SURVIVING HEALTHCARE: SEXISM AND SEXUAL VIOLENCE IN THE HEALTHCARE WORKFORCE

SURVIVING IN SCRUBS
Tackling misogyny in healthcare

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Conflict of Interest
There are no conflicts of interest to declare.

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Intersectionality
In writing this report we recognise that sexual violence should be tackled via an intersectional lens. It is important to recognise that people who live at the intersection of multiple identities experience sexual violence at higher rates. The healthcare community is diverse and in order to tackle sexual violence we must recognise this in supporting those who are affected and implementing measures to end sexual violence.

The views expressed in this report are from Surviving in Scrubs and do not represent those of any other healthcare or research organisation.

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SURVIVOR STATEMENT

“Being repeatedly seriously sexually assaulted at work was traumatic, but the trauma caused by years of investigations and processes was arguably worse. The assaults were like the workplace equivalent of domestic abuse; increasingly feeling unsafe and later able to recognise how the perpetrator subtly and cleverly exploited my emotions and vulnerability. I was all too aware of the “risks” in reporting, knowing victims are often further victimised and re-traumatised. It was impossible to see a good outcome once the assaults had occurred. Some said I was brave for reporting, but I was broken and felt forced to choose the least bad option.

The toll taken by processes was far worse than my worst-case scenario. 4 months of internal Trust investigations, 16 months of police investigations and many months of GMC investigations. Erstwhile a target for further harassment and intimidation. I repeatedly relived the trauma and had my own professionalism and honesty questioned. By claiming these unwitnessed assaults were consensual created a “he said – she said” scenario leaving me feeling I was on trial. I felt silenced to protect the integrity of investigations. It was a long, lonely, and isolating journey.

I have been diagnosed and treated for PTSD, but psychological support was never offered and repeatedly denied. Without my own knowledge, resources and personal support, the outcome could have been very different. I realise now how important it is to address sexual misconduct early. It deeply saddens me how many of us missed the opportunity to address the perpetrator’s inappropriate comments and behaviours which ultimately caused so much harm to so many, including indirectly on patients.

Everyone is entitled to feel safe at work, yet hearing and reading the stories of others confirms that this is not the case for far too many and the effects ripple more widely. Whilst realistically it may not be possible to completely eradicate these behaviours, cultures and processes can be improved and victims supported and empowered. Organisations can promote good professional behaviours and psychologically safe workspaces. The threshold for action has to be set earlier than where most policies kick in, as soon as behaviours fall below an acceptable standard. We need to work collectively to provide environments which promote safety for everyone, to enable the best possible care to be delivered.”

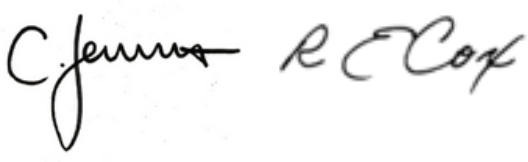
FOREWORD

We would like to thank every individual who has submitted their experiences to our website. We appreciate that the retelling of traumatic experiences can evoke painful emotions, flashbacks and in some cases a reliving of that trauma. We know that talking about being a survivor of sexism, misogyny, sexual harassment or sexual assault is not easy, but even when speaking up the voices of the survivor is not always heard. We want to let you know that we hear you, we see you and it is because of your testimony, your voice, that we have been able to compile this report.

This report demonstrates the scale of sexual misconduct in the healthcare workforce, as well as the impact on the survivors, difficulties with reporting and the culture of tolerance that permeates the healthcare workforce. This is an issue that affects everyone working in healthcare, and this report brings together the experiences of workers from different disciplines, professions, levels of seniority and locations around the UK. This report offers a broad representation of what is happening, rather than limiting the conversation to a particular professional group.

It was our aim when starting the Surviving in Scrubs campaign, to bring about a positive change for the whole of healthcare, and we hope that this report is the start of that aim coming to fruition.

We have drawn together key themes from the testimonies submitted on our website which apply to all staff groups. As such we want to see all healthcare organisations pay attention and really listen to our recommendations. It is imperative that those in positions of power listen to the voices of survivors, because it is through this dialogue that we will bring about a clear cultural shift, where sexual misconduct is no longer tolerated and perpetrators are held to account.



Dr Chelcie Jewitt and Dr Becky Cox

EXECUTIVE SUMMARY

Surviving in Scrubs was set up to raise awareness and campaign against sexism, sexual harassment and sexual assault within the UK healthcare workforce. The conversations and research relating to these issues had not been broadened to include colleague-to-colleague incidents amongst the whole healthcare workforce prior to this campaign. The creators of the campaign – Dr Becky Cox and Dr Chelcie Jewitt – both have lived experience of sexual violence perpetrated by healthcare worker colleagues, and wanted to amplify the voices of survivors that were not being heard.

At the core of this campaign is the website – www.survivinginscrubs.co.uk – where anyone who works in healthcare, irrespective of profession, specialty, location or seniority can anonymously submit their testimonies of sexual misconduct perpetrated by a colleague. The main focus of the campaign is to gather and use the collective narrative of survivor stories as evidence to campaign for change from healthcare organisations including the NHS, medical colleges and associations, healthcare regulators and healthcare universities.

What is this a report of?

This report is the first analysis of stories submitted anonymously to the Surviving in Scrubs website. It is an analysis of 150 stories, detailing 174 incidents of sexism, sexual harassment and sexual assault occurring colleague to colleague within the healthcare workforce.

Why is this report needed?

The findings of this report contribute to the wider understanding of the experiences and impact of sexism, sexual harassment and sexual assault in the healthcare workforce. The prevalence of these issues and behaviours are of national public interest as the NHS is not only the largest employer in the UK, but it comes into contact with every member of the UK population at some point in their lifetime. We need to realise the scale and understand the impact on staff and on patients.

What are the key findings?

