

Medicine, misconduct and confronting #MeToo

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In 2017, after press coverage of alleged sexual abuse by prominent men, Alyssa Milano posted a tweet: ‘If you’ve been sexually harassed or assaulted write “me too” as a reply’. #MeToo then trended. While the hashtag was not new, having been used by Tarana Burke a decade earlier, what was new was the sheer volume of posts and publicity: 1.7 million tweets from 85 countries.¹

In the UK, it was clear that sexual harassment and violence remained societal problems, also affecting life and work within the NHS. A flurry of articles highlighted both sexual misconduct and harassment occurring within the healthcare profession.² Over half a decade later, with many pronouncements of the need to address these issues, there remains little actual training for healthcare professionals on the issue. The e-Learning for Healthcare platform contains no training on sexual harassment and only briefly addresses the wider connected issue of bullying. While active bystander training has been recommended for addressing issues of equality and inclusion in the NHSE/I London Equality and Inclusion Programme, there is no such programme that focuses on sexual harassment and violence for NHS employees.

We therefore ask: has #MeToo achieved anything? What can we do in healthcare to drive real change around harassment and sexual violence affecting those working within the NHS? How can we turn all the rhetoric into action, rather than just ‘institutional hot air’?

How bad is the problem?

Quite shockingly, ‘it is not known exactly how widespread the problem of sexual harassment is in medicine’.³ Data vary greatly on how widespread the problem is.

A 2019 UNISON survey found 8% of NHS staff surveyed identified being sexually harassed in the past 12 months, with behaviour ranging from lewd sexual comments to rape.⁴ The BMA themselves acknowledge that sexual harassment can take many forms, as shown in Box 1. The survey recorded sexual harassment was most often committed by colleagues (54%), as opposed to other workers (24%) or patients (42%). It also identified that women are disproportionately affected (81%). This is consistent with the Searle Report into Sexual Misconduct, which analysed over 275 fitness to practice cases involving sexual misconduct: 88% of perpetrators were male, with this figure jumping to 100% for cases involving doctors.⁵

However, the data collected may reflect a reporting bias. Data in society more widely suggests over two-thirds of 18–24 year-olds have been sexually harassed in public.⁶ Men and non-binary individuals may not be coming forward due to the societal stigma associated with being a victim, and therefore the true picture is hard to glean. What #MeToo showed was the sheer prevalence of sexual harassment and violence, and why all of us need to consider respectful relationships and assume roles as active bystanders.

Why is this happening?

While the causes of sexual misconduct within the medical profession are multifaceted and complex, power imbalance certainly plays a role.⁷ The UNISON survey found perpetrators were predominantly older than their target (61%) and often employed in more powerful roles (37%).⁴

The professional cost of speaking out leads to a culture where sexual harassment and violence can

Box 1. British Medical Association's Definition of Sexual Harassment.

The BMA states sexual harassment occurs when an individual engages in unwanted behaviour of a sexual nature, which can include:

1. Written or verbal comments of a sexual nature including remarks about an employee's appearance, questions about their sex life, offensive jokes
2. Propositions, advances or making promises in return for sexual favours
3. Emails/social media messaging with content of a sexual nature
4. Displaying pornographic or explicit images
5. Unwanted physical contact and touching
6. Criminal behaviour, including sexual assault, stalking, indecent exposure and offensive communications.

Source: BMA: British Medical Association.³

Box 2. But what if I realise I've done something problematic or am 'called out'?

Everyone has moments when they have said or done something disrespectful that they regret. Sometimes we misjudge a situation or did something in the past before we realised the conduct was problematic. Sometimes we do not realise the discomfort caused by our words and actions.

It is common to feel shame or anger when our behaviour is called out. Take a minute to notice how you are feeling and acknowledge those emotions. When somebody points out your conduct was problematic, they are not necessarily attacking you as a person.

