WPSMS
The Working Party on Sexual Misconduct in Surgery

# BREAKING THE SILENCE

## Addressing Sexual Misconduct in Healthcare

AN INDEPENDENT REPORT ON SEXUAL MISCONDUCT
BY COLLEAGUES IN THE SURGICAL WORKFORCE

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**Find out more online at:** https://www.wpsms.org.uk/

Please note this report contains wording on sexual misconduct which some may find distressing. Please see sources of support here.

UNIVERSITY OF SURREY

University of Exeter

# Contents



*A note on language*

This report and our work raise sensitive issues. We have listened to a wide variety of professionals including those impacted by sexual misconduct. We do not use the terms 'victim' or 'survivor'. While victim is used as a legal term, the common usage of the words 'victim' and 'survivor' can confer an assumption as to how a person who has been targeted by a perpetrator feels. Many report to us they feel neither of the above but are simply angry at what happened to them, furious that justice has not been served and morally injured by the fact that the person who assaulted them, remains in post.

# Foreword

## Professor Dame Jane Dacre

*Emeritus Professor UCL and Past President Royal College of Physicians*

The role and status of women in society has been changing slowly over hundreds of years. From the Middle Ages, when women's role was defined by bearing children and assertive women were regularly branded as witches and suffered imprisonment or death, through a time where women were considered constitutionally too weak for higher education, to today, where women are accepted as equals. Or are they?

Women have been allowed to qualify as doctors for over one hundred years, which is to be celebrated. They are providing high-quality service to their patients and working in all branches of medicine. In some specialties, including surgery, women are still in the minority, and there have been attempts to increase the number and recognition of those working in areas considered to be more difficult for women to have successful careers, highlighting a changing and more welcoming culture.

This report shows that we still have a long way to go in demonstrating the respect that our female colleagues deserve in the surgical workplace. The survey findings of sexual misconduct are eye-watering and upsetting. It is difficult to read some of the testimonies, and this work should galvanise all healthcare organisations to make sure the problem of sexual misconduct is eliminated.

I applaud the bravery of the authors, Professor Carrie Newlands, Miss Philippa Jackson and Ms Tamzin Cuming, those who have responded to the survey, and those who have spoken out in trying to highlight the problem so that it can be solved. This is a difficult and sensitive issue, unlikely to be confined to surgery, or healthcare. As a society, we aspire to equality, so we cannot continue to turn a blind eye and ignore or condone sexual misconduct, which will always be unacceptable behaviour.

# Acknowledgements

This report is the result of the dedication of WPSMS members, advisors and supporters. Dr Chris Begeny of the University of Exeter has played a pivotal role in our research. Miles McGibbon has overseen the development of the WPSMS website and provided technical expertise to the Working Party. The Royal College of Surgeons of England (RCS England) has kindly assisted with technical aspects of report production.

Thanks are due to Lucy Davies and Nicola Kane of RCS England, Dr Chelcie Jewitt and Dr Becky Cox of Surviving in Scrubs (SiS), Claire Light, Head of Equality and Diversity at the General Medical Council (GMC) and Dr Fiona Donald, President of the Royal College of Anaesthetists (RCoA) for their invaluable support to this project.

Ms Clare McNaught, Vice President of the Royal College of Surgeons of Edinburgh (RCS Edinburgh), Judy Finn of the Royal Australasian College of Surgeons (RACS), Professor Scarlett McNally, President of the Medical Women's Federation and Professor Dame Jane Dacre, Chair of the Expert Panel of the Health and Social Care Committee, as well as Catherine Hinwood OBE, Dr Peter Aitken and Dr Navina Evans of NHS England (NHSE) have all given their time, wisdom and support. We are truly grateful.

WPSMS would like to thank the survey participants and others for sharing their experiences with us. Their trust and honesty have made our research and this report possible, and the prospects for meaningful change a reality.

# Comment from the Joint Royal Surgical Colleges

The findings of the working party's survey on sexual misconduct in surgery are shocking. As leaders of the four surgical royal colleges, we want to send a strong message: these utterly unacceptable behaviours have no place in surgery. We would like to thank the working party for having the courage to speak out on this very serious problem. We will work with the group and colleagues across healthcare to ensure that surgery is the safe and welcoming profession it should be.

**Professor Rowan Parks**
**President of the Royal College of Surgeons of Edinburgh (RCS Edinburgh)**

**Mr Tim Mitchell**
**President of the Royal College of Surgeons of England (RCS England)**

**Mr Mike McKirdy**
**President of the Royal College of Physicians and Surgeons of Glasgow (RCPSG)**

**Professor Laura Viani**
**President of the Royal College of Surgeons in Ireland (RCS Ireland)**

*A note on quotes*

All quotations from survey participants were given with specific permission for the anonymous use of free text entries in published work. We are grateful to all the survey contributors who have allowed us to use their words. Only a small number have been used in this report for illustrative purposes. There will be further publication of contributions with scientific qualitative analysis. Some other quotations in this report are from direct contact with WPSMS and who have given permission for their words to be used. Others are in the public domain.

# Executive Summary

Why does addressing sexual misconduct by colleagues in the healthcare workforce matter?

*I witnessed a newly qualified consultant, doing hand surgery on an anaesthetised young female patient, lift up the drapes to 'inspect' her breast augmentation surgery.*

*When I needed senior support overnight with unwell patients, this was refused by seniors, as they thought I had been the one to report (**the perpetrator**) for sexual misconduct. I wasn't the one who reported him.*

*"All too often victims of sexual misconduct don't feel able to come forward because of the power imbalance at play. In most cases that come to us, the perpetrator is a senior male doctor acting inappropriately towards a younger female doctor."*

*Charlie Massey, 2 May 2023*

*I looked into quitting, my mental health plummeted, and I had very very dark moments alone. Nearly 5 years later, I am still in therapy, to deal with what happened, in the job I had dreamed of doing.*

1. Sexual misconduct, a term to describe sexual harassment, sexual assault and rape, is defined as unwanted behaviour of a sexual nature. These acts are illegal or criminal.

2. We know that many doctors who perpetrate acts of sexual misconduct towards colleagues also demonstrate this behaviour towards patients[1].

3. We also know that patients who are cared for by dysfunctional teams have poorer outcomes.[2]

4. There are damaging, untold personal costs for individuals who are targeted by sexual predators. Working in an environment where sexual violence is normalised is not healthy and damages the caring relationship those targeted have with patients.

5. Sexual misconduct disproportionately affects women. In surgery, the 'leaky pipeline' is described, with high numbers of women entering medical school, but few becoming surgical consultants. Many women do not choose to enter the male world of surgery and many others leave as a result of the toxic misogyny they experience.[3]

*Consultant giving the lecture put up an image of half-dressed woman apparently to demonstrate a clinical point.*

*A pornographic image was sent on a consultant WhatsApp group. I called it out and multiple subsequent discussions have been time consuming, upsetting and disruptive. Separate groups have now formed and I am not included in those where this kind of material is being shared.*

*Derogatory comments were continuous and prolonged. I ended up handing in my notice as a substantive consultant. These comments are endemic in surgery.*

*I felt: sad, frustrated, hurt, angry, Let down by the system I had worked so hard for, concerned about my future, extremely worried, ignored, muted, broken, anxious, uncared for, devalued, discarded, worthless.*

Since 1995, more women than men have entered UK medical schools every year. In 2022, 62 percent of entrants were women.

In 2023, 35 percent of Surgical Speciality Trainees and 15 percent of Consultant Surgeons are women.

***Office for Students Data and NHSE data 2022/23***

Why is this report being published?

6. The Working Party on Sexual Misconduct in Surgery (WPSMS) was formed in 2022 to gather data and effect change.

7. An ethically approved survey was conducted in 2022 to collect data about the experience of sexual misconduct by colleagues within the surgical healthcare workforce. Participants were specifically asked about their experience in the last 5 years.

