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Integrating Interdisciplinary Lenses

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INTRODUCTION

In this chapter we discuss issues faced by doctors in relation to sexual abuse. We consider organisational and institutional factors such as cultures of workplaces which can either predispose or help prevent occurrences of sexual abuse. We discuss principles and arguments for an interdisciplinary and generalist approach in the management of individuals exposed to sexual abuse, using a case discussion as an example. We also discuss the application of an integrated approach to influence change in systems at scale to reduce prevalence of sexual abuse.

In considering the integrated approach, we describe the remits of postgraduate medical training, regulatory organisations and legal systems in the UK. It is likely that similar systems and processes exist in other countries as well – the important matter is the transferable processes and issues rather than specific frameworks. We reflect on impacts for doctors subject to sexual abuse, and the range of resultant health and professional issues. Where relations between doctors have deteriorated to the level of sexual abuse, we highlight a range of other professional breaches we have also encountered, which may further compound the negative impacts and long-term health of the victims. We take the view that the possibility of such further complexity be explored in cases of doctors abused by doctors.

In order to respond, we describe principles that allow a holistic approach to be taken to address wide ranging impacts on victims. We consider factors in medicine which may lend themselves to abuse of positions of trust to raise awareness. We recommend changes to the management of doctors in training and culture of health care systems to reduce incidence, react with compassion and fairness, and reduce the negative impacts – both personal and professional – to the doctors involved.

Earlier parts in this book have documented what is currently known about sexual harm of doctors by doctors. Research into causes, prevalence and impact of sexual harassment and abuse in medicine (1; 2) is being undertaken. It is clear that sexual harm has been and is a common experience, (3) and it has highly significant impacts for victims, including detrimental physical, mental, social and occupational sequelae. (2; 4) Risk factors identified by Bhaji and Altomare (5) for

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all forms of discrimination and harassment (not just sexual) included training status, gender, ethnicity, culture, sexual orientation and language spoken. The significant majority of perpetrators are men, (6) and the structure of training, power differentials and dynamics of work in medical workplaces (1) can create environments where perpetrators' behaviour is both triggered and difficult to address. In chapter 3 on 'the role of men' we discuss why sexual abuse occurs in the medical workplace in greater detail.

WHAT WE KNOW ABOUT SEXUAL ABUSE OF DOCTORS BY DOCTORS

Sexual abuse is defined as unwanted sexual attention, which can be verbal or non-verbal, and involve coercive behaviours or unwanted physical contact, through to violent assault. (4; 7) As noted in the #metoo campaign, (8) coercion into sexual favours linked to suggestions of opportunities for career advancement also occurs within medicine. (9) This leads to a pernicious situation for victims, who have invested several years of study and naturally hold career aspirations, then being in a position of fear that disclosure will negatively impact their future careers.

Research into causes, prevalence and impact of sexual harassment and abuse in medicine (1; 2) is being undertaken. Results show significant negative impacts on physical and mental health (4) as well as confidence at work. Even the mildest form of abuse (persistent verbal sexualised attention) can impair career progression due to these negative health impacts. Furthermore, studies show that victims are often reticent to report, citing perceptions of negative reactions from colleagues, fear due to power differentials between perpetrator and victim, concerns that confidential access to supportive systems may be lacking, and worries that negative effects on career progression, health and feelings of self-worth (4; 8) will result. Therefore, it is incumbent upon organisations and systems such as health care employers, post-graduate medical education bodies and regulators (e.g. General Medical Council) to listen, offer a safe space to disclose and then act effectively.

To consider systems factors that may predispose to abuse within health care settings, or conversely reduce risk, we need to visit evidence highlighting prevalence of abuse, and any relevant individual or organizational risk factors. We consider a range of international systematic reviews in relation to medical sexual abuse to understand who the victims may be.

The experience of abuse is common among the health care workforce and has negative impacts. Fnais et al.'s (3) international systematic review revealed statistically significant greater harassment of women. A systematic review on bullying, undermining behaviour and harassment in the surgical workplace by Halim and Riding (6) showed increased rates of sexual harassment in women across a number of countries, disciplines and contexts. Such experiences impact career decisions, with students moving away from specialties where they experienced harassment. (1; 6) Risks for medical students seem to be more pronounced for women, ethnic

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minority groups and LGBT students. (2; 6) A study of fourteen US medical schools (10) showed that 83% of female respondents had suffered sexual discrimination or harassment, while 41% of male medical students also had this experience. The effects on this group of wider bullying and harassment included stress, poor work satisfaction, depression, and suicidal ideation. More broadly, risk factors identified by Bhaji and Altomare (5) for all forms of discrimination and harassment included training status, gender, ethnicity, culture, sexual orientation and language spoken, in that order of prevalence.