Sometimes we want to explain and be forgiven, but this might not be on offer at that moment. Part of empowerment is allowing the other person to speak and be heard, and if you appear to only want to see and explain your side of the story, you might compound the issue. Open questions can be helpful: 'how did I make you feel?' or 'what do I need to know or do differently to be better next time?'. Asking questions tells the other person you are listening. Their answers might be difficult to hear, but this openness can show you are trying to take feedback onboard. If able to, offer an apology and take accountability. Depending on the severity of what has occurred, having a mediator or third-party present may be helpful.

If you are in doubt as to whether your conduct could leave you subject to Fitness to Practise Proceedings by the GMC or was criminal under the Sexual Offences Act 2003, Protection from Harassment Act 1997 or associated legislation, you should always seek the advice of a lawyer.

continue. While the General Medical Council states that it operates a 'zero tolerance approach to harassment, bullying and victimisation',⁸ 'given the personal and professional cost of whistleblowing, it is understandable that victims choose to remain silent'.⁹ Such silence can lead to a false sense that conduct is 'normal' and 'part of the culture'.³ It can also perpetuate a 'mismatch' between perceptions of those with and those without power: 'while male clinicians consider they are indulging in harmless flirtation, women may see this as misogynistic, demeaning and scary'.¹⁰ The UNISON survey also highlights that many NHS employees have little confidence in their organisations' reporting procedures.⁴

Intervention and culture change programmes at the heart of #MeToo have gone a long way in challenging inaccurate beliefs over what is acceptable, but there is more work to be done to decrease incidents experienced by those in the NHS. To date, there is no e-Learning module to drive prevention, and much of the work to date has focused on reporting.

What can we do?

All levels of healthcare and institutions must act. The 2017 Searle Report made clear that staff training is an important factor in reducing incidents of sexual misconduct in the workplace.⁵ But we cannot place responsibility on individuals alone.

Leaders need to also act.⁷ Launer also suggests 'the crucial factor in tackling negative behaviour seems to be that someone in authority in an organisation accepts that it exists on a significant scale, believes in the seriousness of the problem, and is determined to challenge it'.¹⁰

Critically, one step that crosscuts all levels of healthcare is training people to intervene, empowering all to challenge any poor behaviour. The British Medical Association endorses the active bystander model to address racial harassment already.¹¹ Active bystander programmes aim to develop the skills and confidence of individuals to challenge beliefs and assumptions that lead to poor behaviour using different tools, either in the moment or after the event. Its aim is to equip people with a range of options to respond, while modelling good behaviour and shifting the culture. A review of the literature for Public Health England concluded that bystander programmes in universities could lead to 'positive attitudinal and behavioural change at the individual level, but also to a reduction in perpetration and victimisation at the level of the whole community'.¹² While some recent studies have expressed doubt about the so-called 'bystander effect', where individuals are supposedly less likely to act when in groups,

even this research suggests that empowering people to act and co-opt each other in responding to events or incidents offers an important opportunity to address issues such as sexual misconduct.¹²

Most programmes focus on training people to respond through roleplays and other action-driven responses. One approach involves using the five Ds – direct action, distract, delegate, delay and document, as shown in Figure 1.

Direct action involves confronting poor behaviour using verbal and non-verbal cues. For example, this could include a headshake, naming the behaviour as bad, or even telling the person how the behaviour is making you and others feel. Individuals may perceive there to be a delicate balance between maintaining professional relationships and communicating discomfort. Using questions instead of statements, such as ‘what makes you say that?’ or ‘I’m surprised to hear you say that because...’, can be a less confrontational way of getting someone to recognise and reflect on their words and actions. If you exhibit such behaviour and are called out, see Box 2.

Sometimes taking the direct approach may escalate an already unsafe situation, especially if someone is intoxicated or aggressive. Distracting people can diffuse the situation through derailing it. This can involve asking an unrelated question or requesting help with a simple task to create space between the individuals.

Delegation involves seeking help from a third party. This is particularly useful if safety or power imbalances prevent other actions. You might involve other individuals present, human resources or even

the authorities. We must be careful, though, to respect the wishes of the person experiencing the harassment, as they may not always want the escalation or to talk about the situation with others. Be mindful of the relationship certain groups have with minorities and pay heed to your safeguarding training.