8. This research titled "*Sexual harassment, Sexual assault and rape by colleagues in the surgical workforce and how women and men are living different realities: an observational study using NHS population-derived weights*" which has been published in the British Journal of Surgery,[4] analysed anonymous online survey responses from 1,434 participants (51.5 percent women) from the surgical workforce. Two-thirds of women (63.3 percent) had been the target of sexual harassment from colleagues, along with almost a quarter of men (23.7 percent).

9. The data show nearly a third of women (29.9 percent) had been sexually assaulted by a colleague, while the majority of participants (89.5 percent of women, 81 percent of men) said they have witnessed some form of sexual misconduct by colleagues. Sexual coercion was common, with 10.9 percent of women having experienced forced physical contact linked to career opportunities.

> *I had been warned about this consultant's behaviour by other female trainees before starting the job. I had also been told that a female trainee that had complained about him was blacklisted and not trained. All behaviour warned about happened: back/neck massages, hip thrusting, fixing his mask on your shoulder, an 'accidental' boob graze.*

> *He increased unwanted touching over a period of time. Initially hand on my shoulder and then on my waist. When I was in the scrub room putting my gown on, he reached his hands up under my scrub top from behind me and fondled my breasts. I was too shocked to respond and felt I had somehow invited it by not objecting to him touching me before. The perpetrator made it very clear how friendly he was with my supervising consultant and how senior he was within the organisation. I felt it would be his word against mine.*

10. Participants had been raped at work, as well as in other work-related contexts including teaching spaces, conferences, and after-work events with colleagues.

11. Only 16 percent of those impacted by sexual misconduct made a formal report.

> *I can't bring myself to officially name him because it's a small world and I'm afraid of how he may influence other seniors in my future career.*

12. The study also found a widespread lack of faith in accountable organisations' adequacy of dealing with sexual misconduct. These included the British Medical Association (BMA), the GMC, Health Education England (HEE), NHS Trusts, and the Royal Colleges.

13. The data show significant differences between the numbers of women and men who experienced sexual misconduct by colleagues and their views of the accountable organisations' adequacy in dealing with the issue. The study title notes "Women and Men are Living Different Realities".

Her "*total lack of experience in conducting an investigation*" resulted in her adopting a line of questioning that was "*intrusive*" and "*well beyond the scope of the terms of reference for the investigation*".

Employment Tribunal Findings 2023.

The majority of those who had experienced sexual harassment at work were targeted by a colleague.

71 percent did not report it, fearing retaliation, career damage, not being believed and fearing nothing would be done.

Only 15 percent who did formally report it believed their case was dealt with properly.

*"It's Never OK" 2019 Unison report on Sexual Harassment in Healthcare.*

*This consultant would pretend to dry hump nurses from behind whilst in clinic. He obviously thought this was very funny and said things like "Oh, (name of nurse) how can I resist?"*

*I watched a consultant fiddle with the hair of an industry representative, and kiss the back of her neck, at work. She was in a difficult position and did not want to report the incident.*

14. A Round Table meeting was held at the GMC on 2 May 2023, organised by WPSMS and attended by key stakeholders to discuss
the data and explore actions required to tackle this problem.

15. This meeting's focus was to raise awareness and start the process of identifying the challenges and barriers to progress, and to begin the process of change.

16. Some of that change is underway, but there remains much to do.

17. The 2019 UNISON report on Sexual Harassment in Healthcare showed sexual harassment by colleagues (which we term here sexual misconduct as per current definitions) to go largely unreported for reasons of fear. Prior to our research, little had changed since that publication.

18. Sexual misconduct by colleagues is a problem for all of healthcare including patients. It is not just about surgery and it's not just about doctors.

19. This report is being published to highlight this as an issue of national concern.

20. Our recommendations focus on England in view of the devolution of responsibility for healthcare in Scotland, Wales and Northern Ireland which have differing structures. Nevertheless, we urge this to be seen as a UK-wide issue and for there to be engagement between politicians, healthcare providers and regulators to ensure parity for all members of the UK healthcare workforce.

21. The WPSMS calls for urgent measures to support prevention and to ensure robust investigation of sexual misconduct in healthcare.

"***We would expect a proactive and learning organisation to exhibit characteristics of openness and reflection, to co-opt external stakeholders to provide challenge, and to identify improvements, strategic learning, and enduring improvement plans.***"

Baroness Casey DBE CB
The Casey Review into the Metropolitan Police, 2023.

### *A note on intersectionality*

WPSMS supports the right of all healthcare workers to be treated equitably and with respect. The research we have reported compares the differing realities of sexual misconduct between those who identified as men or women, whose sexuality and ethnicity has not been independently reported in our paper. Existing evidence suggests that LGBQT+ people experience sexual misconduct at similar or higher rates than heterosexual people.* Data related to participants who identified as non-binary will be reported in a future publication with care, with an intersectional lens and with ethical advice to ensure anonymity.

The PRiSM committee are grateful to the authors of this report for their acknowledgement of the complexity that intersectionality brings to this issue and subsequent discussions. As regards the LGBTQ+ community, the evidence is sparse due to the difficulty in identifying the accurate number of LGBTQ+ surgeons. The RCS England census this year has for the first time looked to address this. However, there is a significant number in our community who prefer not to answer demographic questions and remain hidden within our profession due to fears of discrimination. LGBTQ+ trainees experience higher rates of bullying and sexual harassment which in consequence result in trainees being twice as likely to leave their training programme or more worryingly commit suicide.*

We must not underestimate the effect that sexual misconduct has on colleagues and we in PRiSM hope that the scope of this work will enlarge over time to include all groups outside of the surgical stereotypical majority group.

Miss Ginny Bowbrick, Chair RCS England Pride in Surgery Forum (PRiSM)

*Heiderscheit EA, Schlick CJR, Ellis RJ, et al. Experiences of LGBTQ+ Residents in US General Surgery Training Programs. *JAMA Surg* 2022 ;157(1): 23–32.

*Male consultant asking a more junior colleague who is lesbian about what sexual activities lesbians undertake. Occurred in anaesthetic room, on the ward etc.*

*Witnessed consultant touching male trainee's inner thighs, bottom etc, in public places. Never consensual.*

# RECOMMENDATIONS

**Accountable healthcare organisations:**

The nine Professional Regulators

Healthcare Regulators: the Care Quality Commission (CQC) in England

Royal Colleges

Trade Unions

Employers, including the private sector

Healthcare Education Bodies

These recommendations have been reached as a result of the research of the WPSMS, opinions expressed at the Round Table and the contributions of other experts whom we have consulted. The recommendations follow the principles of recent work by the World Health Organisation (WHO) on Sexual Misconduct, encompassing zero tolerance, consequences for perpetrators and cultural change. We have tried to ensure that proposals will be workable in practice and will continue to work collaboratively with stakeholders to effectively address sexual misconduct in healthcare. The recommendations are themed to cover a national implementation and investigation strategy, policies and codes of conduct, education of the workforce, culture and performance of accountable organisations, and data collection.