1.The findings evidence **systematic and institutional** sexism and sexual violence within healthcare in the healthcare workforce.

2.The stories describe the **significant power imbalance** between powerful senior male staff perpetrating sexual violence to junior female staff members in healthcare, in a normalised culture of sexism, entitlement, and the devaluing of women staff.

3.Perpetrators of sexual violence are described as being **well known**, acting within a **culture of tolerance**, while survivors struggle to raise concerns and face enduring impacts on their wellbeing and careers.

4.Institutional sexism leads to survivors describing experiences of **maternity and reproductive discrimination**, reduced pay and lost training and career opportunities.

5.Aspects of the **environment unique to healthcare** were reported in the stories with perpetrators using one on one clinical environments, clinical skills training and patient care as settings for sexual assault.

6.The **resulting risk to patient care** was documented as women healthcare workers reported their clinical judgements questioned, decisions not taken seriously, clinical requests being ignored, and referrals being refused.

Who are the survivors?

- Nurses, doctors, paramedics, psychologists, administrators, dentists, carers, optometrists, pharmacists, managers, healthcare assistants and healthcare students were survivors in the stories analysed.

- **62.3%** were doctors and **8.38%** were nurses. **11.9%** were healthcare students including nursing, paramedic and medical students.

- Of the doctors who documented their grade **88.8%** identified themselves as junior doctors.

Who are the perpetrators?

- **76.1%** of perpetrators were doctors, **7.4%** were nurses, and **5.5%** were managers.

Of the doctors who were perpetrators **77.6%** were consultants.

What incidents were there?

- **42.3%** of incidents included sexual harassment and **36.8%** included sexism, **20.6%** of incidents involved sexual assault, **1.9%** rape.

Where is this happening?

- **50%** of incidents occurred in patient facing environments including hospital wards, theatre, and clinics.

What Survivors Want

Survivors tell us they wish to feel safe to work in a healthcare environment free from sexist discrimination and sexual violence. Prevention of these behaviours is our definitive aim. However, whilst these behaviours still occur, survivors wish to be listened to and to be believed. They urgently need access to a sensitive and safe pathway to report sexual violence that can be anonymous if they wish, to continue to work without the risk of losing their job or future career, and to receive specialist accessible support.

To this end, we recommend the following action to ensure that survivors are safe at work:

1.**Education** on sexism and sexual misconduct for all staff in healthcare including students, with a focus on responding to reports of sexual violence for managers, culture change, allyship and preventing sexual misconduct.

2.**Research** into the impact of sexism and sexual violence on the workforce via an intersectional lens and development of evidence based interventions to address the culture of sexism and prevent sexual violence.

3.An **independent inquiry** into the culture of sexism and sexual misconduct in healthcare.

4.Improved support for survivors, with access to specialist sexual violence support from independent sexual violence advocates provided by healthcare employers.

5.A **review of current policy** and past cases by healthcare employers to improve internal processes.

6.**Introduction of specialist sexism and sexual misconduct policies**, separated from other workforce policies, available in every healthcare employer.

7.An **independent anonymous reporting system** available across the NHS.

8.**Reform from healthcare regulators** to reduce the number of cases dropped before investigation and improved psychological safety measures for witnesses during the investigation and tribunal processes.

9.**A system to improve communication** between healthcare employers, regulators, and the police. Mandatory reporting from the employer to healthcare regulator should be introduced for cases of sexual harassment and assault.

BACKGROUND

In 2021 the British Medical Association (BMA) published their report on Sexism in Medicine. This documented the findings of a survey of nearly 2,500 UK NHS doctors. Shockingly, 91% of female doctor respondents had experienced some form of sexism, with 56% experiencing unwanted verbal conduct, and 31% experiencing unwanted physical conduct (1). The recent report from the Working Party of Sexual Misconduct in Surgery found that almost 1/3 of female surgeons have been sexually assaulted at work (2). This is not only a problem for doctors – a Unison survey from 2019 demonstrated that 8% of the 8487 allied health professions who responded had been sexually harassed in 2017-2019, and in 2021 the Nursing Times published the findings of a survey reporting that 60% of nurses who responded had experienced sexual harassment at work (3,4).

Though data is limited, similar figures are repeated on an international level. In 2015, the Royal Australasian College of Surgery reported 30% of female surgeons have experienced harassment at work, and in 2020, the US residency survey reported 19.9% of female surgical trainees had been sexually harassed (5,6).

These numbers demonstrate a huge issue facing the healthcare workforce. There are potential ramifications for staff and patient well-being and safety. The human costs of these experiences warrant urgent consideration and include guilt, shame, loss of professional identity, mental health issues and wanting to leave their profession (3).

Surviving in Scrubs was set up in 2022 in order to amplify the human experience of the survivors of sexual misconduct within healthcare, through the collective narrative of anonymous survivor testimonies submitted to our website (7). Using the voices of survivors we have been able to highlight the issue of sexual misconduct in healthcare on a national and international stage, advocate for victims, and campaign for psychologically safe reporting processes and other impactful policy changes.

We have compiled this report as a written contribution to the evidence base surrounding these issues of sexual misconduct and to ensure that the testimony we have gathered will be utilised to enable real change. The resulting actions from healthcare employers and organisations must address the real-world issues presented by survivors. We want to offer insights that can be harnessed to support a sustained positive transformation to the damaging culture of sexual misconduct which is prevalent throughout healthcare.

Aim

In compiling this report, we want to share what we have heard about people's experience of sexual misconduct, including where, and how this can happen, experiences of seeking support and raising concerns in healthcare settings and about the impacts these experiences can have on healthcare staff. We will report on what we have heard about where and in what context these experiences occur, and consider the settings and types of sexual violence encountered.

METHODS

To compile this report, we have collated and summarised the experiences recounted in 150 stories describing sexism, sexual harassment and sexual assault within the healthcare workforce submitted to the Surviving in Scrubs website anonymously between 2022 and 2023 (7). The stories are submitted voluntarily by survivors and recount incidents of these behaviours, challenges faced and the impact.