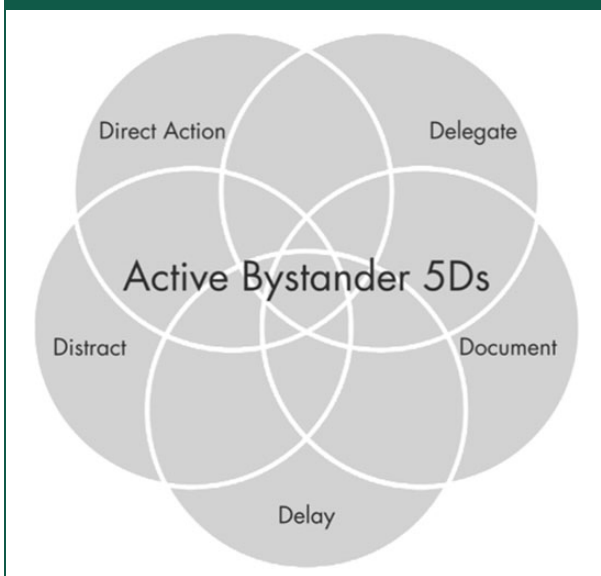
Delay encompasses actions taken after the event to support the recipient. This can involve acknowledging what has happened, checking if they are okay, asking how you might support them and signposting resources or organisations that can help. If someone discloses sexual misconduct or harassment by a colleague, it is important to respond by being calm, listening carefully and being non-judgemental. The GMC Dignity at Work policy provides a step-by-step process that individuals can follow if raising concerns with their employer.⁸

Always remember to document. Keeping a private personal written record for yourself can provide the other person with a choice about what they do down the line if they ask you to act as a witness.

The authors are aware that over the last few years a whole genre of videos calling out ‘Karens’ and ‘Kens’ for racist, sexist and other discriminatory behaviours has emerged. While Hollaback! and other organisations highlight such videos can call out systemic discrimination and harassment, creating teachable moments, filming and the use of recordings in workplace and clinical settings may infringe clinical values and ethics, as well as professional and legal requirements. The General Medical Council’s social media guidance, for instance, states ‘you must make sure your conduct... justifies the public’s trust in the profession’.¹³ Notable caution should be exercised outside the clinical setting also, as sharing videos without consent can also risk further harm, including re-traumatisation and secondary victimisation.

Witnessing or being told by a patient about sexual misconduct by a doctor towards them places you under a duty to report. You should remain mindful of safeguarding and workplace policies on reporting; however, troublingly the General Medical Council’s position with regards to doctors’ actions towards other healthcare professionals is less clear and depends on whether a fitness to practice threshold is met.¹⁴ Many human resources departments have both informal and formal grievance processes to investigate misconduct. Some organisations also have anonymous reporting systems in place to allow the collection of data and to guide changes and interventions without identifying those involved. It is critical you inform yourself about options, not just so you know what you might do, but also so you can offer options to those who experience poor behaviour and support them in deciding what they want to do.

Figure 1. The 5Ds of Active Bystander Interventions.



Considering this complexity and the various options available in the NHS to prevent and respond to harassment and violence, training is key to effectively address the issues raised by #MeToo. So, we ask why this isn't being done?

What next?

While the Higher Education sector has been quick to adopt various forms of intervention training, healthcare has fallen behind. While some trickle-on effect can be expected from those coming out of degree programmes, good practice and group acceptance of collaborative responses require continued training and skills. Intervention and culture change programmes offer not only the chance to practise and refine bystander skills, but also allow restatement of the institutional, professional and NHS ethos.

We note the tools we have suggested in response to the issues highlighted by #MeToo can also be applied towards tackling racism, homophobia, disablism, transphobia and other forms of discrimination. While some of us are more vulnerable to experiencing sexual harassment and violence, it is important to remember that most of us have experienced disrespect or bullying in our lifetimes.

We all can address poor behaviour and can support a culture of inclusion, dignity and respect in healthcare. It is time the NHS and Health Education England, alongside other healthcare and professional bodies in the UK and beyond, develop training and take proactive, preventative steps to change the culture and support a respectful, empowered healthcare workforce.

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