## Implementation and Investigation

We ask the Department of Health and Social Care (DHSC) and accountable organisations to support:

1. **A National Implementation Panel to oversee progress by organisations on the recommendations in this report.**

2. **Reform of reporting and investigation processes of sexual misconduct in healthcare, to improve safety and confidence in raising concerns and to ensure investigations are external, independent and fit for purpose.**

> *I had 2 days of MHPS (Maintaining High Professional Standards) training and was thrown in at the deep end. I was asked to make a judgement on whether a sexual assault had taken place. I felt really uncomfortable. Should the police not have been involved? (Surgical Clinical Director)*

> *No-one talked to the perpetrator or disciplined him.*

> *The Clinical Director interviewed the perpetrator who denied everything. No record was taken, no action was taken. One consultant who was present, said nothing. It is common for consultants to fail to notice, or notice but deny what they have seen, or explain it as acceptable.*

## Policies and Codes of Conduct

We call for:

3. **Every NHS Trust and healthcare provider to have an appropriate, specific and clear Sexual Violence/Sexual Safety Policy in place.**

4. **All healthcare educational bodies and professional associations to have an appropriate, specific and clear Code of Conduct which includes sexual behaviour. These codes should be signed up to by those who are employed by, study at, and belong to these entities, and should apply both within the workplace, and at work-related events such as conferences.**

> *One of my trainees described how her male consultant had followed her back to her room at a conference. She confided in her TPD and me as a senior female consultant. She didn't want to report it, fearing consequences and reputational damage.*

> *I had to wear an extra-large scrub top and used a safety pin to close the V-neck at the front. The consultant said to me in front of other male consultants in my department that I should take the pin out so they had something good to look at. No one questioned him. I walked away. I regret not having said anything and feel guilty for all the other women this may have since happened to.*

> *Sexual images of both naked men and women were forwarded on a work group consultant WhatsApp.*

5. **Accountable organisations and professional associations to support and enact relevant pledges and charters such as the BMA Sexism Pledge and the NHSE Sexual Safety Charter.**

> *My future supervisor at an annual dinner touched me by linking through my arm and put the palm of his hand on the bare skin of my back. I could not say anything and felt it would be seen as ridiculous to raise a concern. I worried that I should have worn a different dress. I felt very uncomfortable. Other female trainees know this consultant for behaving like this and it is talked about amongst us that he needs to be watched out for.*

## Education

We ask those responsible for the ongoing education of the healthcare workforce to:

6. **Integrate learning in recognising and taking appropriate action on sexual misconduct at all stages of a career in healthcare.**

7. **Ensure active bystander, unconscious bias and awareness-raising training for all members of the healthcare team, with specific reference to dealing with incidents of sexual misconduct.**

8. **Ensure all those involved in receiving reports of and/or investigating sexual misconduct have received specific validated education including learning from previous cases and have appropriate expertise, including critical competencies.**

> *"I was genuinely committed to surgery, and I was genuinely committed to medicine. I knew there was sexism in surgery. I always knew that. But I genuinely thought that if I worked hard enough, I could beat it."*
>
> Employment Tribunal Findings 2023.

## Culture and Performance of Accountable Organisations

We call upon accountable organisations to support:

> *Ridiculous that a senior surgeon would have pornography on his phone to show to colleagues. Personally, I felt physically sick.*

9. **The reform of healthcare regulators' professional guidance to include sexual misconduct towards colleagues.**

10. **Engagement of all stakeholders with the Implementation Panel, (as described in Recommendation 1) to report progress and to share data and expertise.**

> *I was told that my complaint was possibly the 4th or 5th about this consultant. I was told not to refer to it as sexual harassment as this could be defamation of the consultant which could be used against me legally. Incidents were raised to both training programme directors and I was told it was taken to the hospital clinical director. The consultant remains employed 4 years later.*

11. **The agreement of standards for the management of reported incidents of sexual misconduct and scheduled prospective auditing of performance by organisations against those standards.**

12. **The inclusion in NHS, GMC and other relevant surveys, of questions on workforce satisfaction as to the adequacy of those organisations in dealing with sexual misconduct.**

> *Someone in HR advised that incidents over 2 years ago are impossible to challenge as the law allows that someone may be a changed man.*

13. **An equality and diversity-promoting agenda to improve the representation of women in local and national leadership roles, across all specialities and workforce groups in healthcare.**

> *There's a WhatsApp group where one person posts memes of a sexual nature which I don't like, but I don't engage with them.*

## Data Collection

We ask that there be:

14. **Improvement or implementation of appraisal/assessment/end of placement or employment feedback systems for staff and students to include questions on their own and others' behaviours regarding sexual misconduct and safety.**

15. **Collection of data specific to sexual misconduct including the above, by healthcare organisations, regulators and educational bodies and that these data are shared with the Implementation Panel. The CQC should have access to these data at registered organisation and national level and these should be included as a measure in an organisation's CQC rating.**

> *The orthopaedic consultant, during an operation, discussed with his (male) trainee how they like blow jobs. It was my first day in theatre.*

# IMPACT STATEMENT

"I was sexually assaulted by a trusted recent clinical supervisor one evening at a conference when I was a first-year registrar trainee. He was drunk, he touched my breasts and punched my arm when I tried to get away, bruising me. Sometime later he started calling me and threatened my career if I spoke to anyone about the incident.

A senior mentor I approached for advice informed me he was known for this behaviour. Why had no one warned me? I had trusted this man.

The deanery told me they did not want to hear the details or be involved. This was a police matter, not a training matter.

The police were kind and spent time talking to me but made it clear that I lacked evidence and that any action they could take would be limited.

I have had to live with this incident on many levels. I lost trust in someone I looked up to and I lost faith in my ability to judge people and my relationships. As a woman, I feared repeat incidents in all areas of my life. As a trainee, I listened to sexual jokes from colleagues and feared they would attack me. I am still too scared to attend any work social event, and I still never allow myself to be in a closed room with a male colleague or patient.

People have defended the perpetrator, blamed me, not believed me or have normalised the incident. I am aware of others who have been sexually harassed by him both before and after myself. I feel powerless to protect those who are yet to be subject to his behaviour. He remains in post."

# Introduction

Sexual misconduct happens. It is not new. Sexual misconduct in surgery came to prominence after some powerful stories were shared in an article in the *Bulletin of the Royal College of Surgeons of England* in September 2021.[5]

> *One author of this paper (SF) reached out to over 20 women in surgery who have, in the past, shared with him via social media experiences of sexual harrassment, discrimination, sexual assault and rape. Not a single one was willing to co-author, even with the guarantee of anonymity.*[1]

There were subsequent responses from an anonymous surgeon[6] and from plastic surgeon Miss Philippa Jackson,[7] with a swathe of anonymous reports following on social media. The Working Party on Sexual Misconduct in Surgery (WPSMS) was formed in early 2022 as an independent group in response to this initial breaking of the silence.

> *He'd frequently rub himself against me repetitively during surgery, grunt and gasp in my ear, then leave the operating theatre before the operation was over. The scrub nurse used to help me close up. She once cried with me after surgery and reminded me that she was powerless to do anything, but that she cared.*[6]

> *One morning in a corridor, when discussing a case about to go to theatre, the member of staff commented on my breasts, hugged me and rubbed his erection on my thigh..*[7]

> *I sought advice during the process from both my indemnifier and union, and not once was it suggested that this constituted a sexual assault and that I could speak to the police.*[7]

> *He began to rub his erection against my hip or buttocks whilst we were both scrubbed up, and breathe heavily into my ear, while I performed surgery on anaesthetised patients.*[6]

> *...while the actions of my supervisor were humiliating and traumatic, it was the silence of those I considered friends and trusted colleagues, which hurts to this day.*[6]

> *...she said: 'And are you sure you want to make this a formal complaint? Or is this something we can handle...less formally?*[7]

In order to bring about change, data were required to determine the scale and nature of the problem around sexual misconduct in the surgical working environment. Involvement of academic psychologists allowed the WPSMS to design and adapt a confidential survey with ethical approval, which was distributed through email servers to members of the surgical workforce in the UK and Republic of Ireland from September to December 2022.

Raising concerns about perpetrators of sexual misconduct who may be in positions of power is fraught with difficulty. It is known there is a culture of silence around this behaviour. Targets of sexual misconduct are usually but not always women, and those with other or multiple protected characteristics are at more risk.[8] We aimed to reach a broad cross-section of the surgical workforce, including those who have never witnessed or experienced sexual misconduct. We also wanted to reach those who left a career in surgery because of experiencing or witnessing sexual misconduct.