They are freely available to view at https://www.survivinginscrubs.co.uk/your-stories/
Stories were included if they contained descriptions of sexism, sexual harassment or sexual assault including rape, perpetrated within the healthcare workforce colleague to colleague.

Sexism was defined as treating an individual less favourably due to their sex such as prejudice, stereotyping or discrimination (8).

Sexual harassment was defined as unwanted conduct of a sexual nature, which has the purpose or effect of either: (a) violating the complainant's dignity; or (b) creating an intimidating, hostile, degrading, humiliating or offensive environment for the complainant (8).

Sexual assault was defined as one person intentionally touches another person sexually without their consent. The touching can be done with any part of the body or with an object, Sexual Offences Act 2003(9).

Rape was defined as a person using their penis without consent to penetrate the vagina, mouth, or anus of another person. Assault by penetration when a person intentionally penetrates the vagina or anus of another person with any part of their body or an object without that person's consent, Sexual Offences Act 2003 (9).

Survivors were defined as anyone who has experienced sexism, sexual harassment or sexual assault working in the healthcare workforce. Survivors were of any healthcare profession including doctors, nurses, allied healthcare staff and administrative staff. Healthcare students were also included. Perpetrators were any healthcare staff who were documented to have committed these behaviours.

All genders were included. We do not have a mandatory requirement for survivors to submit data on their ethnicity, sexuality or disability. We have a few stories where this information was given but were unable to analyse these due to the small number. In future we plan to collect this data so that we can produce evidence of intersectional experiences of sexual violence within healthcare and subsequently provide specialist recommendations.

Stories were included in which the incident occurred in any healthcare related environment including: community and secondary care clinical environments, clinical education, conferences, digital media, and out of work events such as parties. All stories described experiences in the UK healthcare system.

Stories that detailed sexism or sexual violence perpetrated by patients are not included in this report.

FINDINGS

Between 2022 and 2023, 150 anonymous accounts of sexual misconduct in UK healthcare settings were posted to the Surviving in Scrubs website. These stories are reflected here, within this summary report. They represent 174 different incidents.

The themes identified through our review of these survivor accounts are summarised in Figure 1, which maps how they interact with each other, and are described below:

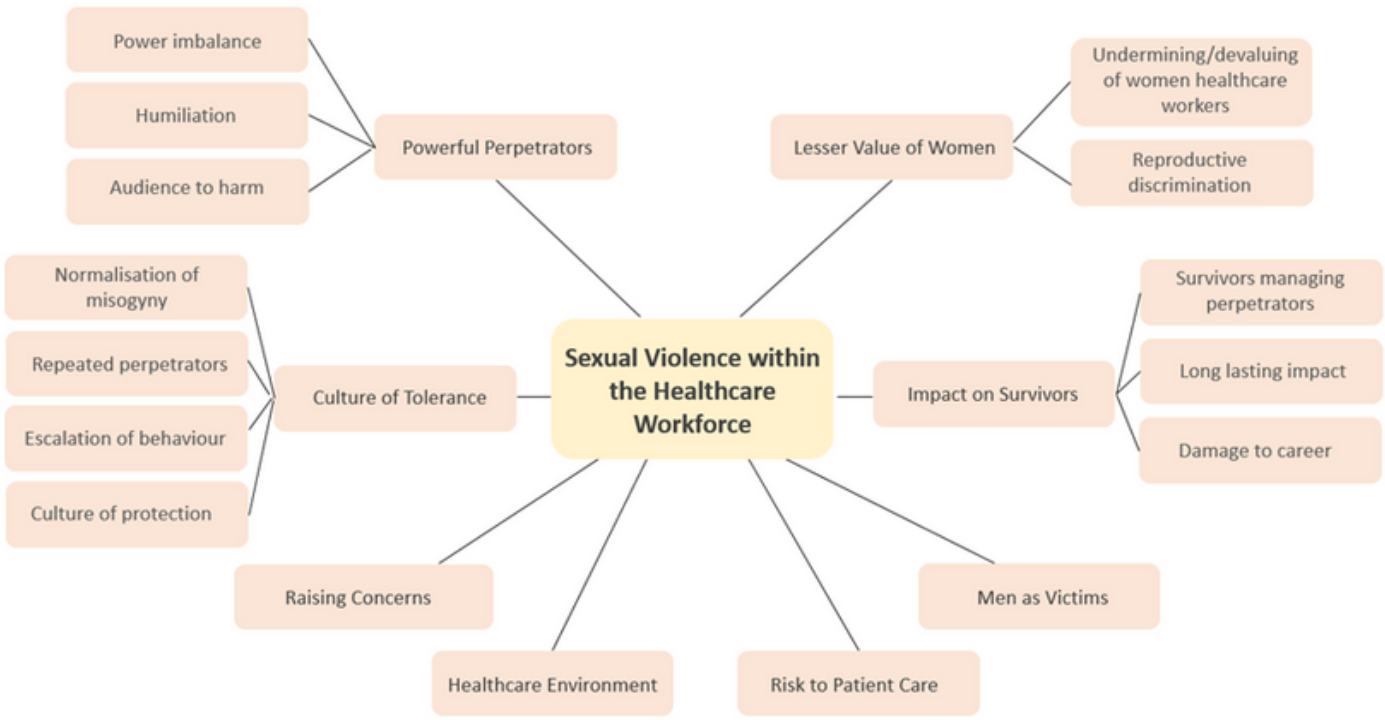


Figure 1. Map of codes and themes.

Powerful Perpetrators

Multiple stories demonstrated how the power imbalance inherent within medical hierarchies intersected with experiences of sexism and sexual misconduct. For example, consultants targeting junior colleagues such as foundation doctors or medical students. Survivors described feeling vulnerable, too junior to say anything, and under pressure from senior male superiority.