Who are the perpetrators of sexual abuse in medicine, and how do they interact with victims? In their 2019 report, Searle et al. (11) consider the 275 cases in the UK of a range of clinical health care professionals where sexual misconduct with either colleagues or patients was reported to the health care regulators. Eighty-eight per cent of the perpetrators were male. Of those in the study who were doctors, 100% of the 94 perpetrators were male. Colleagues were the target in 32% of all cases, and in 54% the location of abuse was the workplace.

In chapter 3 on the role of men, we discuss theories to explain why sexual abuse in the workplace may occur, including the four factor theory, (12) which cites individual psychological factors alongside those individuals overcoming personal or organisational restraints. These themes have been developed further in the creation of scales such as the 'Likelihood to Sexually Harass Scale'. (13)

The UK literature evidences increased prevalence of sexual abuse within medicine where predisposing vulnerabilities of the victim exist. (1) Very often there is disparity in power, both in terms of seniority and commonly also in gender. We explore these themes in more detail in chapter 3.

ENVIRONMENTS WHERE ABUSE TAKES PLACE

If we are to reduce prevalence of sexual abuse within medicine, and also to manage cases effectively, we need to consider environmental factors. Searle et al. (11) report on the types of workplaces where incivility is common or tolerated. She describes the link between this and professionals losing connection with their professional standards of behaviour, in the extreme leading to sexual abuse. Several potential predisposing factors exist within medical environments. Firstly, power imbalances (14) create fear of negative personal and career impacts arising from disclosure. Secondly, a high-pressure environment, long hours and disruptive work patterns impact on work-life balance. This can lead to feelings of dehumanisation (14) and increased risk of perpetrating abuse. Some signs of dehumanisation include loss of empathy and moral disengagement, factors also noted in those perpetuating sexual abuse.

Parallels in terms of loss of empathy, responsibility and moral disengagement were found when professionally led self-regulatory systems failed in terms of patient care in the Bristol and Mid Staffordshire scandals. Here the adverse events were poor

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patient outcomes, but again with environmental culture highlighted as one where poor professional behaviours were thriving. Investigation revealed inappropriate protection by the organisation of colleagues whose performance was poor, failure to proactively investigate poor outcomes, and negative treatment of whistle-blowers. (13) If we are to respond appropriately to disclosure of sexual abuse in the medical profession and address under reporting, it is imperative that such organisational failures in self-regulation are addressed.

The Professional Standards Authority (PSA) (15) in the UK acts to improve the regulation and registration of health and social care workers, and the organisations they work for, with the ultimate aim of protecting patients. The PSA's first published guideline provides a framework to support the prevention of sexual abuse and the care of victims and provides a framework for reporting. (16) Sadly, sexual abuse still occurs and remains underreported in the National Health Service (NHS). (11)

We have drawn attention to cultures predisposing to abuse and should also consider the converse. Many organisations build better cultures, protect patients, and manage professional groups by effectively self-regulating through a range of both formal processes and informal peer networks. Such networks involve the sharing of ideas around professional values. Examples of formal protective processes include identifying Freedom to Speak Up Guardians in each trust or developing educational supervisors and programme directors who undergo regular accreditation and feedback from learners. Freedom to speak up within the NHS comes under the remit of the National Guardian's office. It is an independent body with the remit of driving culture change in the NHS and promoting disclosure regarding any issues which may adversely affect patient care. There are appointed Freedom to Speak Up Guardians in each NHS Trust who promote disclosure and to whom staff can disclose any concerns.

Sanfey and Ahluwalia (17) describe the value of increased clinical engagement to develop open cultures and early self-correction both individually and organisationally, leading to a high-functioning NHS organisation. The professionalism discussed is focused on behaviours that improve clinical outcomes, although other professional behaviours are also considered. Further research would be needed to consider if their proposed approach also applies to prevention of sexual abuse in the health care workplace.