The survey was designed to benchmark sexual misconduct within the surgical workforce, assessing the rate of incident reporting and how these reports were dealt with. We also investigated the attitude of respondents to responsible organisations. Our survey design ensured maximum safety for participants in order to reassure them that they could give sensitive information without potential personal repercussions.

> "Even with this additional 'use of open text' consent, **we will not publish or present any personally identifying data/text.** Any integration of open-text responses (quoted or paraphrased) into scientific publications or reports will only be done: (i) **with your consent** (provided below), (ii) in anonymised form (e.g., any and all names, specific locations, unique or individuating details will be removed), and (iii) **without any other demographic information connected** to the text (e.g., any open-text responses incorporated into publications will not state the current or any previous region, grade, etc. of the person who provided that text response, nor any identifying information about other individuals referred to in that text response)."
>
> Consent wording as supplied to survey participants.[4]

The research, published on 12 September 2023 in the *British Journal of Surgery*[4] demonstrates that sexual harassment and sexual assault are commonplace within the surgical workforce and rape happens. The data relating to the last five years have been prioritised for publication; this behaviour can no longer be dismissed as a thing of the past. It is happening now.

Women and men are experiencing differing realities, and the workforce has justifiably lost faith in the current reporting and investigation processes.

Wilful blindness[9] to sexual misconduct in healthcare is an institutional failure that has permitted continued unacceptable and criminal behaviour. Individuals' reports have been suppressed, those targeted have been ignored and moved elsewhere, and perpetrators have been able to continue to abuse with impunity.

This report is a call to action for healthcare institutions to face up to the shocking reality of sexual misconduct within their organisations.

# The Round Table

A Round Table on Sexual Misconduct in Healthcare took place on 2 May 2023, to present the results of the initial analysis of the data and bring together organisations to plan the necessary first steps towards wide-reaching change. Key stakeholders with responsibility for training, standards, regulation and the workforce were identified and invited to participate.

The GMC hosted the event and logistical support was provided by RCS England (Appendix 2: Round Table attendees). Ms Tamzin Cuming chaired the event and described the origin of the WPSMS, emphasising its independence. She stated the goals of the Round Table were to establish actions to bring about change.

Charlie Massey GMC Chief Executive talked of the work the GMC was doing, and spoke with conviction, saying, "*The work to tackle sexual misconduct is absolutely critical and I remain resolutely committed to it both personally and on behalf of the GMC.*"

A version of the impact statement included in this report was read by Dr Chelcie Jewitt and commented on by Dr Becky Cox, founders of Surviving in Scrubs.

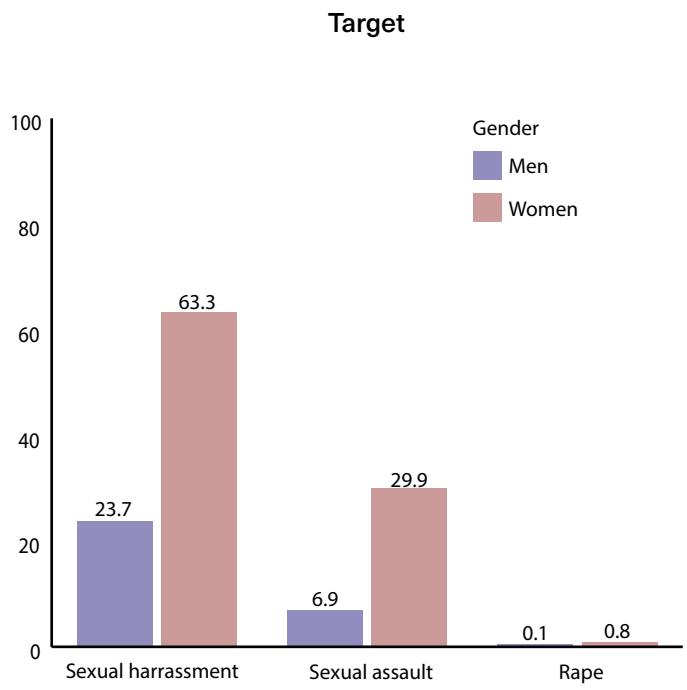
Professor Rosalind Searle outlined the academic context of sexual misconduct in the healthcare workplace, and described:

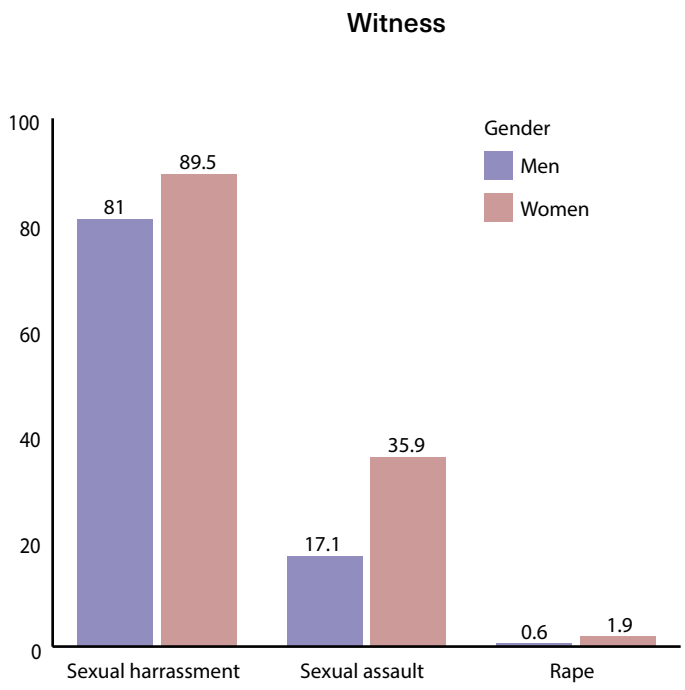
- How perpetrators are usually male and demonstrate a need for power, and that they select conducive workspaces where they can eventually dominate their domains;
- That perpetrators may become too significant to call out and remove;
- How workplaces can become distorted to fulfil powerful perpetrators' sexual goals while concurrently saddling these organisations with costly non-disclosure agreements in the guise of protecting an organisation's reputation;
- Evidence from her studies for the Professional Standards Authority[10,11] in 2016 and 2019 which showed that sexual misconduct was more prevalent by doctors than by those in nursing or allied health professional groups, and that they received inconsistent and lesser regulatory sanctions.

The WPSMS research was presented to the Round Table attendees by Professor Carrie Newlands.

Sufficient data for analysis was supplied by 1,434 respondents, 51.5 percent of whom were women.

Sexual harassment — following precise definitions — was described by 63.3 percent of the female respondents along with almost a quarter of men (23.7 percent). Being the target of sexual assault in the last five years was reported by 29.9 percent of women.



Witnessing and being the target of sexual harassment and assault were significantly more commonly reported by women than men.

Sexual misconduct does not take place only when women are present to witness it. Men and women seem to significantly differ in their perception of what constitutes sexual misconduct. The gender difference is in the realisation of what they are seeing.

Specific details were given by participants of 872 episodes of sexual harassment, 81 sexual assaults and 5 rapes. Only 16 percent of incidents were formally reported. These data do not form part of the current paper and will be separately published.

Survey participants were asked how well they felt the following accountable organisations were managing this problem — the GMC, NHS Trusts, the BMA, HEE, and the Royal Colleges. Dissatisfaction was high; higher for those who had been targeted and for women. For men who had witnessed sexual misconduct, their views of the organisations were comparable to those of impacted women.