Survivors described their experiences of senior staff exploiting trust to abuse junior staff and their perspectives on the potential for a sense of entitlement for seniors to behave this way. In some accounts harassment was across professional groups, including descriptions of male nurses targeting female junior doctors.

Humiliation was described as a tool which could be used to emphasise power dynamics. Multiple stories described experiences of feeling ridiculed in front of the team during case presentations, ward rounds or during education sessions in front of peers. That these experiences happen in open spaces suggests the normalisation of these interactions in some healthcare settings. There were accounts that recount experiences of patients being offered the opportunity to become involved in the dialogue by perpetrators, which was experienced as further victimisation by the survivor:

"I was doing ward rounds with my registrar (senior) who, to male patients on the ward would gesture to me and say "don't we have a pretty female doctor with us today". Needless to say I found the rounds awkward, and felt objectified not only by the registrar, but also the patients who he was inviting to 'check me out' with."

Culture of Tolerance

The stories depict an embedded and normalised culture of misogyny within healthcare, including descriptions of frequently overheard banter making light of women in the workplace or using sexist language for entertainment. One story describes a junior male team member having to demonstrate sexist behaviour to be accepted (initiated) into their clinical team. One survivor commented on a sense of 'hypermasculinity' in the ambulance service, which they saw as valuing a male hero culture. Another survivor described a cycle of abuse with male medical students encouraged to take part in sexist behaviour. One survivor towards the end of her career describes how entrenched and normalised expectation of behaviours for colleagues could become, with decades of sexist behaviour remaining unchanged.

Multiple stories describe known perpetrators working unchallenged within the healthcare environment. The stories describe multiple victims with repetitive behaviour described as common knowledge and becoming routine. One survivor referred to a perpetrator as the "Jimmy Saville of the surgical community".

"On talking to another female senior, I was informed that he was known for this behaviour, that he'd got away with so much before and he was capable of ruining careers."

Alongside these accounts of repeated behaviours, some stories describe escalating behaviour, with progression from sexist comments such as innuendo intensifying to sexual assault.

Stories describe these behaviours as often occurring without challenge. Colleagues are described as remaining silent, and in some cases protecting or colluding with the perpetrator. Individuals are perceived as acting with impunity, with one survivor describing a consultant perpetrator as untouchable. Survivors described feeling gaslit by colleagues, including incidents being diminished, laughed off, forgotten or denied.

Lesser Value of Women

"I don't need you in the department but I need him."

We heard accounts of women healthcare workers perspectives that they felt they were predominantly valued for their appearance rather than their knowledge and skills. They recount how when they are successful, that their achievements are put down to being favoured because of their looks or sexual value.

Others describe their sense of being looked over, belittled, and sexualised. We heard exemplars of being exposed to degrading and derogatory language, including comments about female staff member's bodies, intrusive questions about sex life and sexual propositioning. One survivor recalled being sexually propositioned by a male consultant who was covered in a female patient's blood at the end of surgery.

At the start of their careers as students and juniors, survivors described being encouraged to work in specialties considered family friendly such as general practice or paediatrics. Survivors describe their experience of assumptions that they were of a lower seniority than they were because of being female. Others include assumptions about professional role, such as female doctors being called nurse. Survivors describe being assumed to have inferior clinical knowledge and skills, or having their clinical decisions questioned. Furthermore survivors reported being told they were "not worth training" and are "easily replaceable". Women survivors describe being assigned feminised duties such as making the tea, tidying up, and administrative tasks in lieu of valuable learning opportunities or clinical experiences when compared with male colleagues.

Another area of gendered exploitation was in the context of women's reproductive and maternity rights.

"As a GP trainee I was told almost every week "we don't employ women of child bearing age"... This stayed with me & I locumed for 9 sessions per week up to 39 weeks with my first baby as I felt so unworthy & unjustifiable to have maternity pay & leave- after hearing these comments."

We heard accounts of how these rights were experienced as challenged or disregarded. This included examples of women not being hired in case they have children, pregnancy used as an opportunity to discriminate against women, being refused workplace adjustments due to pregnancy, and the expectation they will leave the workplace once they have children. One survivor said she felt she was made to feel she could not be a mother and a doctor. Other survivors documented that once they had children they felt their commitment and ability to work was questioned, being reminded by seniors of the negative impact of having children on their careers. One survivor commented that her male doctor partner had never been questioned about his family plans.

Impact on Survivors

"I was punished for someone else's poor behaviour, I had to stop working in an area where I had 10 years specialist expertise."

Survivors described the wider and enduring impact of sexism and sexual violence on their careers beyond the immediate experience. They described the presence of a gender pay gap, with one survivor describing being replaced by an equivalent male colleague paid more to do the same work. They documented losing training opportunities, for example with male surgical trainees given more opportunities to attend theatre than women trainees. They described being less likely to be offered senior positions, fewer academic opportunities and being less likely to receive awards for equivalent work.

Survivors who had experienced sexual harassment or violence reported having to protect their careers, ignoring incidents and continuing their work. They described fearing repercussions with one survivor being told not to say anything that could affect her career and another described threats to her career from the perpetrator.

Survivors reported having to prioritise clinical work over their own wellbeing, describing a sense of duty and responsibility even immediately after an incident.

Stories documented being asked for sexual favours in return for career advancement. One paramedic recalled being asked for nude photographs by her supervisor in return for passing a placement.

Within the stories, there are accounts of the tactics which survivors used at work to protect themselves. Women described changing their outfits to hide their body, avoiding known perpetrators, and warning new colleagues about perpetrators.

Many of the accounts document the tolls these experiences have led to. There were accounts of survivors struggling with their mental health, taking time off work, chronic health problems, and the impact on their families. Survivors documented being redeployed, changing training job, resigning from their job or in some cases leaving the NHS. Some survivors contrasted this against their experience of the perpetrator keeping their job.