Critical to the development of an effective self-regulating workplace is the empowerment of bystanders to act when seeing and hearing behaviours that are part of the slippery slope towards sexual abuse. This has been noted to be a current weakness in many health care settings (18), and if any of the 25% to 83% (19; 20) of health care workers citing sexual harassment could be protected before attack or outright abuse occurs, positive impacts across our systems would be substantial. Secondly, rigid hierarchy is also cited as a significant risk and especially when this results in a more significant gender and power imbalance at senior compared to junior level. (18) Work within health care settings to encourage open reflection of all

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TABLE 16.1 *Cultures in health service organisations affecting likelihood of abuse*

Potential impact	Cultural factors in the workplace
Increased likelihood of abuse	• Pronounced hierarchy creating power imbalance between professionals • High pressure work environment • Organisation fails to promote healthy work-life balance • Poor professional behaviour tolerated • Poor investigation into breaches of professional behaviour • Negative treatment of 'whistleblowers' (18) • Failure of professionally led self-regulation
Reduced likelihood of abuse	• Supportive, open work culture • Clear systems to protect staff and patients from abuse • Education around professional behaviours and staff safety • Bystanders empowered to speak up • Informal peer networks including discussion around work environment and professional values • Existence of and adherence to investigation procedures • Educational supervisors for each trainee, providing safe space around any issues • Freedom to Speak Up Guardians • Processes to protect those who report abuse • Effective self-regulation

professional and team behaviours across professional levels and groups would do much to empower both bystanders and potential victims to act before matters have deteriorated. Research into the optimal organisational response to early stages of sexual harassment would also be helpful. Where sexual abuse has occurred, clearly there is a need for significant accountability, and its lack has been cited as a frequent reason for failure to report. Much may be learnt from other organisations. Buchanan et al. describe strategies developed in the US military, including the need for regular self-assessment of the organisation for harassment. (21) They recommend education and policies on prevention, open systems to allow disclosure, decisive action and remediation.

We now consider the scenario where sexual abuse of a doctor in training occurs. Within the NHS, there is organisational provision responsible for post-graduate medical training. Within this education and workforce arm of the NHS, a network of trained educational supervisors and directors of medical education exists. Educational supervisors include training programme directors who run regular educational groups for their training cohorts, coming to know them well, and who often are the trusted mentors to whom events are disclosed. A training programme director in the UK is a postgraduate educator employed to provide education, career and holistic guidance during training. Training for supervisors includes developing skills in provision of educational supervision and

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pastoral care, encouraging peer support, and promoting a culture of multi-source feedback.

In addition to support/provision from the postgraduate medical education body, the employing NHS providers will have clinical supervisors who oversee daily clinical practice, also directors of medical education who have oversight of their educational provision and educational teams. Health care settings have access to human resources departments, and more recently in the UK Freedom to Speak Up Guardians and guardians of safe working who have a specific remit to be a point of contact for reports of any concerns around workplace behaviours or working patterns. However, people in these roles do not as yet have specific training in managing sexual abuse of doctors. Not all abuse is managed within the organisation. Some are reported directly to the police, particularly if the abuse involves an attack, acute intimidation, or administration of drugs.

It is clear that the management of a doctor who has suffered sexual abuse will involve understanding a range of their needs, which may span health, education, employment and legal aspects. Offering a holistic understanding of the range of these issues and having the ability to work with the doctor concerned through an integrated and person-centred approach opens opportunities to effectively address the concerns and impacts being experienced. This is similar to the skills used by generalist clinicians in their medical practice, offering opportunities to tackle complex, uncertain and dynamic situations (19) where, clinically, doctor and patient together actively explore and interpret the issues and context. In the case of abuse of doctors by doctors, where the victim may find difficulty seeking and accepting help, such an approach may be empowering and much needed in view of the complexity of the problems being faced. Reeve (22) describes the use of exploration and interpretation, or interpretive medicine, as helping to unleash creative capacity for progress during the experience of illness or effects of trauma. We propose that such an approach provides a strong theoretical foundation for working with abused doctors and clinicians.