*Again, the perpetrator excused their behaviour with "I'm just a tactile person." and "I'm not supposed to do this anymore."*

*Repeated sexual innuendo and comments about nurses or female staff followed by "But I can't say that these days." as a disclaimer.*

*I have experienced mild good-humoured 'banter' on numerous occasions which has never caused me to feel awkward. I recognise I am a senior male member of staff and others may not have felt so secure.*

*There is a difficult dividing line between a bit of fun and genuine misbehaviour. Depends upon the upbringing, culture, degree of sensitivity and confidence levels.*

| Is this organisation adequately addressing sexual misconduct towards colleagues? | % of women who said YES | % of men who said YES |
|---|---|---|
| BMA | 20.4 | 57.8 |
| GMC | 15.1 | 48.6 |
| HEE (now part of NHSE) | 22.8 | 56.1 |
| NHS Trusts | 15.8 | 44.9 |
| Royal Colleges | 31.1 | 60.2 |

Professor Newlands ended by saying "We really are at a tipping point for change and while our data relate to surgery, this is not just about surgery, or just about doctors — and we all have a lot to do to make healthcare a safer place to work and a safer place for patients to be treated."

The final presentation was by Miss Homa Arshad, Advocacy Lead for WPSMS, who outlined a number of GMC sexual misconduct cases already in the public domain, beginning with an example of progress. She discussed cases where bias may have favoured the perpetrator's perspective and influenced the interpretation of the GMC regulations by the Medical Practitioners Tribunal Service.

# Breakout Rooms

Breakout rooms were tasked with identifying the challenges to addressing sexual misconduct in healthcare settings and asked to explore potential solutions that contributed to the recommendations in this report. There were common themes identified by the groups. The combined outputs are presented below.

## Breakout Rooms

The NHS and wider healthcare
The Regulators
The Educators
A National Strategy
Culture Change

## Perceived Barriers

*I was sent an inappropriate e-mail by a consultant which made frequent references to his position of power over me and how I should "play by his rules". When I said I didn't find it funny he told me not to get him into trouble and implied I shouldn't tell anyone.*

*I was afraid to go in the lift due to constant groping from multiple members of the team.*

*He inappropriately touched male trainees as a matter of normal daily activity as well as inappropriate touching of male and female patients. It was well-known in the department. No one would come forward as we are a small specialty and we all knew that our concerns would be ignored and we would be punished. I. I still regret not raising concerns as I know it exposed others to his behaviour. I was a coward to protect my career.*

### *Fear*

Fear related to reporting and dealing with reports of sexual misconduct was noted to be a major issue. There was acknowledgement of the common scenario of a power differential between the individual targeted and the perpetrator, with a real risk to career progression of those impacted if they do speak up.

Recent changes to the trainee assessment programme within higher training programmes for doctors which now incorporate a Multiple Consultant Report, may put trainees at higher risk of sexual coercion. The Staff and Associate Specialist (SAS) group were also noted to be vulnerable, particularly those who were seeking to join a Specialist Register, as they usually remain within one Trust, rather than rotate between posts.

Concerns were voiced about the risk to an individual who speaks up and is not believed or where no action is taken. They may have to continue to work with the perpetrator, placing them at increased risk of further incidents or retaliation. A perpetrator or those complicit in maintaining the status quo may also attempt to block future progress of a trainee.

*He wanted sexual favours in return for signing a form/signing me off. This person is still working with vulnerable people.*

It was recognised that the incidence of vexatious reporting is very low in comparison to the scale of misconduct actually occurring. These situations may be complex.

> *A more junior colleague alleged that a consultant had touched her breast in an operation. An allegation was made to her supervisor. There had been no previous concerns expressed by her or others about the alleged perpetrator. There were many concerns about the junior colleague, and it was being discussed whether to sign her off or not as her competence was questionable. As a direct result of her allegation, she was signed off with no questions about her competence or [her] allegation.*

At organisational level, there was clearly apprehension around the legal implications associated with investigating unwitnessed complaints. Recent lessons from the experience of the Royal Australasian College of Surgeons (RACS) should be noted when reforming UK processes, although there are significant differences in the roles of the UK Royal Colleges and the RACS.

### *Inadequate responses to reports*

Serious concerns were identified across each group around how sexual misconduct by colleagues is currently managed within healthcare. There is a lack of guidance available about how to deal with incidents of sexual misconduct ranging from inappropriate comments and jokes, to sexual assault and rape. Individuals described confusion around who a report should be made to and poor communication between organisations, resulting in unclear responsibility for the wellbeing of the target and the management of the accused.

This lack of a clear line of accountability between the police, the employer and educational bodies was noted to perpetuate the belief that nothing will be done, enabling these behaviours to continue unchecked. There is little transparency regarding incidents and few examples of best practice in the management of sexual misconduct.

> *The incident came out as the perpetrator was the subject of an investigation by the trust. When I was interviewed, the panel asked me, "If it was that distressing, why didn't you report it?" with a tone of disbelief. The perpetrator saw me in the corridor afterwards and said, "It's your word against mine — who are they going to believe, me or a silly little girl?"*

> *He is known as inappropriate with female trainees, who are told they will get good operating numbers if they go in his theatre if "they can cope with his behaviour". He has never been sanctioned for this, even though everyone in the department knows about it.*

Clear and trustworthy support systems for those who report sexual misconduct were noted as vital to improving the wellbeing of those impacted, and are currently lacking.

It was discussed that the majority of healthcare providers are businesses, with well-described conflicts of interest in managing their own reputation and dealing appropriately with misconduct. A senior clinician is an extremely valuable asset, and the combination of scandal and the potential loss of service provision following suspension or dismissal is a powerful influence on how an organisation may choose to deal with a report of sexual misconduct from a junior and often transitory staff member or student.

Most consultant surgeons are men, as are most of those in positions of power within surgical and accountable organisations. It was felt the demonstrated gender difference in perception of sexual misconduct may have contributed to the lack of attention these institutions have historically given to preventing and combating sexual misconduct.

> *Normal interaction can involve jokes with a sexual element which will not offend people who know each other and work together.*

> *It is still acceptable for juniors to 'welcome' advances from senior staff for advancement and opportunities. It's difficult as an observer to decide what is harassment and what is welcome.*

### *Culture*

Behavioural change within the medical workplace was acknowledged to be difficult. Sexism in medicine is rife, and poor behaviour often goes unchecked with bystanders ignoring what is witnessed, failing to report and even joining in. Lower-level behaviours create a permissive environment for predators to thrive in and may be a gateway to more overt and damaging behaviours.

> *The surgeon placed his hand on the chair as the scrub nurse was about to sit down so that she sat on his hand. It seemed to be an 'in joke' or something which had happened before.*

> *I honestly believed this is what surgery was like and that if I didn't deal with it, I wouldn't make a very good surgeon.*

The steep power hierarchies seen in healthcare, while having some functionality, are often unhealthy. Individuals in allied healthcare professions or non-clinical roles may face similar challenges to junior medical staff in reporting sexual misconduct particularly when the perpetrator is senior and powerful.

There was recognition that both the survey and representation at the meeting were focused on a medical doctor perspective and inclusivity would be essential when looking at solutions for the whole workforce.

> *Nurse: "Here's the large instrument." Doctor: "Thank you. I often get comments on the size of my instrument." Awkward laughing from others in theatre.*

> *I really wish I had done more about this. An attractive male nurse was subject to daily banter and touching by female theatre staff. I said, "If men were doing this to a young woman, they would be sacked", so why did they think it was OK?*

> *Good professional behaviours start at medical school. A very important missing group here today, our nursing colleagues. They are often on the end of this. This doesn't just happen in England. It happens across all four countries and of course Ireland.*
>
> *Tim Graham, RCS Edinburgh, 2 May 2023*

> *Interactions with the opposite sex are routinely used to advantage. I'm unsure if it can be regarded as harassment when the affected individual allows it and benefits from it.*

## Risks of Breaking the Silence

Thought must be given to supporting and managing those individuals who have spent many years in an environment where these behaviours have been the norm. Many, while not being perpetrators of sexual misconduct, remain complicit. This work risks the alienation of some of the senior workforce who may find accepting the reality of how women are being treated, and the proposed changes, challenging. Some may choose to leave to avoid potential investigation.