Healthcare Environment

Some aspects of the environment where these incidents and experiences occurred were unique to healthcare. For example, testimonies described sexual assault occurring in settings where lone working or one on one working is commonplace, such as paramedics working on shift in an ambulance together or doctors in an office working late shifts. A paramedic student described feeling vulnerable working one on one with their supervisor in an ambulance cab for 12 hour shifts over long periods of placement. She described being “trapped in a tin box” with her perpetrator. Junior healthcare staff described feeling vulnerable because of frequent job rotations in unfamiliar work environments. Stories documented survivors feeling vulnerable at work events such as conferences, courses, and work parties describing blurred boundaries and the impact of alcohol.

Some of the settings unique to healthcare were identified as creating potential opportunities for sexual assault, for example when teaching physical examinations. A medical student described one of her breasts being touched by a consultant teaching cardiology examinations and another student described being subject to sexually inappropriate comments during the demonstration of eye examinations. Clinical care was also a potential mechanism for sexual assault with a female surgeon describing her breasts being touched by a colleague during an operation. Another frequent example was being sexually assaulted while being scrubbed in for an operation when victims were unable to use their hands to protect themselves or move away from the perpetrator.

Raising Concerns

The stories detail the barriers and challenges of raising a concern following an incident.

“I could never raise this at work without being the problem myself.”

Survivors described feeling fearful, concerned about the risk to their career, humiliation, and repercussions from the perpetrator and their peers. This could be heightened when the perpetrator was in a position of authority or seniority, for example their line manager or supervisor, which is frequently described in the stories. In several stories threats are described from the perpetrator.

Survivors worry that they are going to be made to be the problem instead. Survivors describe feeling that ranks closed around them to protect perpetrators. Survivors describe not knowing who to report to or what the process is, seeing other complaints being handled poorly and fearing they will not be believed.

"It's just him."

During accounts of the process of raising a concern, survivors describe being told not to make a fuss, being advised against making a complaint by human resources and seniors, normalisation of the perpetrator's behaviour and dismissal. One survivor described a manager staying staff on staff abuse is not a patient care issue and no further action being taken.

"The implication is we should put up and shut up."

In instances where investigations were opened survivors describe feeling that they were being investigated rather than the perpetrator. They described further feelings of dismissal, sexist judgements, and feeling isolated. They described experiences of a lack of external investigation, leading to colleagues within the same hospital investigating the case. Survivors also described concerns about the failures of the healthcare regulators to investigate. The lack of support provided by the employer was highlighted in several stories. Survivors also reported outcomes were insufficient, such as a perpetrator of sexual assault being sent on an equality, diversity and inclusion e-learning course.

Men as Victims

The experience of receiving sexist comments, sexual harassment and assault were also reported by male survivors. Stories submitted by male survivors described being subject to sexist comments from groups of women about their bodies, sex lives, and personal lives. One male student nurse survivor described being sexually harassed and groped by female student nurses when training. He described feeling intimidated and uncomfortable but wrote "as a man, we just have to laugh it off".

Sexist comments were described about men working as nurses and healthcare assistants. A male healthcare assistant was told:

"A man has no place doing this job."

Risk to Patient Care

Stories documented the impact of sexist beliefs on patient care. Women healthcare workers reported their clinical judgements questioned, decisions not taken seriously, clinical requests being ignored or overly criticised and referrals being refused. Survivors reported requests from male colleagues were more respected. One senior female doctor described her clinical plan being questioned by a male newly qualified doctor.

One story described an obstetric and gynaecology consultant pausing operations on women to ask students inappropriate questions.

"I had a gynaecology consultant who would ask medical students what the purpose of a vagina was, and repeatedly stopped operations until he got the answer he wanted - that their only purpose was for sex."

From the 150 stories we looked at, 174 incidents of sexism, sexual harassment and assault were reported. The following are a descriptive summary of the survivors, perpetrators and incidents from the stories and contribute to the main findings above. These are a summary of factors from the stories freely submitted to our website. We cannot and do not make any claim that these numbers are representative of the wider workforce or population.

Survivors

167 (96%) of survivors were female with 7 (4%) male. There were no trans or non-binary survivors documented.

A range of healthcare worker professions were represented in the stories as shown in the table. 62.3% (n=104) were doctors. 8.38% (n=14) were nurses. 11.9% (n=20) were healthcare students including nursing, paramedic and medical students.

Profession	Number	Percentage
ACP	1	0.60%
administrator	4	2.40%
carer	2	1.20%
clinical psychologist	6	3.59%
dentist	3	1.80%
doctor	104	62.28%
HCA	3	1.80%
manager	1	0.60%
medical student	16	9.58%
nurse	14	8.38%
optometrist	1	0.60%
paramedic	3	1.80%
pharmacist	5	2.99%
student nurse	3	1.80%
student paramedic	1	0.60%
Total	167	100.00%

Table 1. Table of survivor profession.

Of the doctors who documented their grade 88.8% (n=79) identified themselves as junior doctors (registrars, senior house officers, GP trainees, and foundation year doctors). 8.9% (n=8) were consultants and 2.3% (n=2) were GPs.

At the time of the incident 33.5% (n=49) of survivors were working in surgical specialties, 16.4% (n=24) were working in the general medical specialities, 10.9% (n=16) in psychiatry, 8.9% (n=13) emergency medicine, and 7.5% (n=11) in general practice.

Perpetrators

93.1% (n=149) of perpetrators were male and 6.9% (n=11) were female. There were no perpetrators of any other gender documented.

76.1% (n=124) of perpetrators were doctors, 7.4% (n=12) were nurses, and 5.5% (n=9) were managers.

Of the nursing perpetrators 4 were senior nursing staff at charge nurse and matron level.

Of the doctors who were perpetrators 77.6% (n=90) were consultants, 4.3% (n=5) were GPs, and 11.2% (n=13) were registrars. 5.2% (n=6) were senior house officers and 1.7% (n=2) were foundation year doctors.