It is essential that victims have the element of choice in terms of disclosing abuse. Choice of confidante may be based on developing earlier trust or on recommendation from a peer, and personal preference is sometimes influenced by factors such as age or gender. Some victims prefer the confidante to be a close and supportive colleague, while others prefer as much anonymity as possible, so disclosing to someone removed from their work environment. In addition to concerns about disclosure on career progression and attitude of peers, sensitivity should be shown to the fact that by disclosing such events, the doctor may feel they have exposed a very vulnerable and personal part of themselves. Disclosure itself to another member of the medical profession may in itself feel like a breach of personal boundaries, so as supervisors and medical directors we must ensure that victims feel safe, protected and respected at all times.

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INTERVENTIONS THROUGH AN INTEGRATED LENS

We now move on to consider interventions, within the UK organisational framework. Mental health issues in doctors are common, (23) disclosed late, frequently severe, can involve self-medication due to access to prescribing, and may require specialised help. In the UK, the Practitioner Health Programme (24) and NHS Practitioner Health (25) are free services for doctors with mental health, alcohol, or drug related problems where they can be seen confidentially. These services have been instrumental in assisting the management of the cases known to us where sexual abuse has led to mental health issues. Therefore, our recommendation is that where sexual abuse is disclosed, the victim be referred to a confidential medical service.

In our experience of managing perpetrators of sexual abuse, consideration needs to be given to whether the perpetrator has committed an offence and whether they have breached their duty as a doctor (26) and also as a supervisor (if in this role). A complex role for case managers ensues, such as reporting abuse to the appropriate regulatory authorities as a responsibility in protecting the public and staff, and in upholding the profession's standards, and considering the legal implications of the abuse, including reporting to the police where appropriate. In addition, teams should have an awareness of issues for perpetrators who frequently suffer psychological and physical consequences in the aftermath of discovery, and note that there is an increased suicide risk in doctors undergoing investigation. (27) Therefore, alongside support for victims and referral of the perpetrator to appropriate bodies, case managers should make perpetrators aware of the potential need to access medical or psychological assistance for themselves.

Timely health care, education and career support and appropriate time off can transform outcomes to for victims of sexual harassment. The failure to arrange support or address such issues can have significant consequences for the victim, organisation and even patients, if judgment is impaired due to ill health. In one case managed by our team, clinical judgment of the victim remained impaired for some years, leading to a breakdown in employer relationships and referral to the General Medical Council. This not only led to ongoing emotional trauma but also to negative career impacts. Even if realisation of complex professional breaches comes late, with careful case management, medical assistance, and astute perception on the part of the regulator regarding the complex and non-recurrent causes of the professional breaches, career and health can be restored.

The maxim 'first do no harm' should be considered in relation to unintended consequences of organisations involved in medical education, regulation and employment. Examples where inadvertent harm could be caused include situations where different organisations have jurisdiction over the two parties

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in the sexual abuse and use different thresholds for action. This can sometimes lead to perceived inequity in the management of the different parties. For example, a victim, encouraged to move geographically to another place (for work and protection), also stands to lose familiar environments and peer-support networks.

It is not uncommon for differing views regarding the management of perpetrators to emerge as well. We have experienced differences of opinion in relation to the threshold at which perpetrators should be referred to regulatory authorities for breaches of trust such as the prescribing or administration of medication to victims. One of the previously published concerns of victims of abusive sexual relationships, (28) regardless of professional group, has been that not only is there an abuse of power inherent in the case, but that the perpetrator with higher career status is perceived to be less likely to have negative career consequences. This can magnify the feelings of injustice, and in our opinion this is an area for the relevant organisations to keep in mind in the handling of such cases. If inequity of outcome were to be addressed, it would be likely that victims would feel empowered to disclose. Beyond this, there is evidence that work can be done to improve the self-regulatory potential of organisations (29) and improve their protective influence. Our recommendations would therefore be to take organisational level action to reduce the incidence of abuse, facilitate early disclosure, and ensure that organisational barriers do not further disadvantage victims of abuse.

When dealing with cases of abuse among doctors in training it is common practice to offer colleagues a safe space and supportive case manager to explore the wishes (with regards to dealing with their trauma and concerns) of the doctor, sensitively screen for the full range of possible (physical, psychological, educational and social) complications, and outline options for further help. It is common practice for the care and management of doctors in such difficulty to be undertaken by a team of professionals that includes a senior clinical educator (acting as a responsible officer) and senior managers with expertise in managing such complex situations. All cases involving alleged sexual harassment or abuse would be discussed regularly, negotiating a firm plan of action that remained in place until a satisfactory conclusion had been reached. This team can ensure that the affected learner is directed to appropriate resources and services including the practitioner health programme, (30) occupational health, professional support unit, and legal support, and liaise with employing organisations where abuse is alleged to have taken place. The professional support unit sits in each region. It provides a free service for doctors and other health care professionals in training to address a range of issues which can impact on confidence and progression in training. It typically sits independently of specialty training schools, which can be beneficial to provide separation from any structures where the perpetrator works.