The many impacted staff who have not previously spoken up may feel more empowered to do so if, as we hope, reporting systems become increasingly safe, expert and independent. We encourage speaking up wholeheartedly but warn that the currently dysfunctional system risks being overwhelmed. We urge therefore that the true scale of this problem is acknowledged by those who are tasked with reform of investigatory processes and that our data are used to inform the provision of a service with adequate capacity. Following action by the London Ambulance Service (LAS) to introduce independence to the reporting system for sexual misconduct, there has been a 5-fold increase in reports. There have also been dismissals and each one these has led to an employment tribunal.

Finally, there is a real and saddening possibility that lifting the lid on the shocking scale of sexual misconduct in surgery by colleagues will deter even more women from seeking to become surgeons. We hope this will not be the case.

# Summary

Prevention of sexual misconduct is essential for staff and patient safety. This can and must be achieved through education at every stage for all, and through cultural change within accountable organisations. Effective sanctions for perpetrators are needed to ensure justice and to aid workforce retention.

Women are disproportionately impacted, and improvement of the gender disparity in areas of medicine such as surgery and in leadership roles across healthcare has an important part to play in dealing with this issue.

Those who have been impacted by sexual misconduct rarely report it for multiple reasons, based around fear and lack of faith in those currently tasked with investigating reports. Within individual healthcare organisations, there is insufficient expertise and a lack of organisational memory around this complex matter. Moreover, perpetrators are often powerful individuals, and there is a culture of complicity.

Existing good practice can be found in many other areas, such as the work of the Implementation Panel for the Gender Pay Gap in Medicine as an example of an effective national body overseeing required change. The work of the WHO, the LAS and the RACS on tackling behaviours including sexual misconduct are also useful areas from which to learn.

There are well-established mechanisms within medicine where an external review of clinical concerns can be provided by Royal Colleges in collaboration with Specialty Associations. Invited reviews use an independent, objective and expert review process to assure patient safety and improve patient care and services. These principles could also be applied to implementing change and ensuring independent expert investigation of sexual misconduct in healthcare.

*All the female doctors who enter the department are warned about him. Some of us would even flirt back but it was disgusting and made you feel disgusted. He put the flat of his hand against my abdomen and stroked it as he walked past. It made me feel sick but I pretended it didn't happen. There's no way I would ever name him. He is a senior consultant with friends across the country.*

*I asked more than five different victims of this man if they were prepared to give written statements and they didn't feel they could. The perpetrator remains in the organisation.*

*He said, "Talking about sexual misconduct at work", laughed and squeezed my breast twice with his fingers. The other junior male colleague looked away.*

*The consultant said I should sit down by myself with the perpetrator — I had to go by myself.*

*This supervisor repeatedly asked me out for dinner in person, via text and also called me out of work hours despite my refusing each time. I began to dread going to work for fear of repeats of these unwanted advances.*

*He was sexually harassing multiple junior doctors. The Trust only investigated a year after concerns were raised. It was appalling.*

The recent Home Office-commissioned Operation Soteria designed to improve justice for victims of sexual violence declared that "*investigators and other police staff lack sufficient specialist knowledge about rape and other sexual offending, and there is a need for specialism and research-informed specialist investigative practice for rape and sexual offences*." We should not expect healthcare staff with little training to investigate these matters when the police themselves are currently failing.

There needs to be a safe reporting system where victims can speak up without fear, which encourages confidence in reporting and results in a just outcome. Healthcare needs to be a safe and welcoming environment in which to work. We do not want colleagues leaving a career because they were sexually assaulted. We want robust mechanisms put in place to ensure that perpetrators' behaviours are addressed and that justice prevails for those who have been silenced and damaged.

# Success So Far

WPSMS are pleased to note that, following work by us and others, there has been initial constructive engagement with stakeholders. As a result, some recommendations have already been enacted in 2023:

- NHSE has launched a Charter on Sexual Safety in Healthcare and asked for organisations to sign up to this, and to commit to working towards the principles and actions being in place by June 2024.
- NHSE has circulated a letter to Integrated Care Boards (ICBs) asking for a review of Sexual Safety Policies and noted the need for "*a systematic zero-tolerance approach to tackle this issue which encompasses prevention, support and decisive action against perpetrators*".
- All NHSE ICBs and Trusts were asked to appoint a Lead for Domestic Abuse and Sexual Violence by 13 July 2023.
- The GMC have published an updated version of *Good medical practice – professional standards* for all UK doctors on 22 August 2023 which will come into effect on 30 January 2024. For the first time, this sets out that acting in a sexual way towards a colleague with the effect or purpose of causing offence, embarrassment, humiliation or distress is unacceptable. It gives examples of what constitutes acting in a sexual way and that this can include "*verbal or written comments, displaying or sharing images, as well as unwelcome physical contact*". This adds to the existing duty that doctors must not act in a sexual way towards patients or use their professional position to "*pursue a sexual or improper emotional relationship*".
- The GMC have included new questions in the 2023 National Training Survey, asking trainees about their experience of discriminatory behaviours from fellow doctors or other healthcare professionals, including whether they had experienced "*unwelcome sexual comments or advances causing you embarrassment, distress or offence*".
- Questions on sexual misconduct are to be included in the NHS Staff Survey.

> *"In many cases involving sexual allegations, the GMC's position will be that such serious misconduct is incompatible with continued registration. In those cases, we will submit that erasure is the appropriate sanction."*
>
> *Charlie Massey*
> *2 May 2023*

We are grateful to these organisations for listening and for taking these actions. We see this as a mark of how seriously this problem is being taken and look forward to seeing further major changes. At present, there is a notable gap between policies and professional standards and the aspirations behind them and action leading to meaningful change on the ground. It is this stage that now requires attention from those with the power to complete the task.

# DETAILED RECOMMENDATIONS

> *We need to change that culture from 'everybody knows, but nobody does' to 'everybody knows and everybody does'. And that's what this is all about.*
> *Sarah Thornton, RCoA, 2 May 2023*

## Implementation and Investigation

We ask the Department of Health and Social Care (DHSC) and accountable organisations to support:

1. **A National Implementation Panel to oversee progress by organisations on the recommendations in this report.**

This will collect data and report successes and ambitions, ensuring that this work continues for the workforce of the future. It will necessarily develop its own expertise in the process.

2. **Reform of reporting and investigation processes of sexual misconduct in healthcare, to improve safety and confidence in raising concerns and to ensure investigations are external, independent and fit for purpose.**

This is vital to provide safety for those impacted to speak up and to ensure that perpetrators will not continue to act with impunity. Healthcare providers may have a conflict of interest in wishing to preserve an organisation's reputation. Consideration should be given to designating reporters of sexual misconduct as whistleblowers and affording them protections currently enshrined in whistleblowing law. A clearer framework across professions within which sanctions are applied will ensure the appropriateness and comparability of outcomes. Consistent referral, expert independent investigation and appropriate judgements will help to restore faith in investigations and result in consequences for perpetrators while deterring others.

## Policies and Codes of Conduct

We call for:

3. **Every NHS Trust and healthcare provider to have an appropriate, specific and clear Sexual Violence/Sexual Safety Policy in place.**

At the time of writing, most healthcare providers do not have these in place. In May 2023, it was reported that only 1 in 10 NHS Trusts had a specific Sexual Safety policy in place.[11] Such a policy will give those faced with a report of sexual misconduct an appropriate process to follow and provides a framework against which to judge the behaviours described. Provision of a template that includes consistent definitions of misconduct, sources of support for those raising concerns and for the accused, reporting processes, thresholds for investigation and referral arrangements will improve standardisation. While it is noted that each NHS Trust is an independent body

or business, as are many other providers of healthcare, adherence to effective standards and policies should form part of the CQC assessment of good governance and of the employment of fit and proper staff.