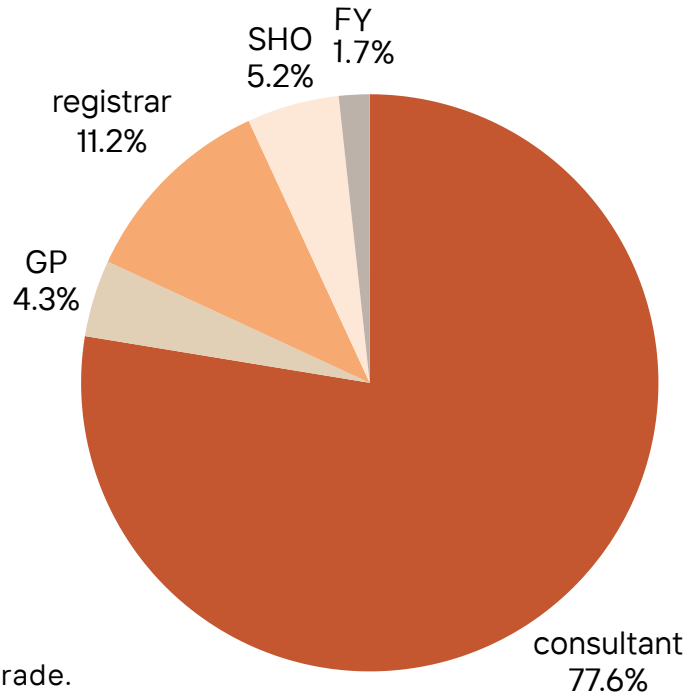


Figure 2. Chart of medical perpetrator grade.

Perpetrator specialty	Number	Percentage
ambulance service	**4**	**4.55%**
anaesthetics	**2**	**2.27%**
emergency medicine	**10**	**11.36%**
general practice	**5**	**5.68%**
ICU	**5**	**5.68%**
obstetrics and gynaecology	**6**	**6.82%**
ophthalmology	**1**	**1.14%**
psychiatry	**2**	**2.27%**
radiology	**2**	**2.27%**
Surgery Composite	**43**	**48.86%**
surgery	30	34.09%
urology	1	1.14%
vascular surgery	1	1.14%
general surgery	3	3.41%
cardiothorasic surgery	2	2.27%
breast surgery	1	1.14%
orthopaedics	5	5.68%
General Medicine Composite	**8**	**9.09%**
cardiology	3	3.41%
general medicine	4	4.55%
stroke	1	1.14%
Total	88	100.00%

Table 3. Table of Perpetrator Specialty, all professions.

Of the doctors who were perpetrators 51.8% (n=43) worked in the surgical specialties. 12.1% (n=10) worked in emergency medicine, 9.6% (n=8) in the general medicine specialties, 7.2% (n=6) in obstetrics and gynaecology and 6.0% (n=5) in general practice.

Male Survivors

Of the male survivors two were doctors, one of which was sexually harassed by multiple team members and the other was sexually harassed by a male consultant. The other 5 male victims were nursing staff sexually harassed and assaulted by one or more female nursing staff.

Type of Incident

Incident Type	Number	Percentage
Sexual Harassment Composite	**89**	**42.58%**
Career opportunities for sexual activity	3	1.44%
Intrusive questions about personal or sex life	1	0.48%
Intrusive questions about sex life	7	3.35%
Predatory behaviour	2	0.96%
Sexualised jokes	12	5.74%
Sexualised staring	1	0.48%
Stalking behaviours	4	1.91%
Uninvited comments on body	18	8.61%
Unspecified sexual harassment	4	1.91%
Unwanted or sexualised emails, messaging	3	1.44%
Unwanted sexual advances or flirting	16	7.66%
Unwanted/sexual or physical advances	1	0.48%
Unwanted/sexual talk	17	8.13%
Sexual Assault Composite	**43**	**20.57%**
Attempted sexual assault	1	0.48%
Touching exc genitals and breasts	27	12.92%
Touching inc genital and breasts	8	3.83%
Unspecified touching	3	1.44%
Rape	4	1.91%
Sexism	**77**	**36.84%**
Total	209	100.00%

Table 3. Table of Incident Type

42.6% (n=89) of incidents included sexual harassment and 36.8% (n=77) included sexism, 20.6% (n=43) of incidents involved sexual assault and 1.9% (n=4) rape. The total number is higher than the number of incidents as many incidents contained more than one of these behaviours.

Setting of Incident

50% (n=59) of incidents occurred in patient facing environments including hospital wards, theatre, and clinics. 9.3% (n=11) occurred in doctor's offices.

DISCUSSION

The findings of this report contribute to the wider understanding into the experiences and impact of sexism, sexual harassment and sexual assault in the healthcare workforce, where there is little existing evidence.

These challenges are contextualised within a wider pattern of lower pay and worse career progression for women. In the UK 36% of consultants are women, despite 47% of doctors in the UK being women (10). Women make up only 40% of the paramedic workforce. Despite more women working in nursing, male nurses make up a higher proportion in the higher paid bands and take a shorter time to advance to those higher paid roles (11). Women are more likely to make up the lowest pay bracket with 74 per cent of band 1 staff being women (10). The gender pay gap for senior doctors is 18.9% for hospital consultants and 15.3% for GPs (12).

Male dominance and superiority within healthcare is introduced to newer generations through sexist humour and the devaluing of women, which is initiated from student level onwards. At the same time female healthcare students are introduced to this culture setting the standards for their place in healthcare for the future (13). Men are favoured for real term career progression, being offered time in theatre, research projects and leadership roles. With women being encouraged to take on feminised duties and work in family friendly specialties.

We highlight evidence from other settings that show how cultures of widespread low level misogyny lead to the permissive development of escalating sexual harassment tipping into sexual violence and assault. (14).

