreatment. Part 1: content. *CMAJ Can. Med. Assoc. J.* **154**, 643–649 (1996).