4. **All healthcare educational bodies and professional associations to have an appropriate, specific and clear Code of Conduct which includes sexual behaviour. These codes should be signed up to by those who are employed by, study at and belong to these entities, and should apply both within the workplace, and at work related events such as conferences.**

A Code of Conduct for educators should include the requirement to report a sexual relationship where there is an educational or supervisory role of one colleague by another, and that role should not then be allowed to continue. Trainees, students and allied healthcare professionals are particularly vulnerable to sexual violence at work-related events outside the workplace, where boundaries may be blurred and alcohol is often involved.

5. **Accountable organisations and professional associations to support and enact relevant pledges and charters such as the BMA Sexism Pledge and the NHSE Sexual Safety Charter.**

Changing the culture of healthcare is vital, and these frameworks are an important step in that process.

# Education

We ask those responsible for the ongoing education of the healthcare workforce to:

6. **Integrate learning in recognising and taking appropriate action on sexual misconduct at all stages of a career in healthcare.**

The WPSMS data show that men report witnessing sexual misconduct far less frequently than women do. Education and raising awareness are required to change attitudes to respect the experience of those targeted and dismantle the endemic sexual misconduct occurring within the healthcare workplace, much of which is trivialised by the prevailing culture.

7. **Ensure active bystander, unconscious bias and awareness-raising training for all members of the healthcare team, with specific reference to dealing with incidents of sexual misconduct.**

Active bystander training, awareness raising, and unconscious bias (including bias reduction strategies and bias mitigation strategies) should be part of training for all members of the healthcare team, with specific reference to dealing with incidents of sexual misconduct. Active bystander training equips individuals with strategies to challenge poor behaviour, including sexual misconduct that they may witness. Only 1 in 5 NHS Trusts currently offer this training on an opt-in basis and of those, many do not specifically deal with sexual behaviours.[12]

8. **Ensure all those involved in receiving reports of and/or investigating sexual misconduct have received specific validated education including learning from previous cases and have appropriate expertise, including critical competencies.**

Many who have spoken to us or given their stories experienced a woeful lack of expertise by those who investigated their report of being sexually harassed, assaulted or raped. Current reporting mechanisms are not clear and not trusted, and there is wide variation in the competency of those carrying out investigations. Within the UK police force, Sexual Offences Liaison Officers act as first responders. There should be clear criteria for involving the police where a crime may have been committed.

## Culture and Performance of Accountable Organisations

We call upon accountable organisations to support:

9. **The reform of healthcare regulators' professional guidance to include sexual misconduct towards colleagues.**

Other healthcare regulators should follow the example set by the GMC in this matter. This recommendation should also apply to any future regulatory body of NHS managers and should include the duty to appropriately deal with concerns raised.

10. **Engagement of all stakeholders with the Implementation Panel (as described in Recommendation 1) to report progress and to share data and expertise.**

It is the responsibility of all of us within healthcare to solve this problem with a zero-tolerance approach.

11. **The agreement of standards for the management of reported incidents of sexual misconduct and scheduled prospective auditing of performance by organisations against those standards.**

There should be on-going independent audit of all sexual misconduct cases of which healthcare organisations and professional regulators are made aware. This should be included as a standing agenda item in organisations' leadership team meetings and a standard reporting item to the Implementation Panel. This will provide data on progress, identify outliers and encourage cultural change.

12. **The inclusion in NHS, GMC and other relevant surveys, of questions on workforce satisfaction as to the adequacy of those organisations in dealing with sexual misconduct.**

Current healthcare workforce evaluations of the adequacy of dealing with sexual misconduct are poor. It is the responsibility of these organisations to improve, and we suggest that they regularly collect data on this to inform them of their own progress. There is vast opportunity to gather data to inform future progress through staff enquiry.

**13. An equality and diversity-promoting agenda to improve the representation of women in local and national leadership roles, and across all specialities and workforce groups in healthcare.**

While women remain under-represented in these spaces, cultural change of the magnitude required to make a difference is a significant challenge. The lack of diversity in areas of healthcare such as surgery is a major contributor to the prevalence of sexual misconduct, but its existence may be one of the underlying reasons why many women do not choose to become surgeons or leaders.

# Data Collection

We ask that there be:

**14. Improvement or implementation of appraisal/assessment/end of placement or employment feedback systems for staff and students to include questions on their own and others' behaviours regarding sexual misconduct and safety.**

We suggest that GMC 360 degree appraisal and Nursing and Midwifery Council, Healthcare Practitioners Council and other professional regulators' feedback from colleagues and patients could include questions on inappropriate behaviour including sexual misconduct.
Examples of this in professional appraisals might include:

"Has anyone raised a concern about your behaviour regarding sexual safety to you, or about you?"
And
"Have you been the target of, or have you witnessed sexual misconduct?"

Students and trainees and those leaving employment should be asked to give specific feedback on sexual safety in their workplace or student placement. It is recognised this may place them at risk, so consideration should be given to anonymous reporting, support and safety. Policies should be followed through to an external investigation where agreed criteria are fulfilled, especially as whistleblowing policies may not apply to all those impacted, such as students and temporary staff.

**15. Collection of data specific to sexual misconduct including the above by healthcare organisations, regulators and educational bodies, and that these data are shared with the Implementation Panel. The CQC should have access to these data at registered organisational and national level and these should be included as a measure in an organisation's CQC rating.**

These data should form part of the CQC rating for a healthcare provider and effective action should be taken where the data point to there being a problem in an organisation or with an individual.

> *I'm one of the few dentists in the room and I just wanted to say that it's not exclusively medicine and surgery this happens in. We've done some work in Glasgow and it's happening in dentistry as well. Now we've let it see the light of day. Don't put it back in the box. We need to work together. It is a massive patient safety issue. It's a massive workforce issue because you'll be losing people out of the profession because of this.*
>
> *Christine Goodall, RCPSG, 2 May 2023*

> *There will be some individuals and organisations who will play down the significance of this and maybe deny that it exists. So, I think there are some principles organisations can sign up to: one is to declare that there is a problem; secondly, something needs to be done about this problem and thirdly, that their organisation will help to do something about it. It's that last part we need to work together to make that happen.*
>
> *Tim Mitchell, RCS England, 2 May 2023*

# Next Steps

WPSMS continue to engage with stakeholders and to contribute to a major national conversation about this serious matter. Liaison is required between stakeholders and policy makers to take our recommendations forward. WPSMS are committed to ensuring progress in this area and will be holding future meetings with relevant representatives.

> ***"Time and time again, those complaining are not believed or supported. They are treated badly or face counterclaims from those they have accused."***
>
> Baroness Casey DBE CB
> The Casey Review into the Metropolitan Police, 2023.

# Report Recipients

- Academy of Medical Royal Colleges
- Amanda Pritchard, Chief Executive NHS England
- Ambulance Services
- Annaliese Dodds MP, Shadow Secretary of State for Women and Equalities
- British Medical Association
- British Medical Journal
- Care Inspectorate Scotland
- Care Inspectorate Wales
- Care Quality Commission
- Confederation of British Surgeons
- Daisy Cooper MP, Liberal Democrat Spokesperson for Health and Social Care
- Dame Helena Kennedy KC
- Dental Schools Council
- Douglas Bilton, Assistant Director of Standards and Policy, Professional Standards Authority
- Equality and Human Rights Commission
- Federation of Speciality Surgical Associations
- General Medical Council
- Health and Social Care Committee
- Health and Social Care Committee's Expert Panel
- Henrietta Hughes, Patient Safety Commissioner
- Hospital Consultants and Specialists Association
- The Regulation and Quality Improvement Authority
- Institute of Medical Ethics
- Independent Healthcare Provider Network
- Kenny Gibson, National Head of Safeguarding NHS England
- Maria Caulfield MP, Minister for Women
- Medical Education Leaders
- Medical Schools Council
- Medical Women's Federation
- National Medical Director's Office
- NHS Domestic Violence and Sexual Abuse
- NHS Employers
- Post Graduate Schools of Surgery
- Professor Dame Jane Dacre, Chair Health and Social Care Committee's Expert Panel
- Project S
- Protect
- Royal Australasian College of Surgeons
- Royal College of Anaesthetists
- Royal College of Physicians and Surgeons of Glasgow
- Royal College of Surgeons of Edinburgh
- Royal College of Surgeons of England
- Royal College of Surgeons of Ireland
- Stephen Barclay MP, Secretary of State for Health and Social Care
- Stephen Powis, National Medical Director NHS England
- Steve Brine MP, Chair Health and Social Care Committee
- Surviving in Scrubs
- Times Health Commission
- Victims Commissioner
- Wera Hobhouse MP
- Will Quince MP, Minister of State for Health and Secondary Care