While there has been a focus on surgical specialties, which is also reflected in the narratives submitted to our website, these behaviours are likely to be seen across all healthcare settings. However, the experiences of sexism may differ in other settings. Stories from general practice frequently describe widespread benevolent sexism. Women are referred to as the ‘nice lady doctor’, and as a result assigned patients with more mental health, social and complex health needs leading to a higher workload and longer hours (15). Alongside being subject to lower pay, sex and maternity discrimination, and sexual misconduct (16). One important factor to note is that GP surgeries are small businesses without human resources departments. Victims can only report to the senior partners or practice manager who are likely to be the perpetrator or work closely with them. There is no system for reporting beyond the surgery itself.

There is no universal reporting system for sexism and sexual misconduct in healthcare. In our website stories, survivors describe not knowing how to report or who to report to alongside distrust of their employer to act effectively and supportively. Very few hospital trusts have a sexual misconduct policy. A Freedom of Information request to hospital trusts by The Guardian newspaper in 2023 less than 10% of respondents had a sexual safety policy (17). Healthcare employers do not have a mandatory requirement to report cases to healthcare regulators. The GMC told us they receive fewer cases than they expect as they believe trusts attempt to deal with cases within their own organisations.

As an organisation, we have heard repeated concerns from survivors about the effectiveness of the healthcare regulators to act on concerns of sexism and sexual misconduct, including cases where the regulators have refused to investigate complaints of serious sexual assault, or of closing complaints at their triage stage. We have specific concerns about the General Medical Council citing colleague-colleague cases as 'not in the public interest' and the 'five year rule' in which incidents that occurred more than 5 years ago will not be investigated. The Working Party on Sexual Misconduct in Surgery survey found respondents rated the adequacy of healthcare organisations to deal with sexual harassment and assault as between 14.5 and 60.2%, with men rating them more positively than women (2).

Sexism and sexual violence in healthcare has consequences for both the individual and the wider workforce. Survivors report having to take sick leave from work or to leave their jobs, in some cases healthcare altogether. This results in the loss of talented, highly skilled highly trained individuals putting further strain on the NHS recruitment and retention pressures. The economic impact of this is unevaluated, with freedom of information data not being made available by NHS Resolution on the cost of staff on staff sexual violence (18).

The data and the conclusions we have drawn are consistent with those from other settings. Comparable patterns are seen across studies conducted across the healthcare system in the UK and internationally (1-6). The data evidences systematic and institutional sexism and sexual violence within healthcare in the healthcare workforce. The scale of these behaviours fits into the pattern of misogyny and violence experienced by women across society, yet the difference is these behaviours are occurring in professions given unparalleled trust by the public, responsible for caring for the most vulnerable people, and who should be held to the highest safety and safeguarding standards.

RECOMMENDED ACTIONS

Following on the analysis of the stories and our knowledge of the sector at large we recommend the following actions:

1. Education on sexism and sexual misconduct for all staff in healthcare including students, with a focus on responding to reports of sexual misconduct for managers, culture change, allyship and preventing sexual misconduct.

2. Research into the impact of sexism and sexual misconduct on the healthcare workforce via an intersectional lens and development of evidence based interventions to prevent sexual misconduct.

3. An independent inquiry into the culture of sexism and sexual misconduct in healthcare.

4. Improved support for survivors, with access to specialist sexual violence support from independent sexual violence advocates provided by healthcare employers.

5. A review of current policy and past cases by healthcare employers to improve internal processes.

6. Introduction of specialist sexism and sexual misconduct policies, separated from other workforce policies, available in every healthcare employer.

7 An independent anonymous reporting system available across the NHS.

8 Reform from healthcare regulators to reduce the number of cases dropped before investigation and improved psychological safety measures for witnesses during the investigation and tribunal processes.

9 A system to improve communication between healthcare employers, regulators, and the police. Mandatory reporting from the employer to healthcare regulator should be introduced for cases of sexual harassment and assault.

These changes must happen across all levels of healthcare in:

- GP surgeries, community services, and hospitals.
- Universities and healthcare education providers.
- Integrated care boards.
- NHS England, Wales, Scotland and Northern Ireland.
- Healthcare colleges and representative bodies.
- Healthcare regulators with support from the Professional Standards Authority.
- Department for Health and Social Care.

RESEARCH PRIORITIES

Further research into sexism, sexual harassment and sexual violence with the healthcare workforce to gain a deeper understanding of the impact and evidence based solutions. We propose further research is required in these key areas:

- The impact of sexism and sexual violence on the workforce: effects on health, absence, and staff turnover.
- The intersectional impact of sexism and sexual violence in the healthcare workforce.
- The impact of sexism and sexual violence on patient care and patient safety.
- Do staff who perpetrate these behaviours also target patients?
- The economic impact analysis of sexism and sexual violence.
- Development and analysis of evidence-based interventions to prevent sexism and sexual violence.
- Analysis of survivor support interventions following sexism and sexual violence.

This work must be co-produced alongside survivors and healthcare workers.

WHAT DO SURVIVORS WANT?

Survivors tell us they wish to feel safe to work in a healthcare environment free from sexist discrimination and sexual violence. Prevention of these behaviours is our definitive aim. However, whilst these behaviours still occur, survivors wish to be listened to and to be believed. They urgently need access to a sensitive and safe pathway to report sexual violence that can be anonymous if they wish, to continue to work without the risk of losing their job or future career, and to receive specialist accessible support.

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APPENDIX

Gender	Number	Percentage
female	167	95.97%
male	7	4.02%
Total	174	100.00%

Appendix 1. Table of survivor gender.

Survivor Grade	Number	Percentage
consultant	8	8.99%
GP	2	2.25%
Junior Doctor Composite	79	88.76%
registrar	6	6.74%
GP trainee	1	1.12%
SHO	18	20.22%
FY	26	29.21%
junior doctor	28	31.46%
Total	89	100.00%

Appendix 2. Table of survivor medical grade.

