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Introduction

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Lived experience narratives are often used to provide depth of understanding to an area of study in medicine, using 'real world' exemplars that explicate theory and models of practice. In our case, the narratives in this part help us understand how the social context of the authors and the people they discuss shape collective experience, and drive the way institutions and individuals respond to sexual harassment within their profession.

When we present this work, we are often told that cases of sexual harassment are unusual, or unique, or outliers. 'We have been working in this field for years', senior leaders tell us 'and we have never seen a case of sexual harassment between doctors'. They may then suggest that survivors must be a little fragile, requiring further training in resilience, or that perpetrators are simply outliers, 'bad apples' in an otherwise highly professional community of senior doctors.

The quantitative evidence, of course, does not support this narrative, but in our experience, the narrative remains remarkably resilient. Rape myths continue to influence our collective understanding of this difficult area, and there is deep cognitive dissonance when we suggest sexual harassment occurs in the cold, hard light of day in a busy hospital, or that perpetrators can be highly respected senior consultants, and survivors can be privileged, intelligent, capable doctors.

Part three is the core of the book. The reason this book exists is because of questions around context. In our early work, we noticed that the majority of the writing in this area was coming from Australia, the UK, Canada and the US, with relatively few contributions from other countries. As qualitative researchers, we are well aware that context is critical if we are to understand social phenomena. In order to understand the relationship between context and sexual harassment, we needed to broaden our experience and understanding.

Over the last ten years, we have reached out to leaders in the field in multiple countries. It has been a deeply challenging task. Many advocates have set up communities through social media, but these are rarely publicly accessible, even if they use English as their main language for discussion. Many survivors are understandably reluctant to speak, and so become almost impossible to find, supporting the narrative

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that survivorship is rare in medicine. Our work was interrupted by the COVID-19 pandemic, when several authors redirected their energies into clinical, public health and leadership work in their own countries. Nevertheless, in this part, we present a community of practice, with survivors, advocates, colleagues, leaders, academics and mentors willing to collaborate to deepen our collective understanding in this challenging area.

AIMS

The aim of this part is to explore how the context of the survivor, perpetrator, policy environment, legal framework, medical training structure and medical workplace conditions interact to influence how and why sexual harassment occurs.

METHODOLOGY

In each chapter, we have asked a diverse group of authors to present three elements:

- An overview of their unique context, including common metrics for gender equity using the UN Sustainable Development Goal 6, and the author's own reflection on the way gender impacts their life and work.
- A description of a case of sexual harassment in their country, which may be identified, or may be a conglomerate synthesised from multiple narratives.
- A reflection that enables each team of authors to reflect on what we can learn from their contexts and experiences.

This is a large part, because we were determined to provide a breadth of contexts. We decided to use the World Health Organization (WHO) regions, to ensure we had diverse authorship. We are well aware that, as white privileged authors, we were likely to have a subconscious bias towards contexts like our own. We have sought in this part to capture the voices of people from all WHO regions. The countries represented are:

- Nigeria and Zambia from the African region
- Mexico and the United States of America from the region of the Americas
- Austria, Germany and the United Kingdom from the European region
- Iran and Pakistan from the Eastern Mediterranean region
- Australia, Brunei, Japan and Malaysia from the Western Pacific region

Using this sampling frame, we have strived to achieve a diverse sample, drawing on multiple accounts and reflections from different countries. We have prioritised the authentic voice and experience of women doctors. In these chapters, you will read people's accounts of experiences, sometimes raw and painful, sometimes presented in composite form. Together, they give a rich and diverse narrative about the experience and understanding of sexual harassment in a variety of medical contexts, and together demonstrate clearly just how complex it is to eradicate it.

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