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# Appendix 1

## Signposting For Support

*Advice helplines*

- Rights of Women's helpline provides free and confidential legal advice to women and girls in dealing with sexual harassment at work. Tel 020 7490 0152.
- SurvivorsUK has a free, confidential national online helpline for men and boys.
- GALOP offer a free, confidential and independent helpline and support service for all LGBT+ people who've experienced sexual assault, violence or abuse.
- Victim Support offers free and confidential telephone support for complainants, patients, witnesses and their families during a GMC investigation. You can talk to them about how you're feeling and what to expect. They can also signpost you to specialist support organisations.
- Within NHS Trusts, Clinical and Assigned Educational Supervisors, Directors of Medical Education, Medical Directors Nursing, AHP and other Line Managers and Freedom to Speak Up (FTSU) representatives are available as sources of advice and support. You can also contact your GP to discuss matters relating to your mental health and wellbeing. Your GP can provide more information about relevant services and supports that you can access.
- NHS staff can also access help at https://www.england.nhs.uk/supporting-our-nhs-people/support-now/
- The Royal College of Nursing provides support for members at https://www.rcn.org.uk/Get-Help/Member-support-services/Counselling-Service
- Unison support advice is detailed here: https://www.unison.org.uk/get-help/knowledge/discrimination/bullying-and-harassment/
- You can also contact the BMA on 0330 123 1245; Free, confidential, 24/7 counselling and peer support services are open to all doctors and medical students https://www.bma.org.uk/advice-and-support/your-wellbeing/wellbeing-support-services/counselling-and-peer-support-services
- Advice for LGBT people is available at: https://www.gov.uk/guidance/advice-and-support-for-lgbt-people and in Ireland, at https://lgbt.ie
- RCS England's Confidential Support and Advice Service (0800 028 0199); provides confidential support and advice from a trained counsellor, available 24/7 https://www.rcseng.ac.uk/careers-in-surgery/wellbeing/
- The Confederation of British Surgeons offers a confidential helpline CBS Helpline https://cbsgb.co.uk
- Rape Crisis covers England, Wales & Scotland Rape Crisis England & Wales | Rape Crisis Scotland
- Sexual Assault Referral Centres (SARCs) are the place to go for forensic examination after a recent sexual assault in order to collect evidence of a crime. They also provide follow-up and counselling services.
- There are SARCs in England & Wales (England & Wales SARC Finder)
- There are also SARCs in Scotland (gov.scot Information Page)
- In Ireland, Rape Crisis Centres can help (Rape Crisis Centers Ireland Map)

*Support for doctors and other healthcare professionals to speak up*

- The GMC ethical hub pages on Speaking up provide advice and tools to help doctors to raise concerns.
- The NHS Speak up helpline, available in England and Wales, offers legally compliant, unbiased support and guidance.
- Freedom to Speak Up Guardians can support anyone in England to raise concerns.
- The GMC's confidential helpline can also provide guidance on how to raise concerns you might be struggling with. You can remain anonymous if you prefer. Although staff are not trained to provide legal or counselling support in relation to sexual misconduct, they can signpost to other organisations. It is available Monday to Friday, 9am–5pm on 0161 923 6399.
- Protect is a UK-wide charity that advises and supports individuals and encourages safe whistleblowing.
- The Independent National Whistleblowing Officer available in Scotland provides information, advice and support on raising concerns.

# Appendix 2

## Attendees and Invitees

## WPSMS Round Table held at the GMC on 2 May 2023

| | |
|---|---|
| The Working Party on Sexual Misconduct in Surgery (WPSMS) | Miss Homa Arshad – *Consultant Trauma and Orthopaedic Surgeon, Advocacy Lead, WPSMS*<br>Ms Tamzin Cuming – *Consultant Surgeon, Chair of the Women in Surgery Forum at the Royal College of Surgeons of England, Co- Lead WPSMS*<br>Miss Deborah Eastwood – *President of the British Orthopaedic Association, WPSMS advisor*<br>Mrs Marieta Franklin – *Speciality Trainee, Trauma and Orthopaedics, WPSMS*<br>Miss Philippa Jackson – *Consultant Plastic Surgeon, Member WPSMS*<br>(Apologies given)<br>Miss Greta McLachlan – *Specialty Trainee, Colorectal Surgery, Co-Lead WPSMS*<br>Professor Carrie Newlands - *Consultant Oral and Maxillofacial Surgeon, Co-Lead WPSMS*<br>Professor Ros Searle – *Professor in Human Resource Management and Organisational Psychology, WPSMS advisor* |
| British Medical Association (BMA) | Dr Alex Freeman – *BMA Council member and Chair of the BMA Culture Inclusion and Implementation Group*<br>Lucy Kerr – *Senior Policy Adviser, Equality Inclusion and Culture* |
| Federation of Surgical Specialty Associations (FSSA) | Miss Ruth Waters – *FSSA and Immediate Past President of British Association of Plastic, Reconstructive and Aesthetic Surgeons (BAPRAS)* |

| | |
|---|---|
| General Medical Council (GMC) | Angela Brenigan – *Policy Manager Standards*<br>Tista Chakravarty-Gannon – *Head of Operations & Outreach Lead for WPSMS*<br>Omolara Cornish – *Project Officer: Regulatory Reform*<br>Kuljit Dillon – *Associate Director for Strategy, Planning and Inclusion*<br>Harriet Foxwell – *Policy*<br>Georgia Jameson – *ED&I Officer*<br>Claire Light – *Head of ED&I*<br>Professor Dame Carrie MacEwen – *Chair*<br>(Apologies given)<br>Stephanie McNamara – *Associate Director Comms and Engagement*<br>Charlie Massey – *Chief Executive*<br>Natalie Randhawa – *ED&I Exec Admin*<br>Chloe Skelton – *Comms* |
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| NHS Employers | Paul Deemer – *Head of Diversity and Inclusion*<br>Danny Mortimer – *Chief Executive* |
| Postgraduate Schools of Surgery (PGSS) | Miss Esther McLarty – *Consultant Urological Surgeon, Chair PGSS* |
| Other | Professor Dame Jane Dacre – *Chair of the Expert Panel for the Health and Social Care Committee (HSCC)*<br>Professor Carol Woodhams – *Professor of Human Resource Management, University of Surrey* |
| Professional Standards Authority (PSA) | Douglas Bilton – *Assistant Director of Standards and Policy*<br>(Apologies given) |

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| Project S | Mr Simon Fleming – *Speciality Trainee Trauma and Orthopaedics*<br>Kate Jarman (Apologies given) |
| Royal College of Anaesthetists RCoA) | Dr Sarah Thornton – *Consultant Anaesthetist, Council Member, Member WPSMS* |
| Royal College of Physicians and Surgeons of Glasgow (RCPSG) | Professor Christine Goodall – *Professor of Oral Surgery and Violence Reduction, Dean of the Faculty of Dental Surgery RCPSG*<br>Dr Stephen Magill – *Chair Dental Trainees Committee RCPSG* |
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