Survivor Specialty	Number	Percentage
ambulance service	4	2.74%
anaesthetics	10	6.85%
emergency medicine	13	8.90%
general practice	11	7.53%
ICU	9	6.16%
obstetrics and gynaecology	7	4.79%
ophthalmology	2	1.37%
psychiatry	16	10.96%
social care	1	0.68%
surgery	24	16.44%
urology	2	1.37%
vascular	1	0.68%
general surgery	6	4.11%
oral surgery	1	0.68%
orthopaedics	15	10.27%
acute medicine	2	1.37%
cardiology	4	2.74%
elderly care	5	3.42%
general medicine	8	5.48%
infectious diseases	1	0.68%
stroke	1	0.68%
renal	2	1.37%
palliative care	1	0.68%
Total	146	100.00%

Appendix 3. Table of survivor specialty.

Perpetrator gender	Number	Percentage
female	11	6.88%
male	149	93.13%
Total	160	100.00%

Appendix 4. Table of perpetrator gender.

Perpetrator Profession	Number	Percentage
administrator	1	0.61%
admissions tutor	1	0.61%
carer	1	0.61%
doctor	124	76.07%
HCA	3	1.84%
IT worker	1	0.61%
manager	9	5.52%
medical student	1	0.61%
midwives	1	0.61%
multiple colleagues	1	0.61%
nurse	12	7.36%
paramedic	4	2.45%
pharmacist	1	0.61%
porter	1	0.61%
psychologist	1	0.61%
student nurse	1	0.61%
Total	163	100.00%

Appendix 5. Table of perpetrator profession.

Perpetrator Grade	Number	Percentage
consultant	90	77.59%
GP	5	4.31%
Junior Doctor Composite	21	18.10%
registrar	13	11.21%
SHO	6	5.17%
FY	2	1.72%
Total	116	100.00%

Appendix 6. Table of medical perpetrator grade.

Incident location	Number	Percentage
ambulance vehicle	2	1.69%
break	3	2.54%
changing rooms	1	0.85%
conference	2	1.69%
corridor	3	2.54%
digital	5	4.24%
doctor's office	11	9.32%
education	7	5.93%
external conference/course	1	0.85%
handover	1	0.85%
hospital car park	1	0.85%
interview	3	2.54%
meeting	7	5.93%
office	2	1.69%
pharmacy	1	0.85%
relative's room	1	0.85%
supervisor meeting	4	3.39%
toilets	1	0.85%
work parties	3	2.54%
Patient Facing Setting	59	50.00%
ward	42	35.59%
clinic	5	4.24%
ICU	1	0.85%
theatre	11	9.32%
Total	118	100.00%

Appendix 7. Table of incident location.

SUPPORT

- Surviving in Scrubs website www.survivinginscrubs.co.uk/get-support/support-for-individuals/

- Your local rape crisis centre will be able to offer support such as information, counselling, group sessions and drop ins. They may also have an independent sexual violence advocate (ISVA) service, who will match you with an ISVA who will support you through reporting and dealing with the police. A list of centres can be found at https://rapecrisis.org.uk/find-a-centre/.
- It is important to see your GP if you are struggling with your mental health, they will be able to refer onwards to talking therapies or trauma focussed services depending on what is available in your area.
- Rape Crisis England and Wales is a national charity offering information, support and guidance for survivors. https://rapecrisis.org.uk/.
- The Survivors Trust, a national charity that supports survivors of sexual assault and rape. Their website has a large information section and they run a helpline and livechat service. https://www.thesurvivorstrust.org/.
- Victims Support offer a phone line, livechat and details for local groups https://www.victimsupport.org.uk/help-and-support/get-help/.
- Mind have a list of resources and signposting http://www.mind.org.uk/information-support/guides-to-support-and-services/abuse.
- Galop offer support for information for LGBT+ survivors of sexual violence and have a helpline 0800 999 5428. https://galop.org.uk/types-of-abuse/sexual-violence/.

For all NHS staff:

- NHS Staff support has links to the Frontline text service and mental health hubs for staff. https://www.england.nhs.uk/supporting-our-nhs-people/support-now/
- Facebook: Tea and Empathy group

For nursing and midwifery:

- Royal College of Nursing offer support for members with counselling and welfare support https://www.rcn.org.uk/Get-Help/Member-support-services.
- Royal College of Midwifery offer workplace support and advice to it's members https://www.rcm.org.uk/supporting/getting-help/workplace-support/.

For allied professionals:

- Health and Care Professions Council have a wellbeing hub with links to support https://www.hcpc-uk.org/covid-19/your-health-and-wellbeing/.

For doctors:

- BMA offer 24/7 counselling and peer support regardless of membership status https://www.bma.org.uk/advice-and-support/your-wellbeing/wellbeing-support-services/counselling-and-peer-support-services. They can also offer advice related to employment on 0300 123 1233 and email support@bma.org.uk.
- BMA wellbeing directory https://www.bma.org.uk/advice-and-support/your-wellbeing#wellbeing-support-services.
- Doctors and dentists can self refer to Practitioner Health, an NHS service that support individuals struggling with mental health problems. https://www.practitionerhealth.nhs.uk/
- Facebook groups: Resilient GP

Support for sexual harassment for any employee:

- Your professional union may be able to offer support on work.
- Employment support can also be found via ACAS and Citizens Advice.

https://www.acas.org.uk/sexual-harassment
https://www.citizensadvice.org.uk/work/discrimination-at-work/discrimination-at-work/checking-if-its-discrimination/if-youre-being-harassed-or-bullied-at-work/

- Rights of Women can offer legal advice and support for sexual harassment in the workplace, they run a helpline and have a guidance handbook. https://rightsofwomen.org.uk/get-advice/sexual-harassment-at-work-law/

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