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TABLE 16.2 *Range of available services*

Service	Reason for recommendation	Services offered
Case management	• May be initial point of disclosure • To assess issue and support needs for doctors in training • In particular assess any arising educational and career progression support needs	• Offer support • Signpost for further help • Arrange any adaptations to education and training, or time out of training for recovery • Take action in relation to perpetrator if they are also a doctor in training
Employer	• Assess safety of the environment at work which may have contributed to abuse occurring • Assess any needs arising for the victim in the workplace • Employer of the perpetrator to investigate any breaches of professional behaviour and take action	• Take action to change the working environment to protect the doctor and others in future • Take supportive action in the workplace for the victim • Maintain victim confidentiality • Support time off, adapted working, or change of working base if desirable to the victim • Take action in relation to the perpetrator
Police and legal action	• If a crime may have taken place such as assault, rape, or use of drugs ('date rape' drugs)	• Investigation and legal action
Occupational health	• Health of the victim is likely to have been affected • Assess the victim's needs in relation to work • Assess the perpetrator if appropriate for fitness to work. Consideration of any conditions affecting their safe practice	• Make recommendations for the employers, in terms of fitness to work, and the need for adaptations, without necessarily disclosing the content of the assessment within normal ethical confidentiality policies
Practitioner Health Programme	• Support doctors with health conditions • Specialises in mental health, also drug and alcohol problems	• Full range of psychological support services led by senior clinicians specialising in doctors' psychological health • Full confidentiality • Easily accessible
General Medical Council	• Referral of perpetrator where professional duties of a doctor may have been breached	• Investigation considered, such as fitness to practise investigation • Decision if any 'conditions' are to be placed on the doctor's practice, or suspension

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REFLECTIONS FROM EXPERIENCE

In this part we share reflections drawn from our experience of managing trainees who have directly or indirectly experienced sexual abuse. We have also drawn out themes from an anonymised case study from another participating country to protect the identity of the victim. In our experience looking after doctors in training, most cases involved women abused by men. The effects of such abuse have resulted in complex mental and physical ill health, as well as affecting work performance and relationships. Most commonly there has been a significant power differential such as supervisor–supervisee or a line manager relationship where there has been an abuse of trust.

By the very nature of sexual abuse there has been a breach of ethical and professional standards, and in our experience, this may spread across several professional domains beyond that of sexual abuse. We recommend that managers of such cases should be alert to this possibility. Transgression of professional boundaries, in addition to those of a sexual nature, may occur during or in the aftermath of sexual abuse. Medication abuse is one such example. Drug administration by the perpetrator is a rare but devastating action as part of sexual assault, made more likely by doctors having access to medications. In a number of cases we managed, psychotropic medication (normally used for anaesthesia or pain relief) was obtained either to perpetrate a sexual assault or prescribed as part of an ongoing abusive relationship, both resulting in significant psychological harm to the victims. Further complicating health factors resulting from abuse can include a range of sexual health and reproductive issues, severe mental health disorders and self-harm. Breach of professional and sexual boundaries on organisational premises may also affect other colleagues and patients, if any events are witnessed or suspected

CONSIDERATION OF ILLUSTRATIVE CASE

The case in Table 16.3 brings together several issues which need to be considered in the context of this book related to the perpetrator and the victim. Taking an integrated approach to support the victim and in the management of such a case is essential.

In this scenario, little is known about the perpetrator, other than his gender, seniority, and a positive reputation professionally. While for the purposes of the book more detail about his personal life could have been given, in reality junior doctors and teams may not have much other background information about their senior colleagues, and especially in the case of a perpetrator grooming their victim. Perpetrators are likely to be able to seek more information than they share. It is normal practice for senior colleagues to inquire about a junior doctor's life as part of a mentoring relationship, but it is unusual for junior staff to be comfortable asking personal questions of their supervisors. Perpetrators may be even less likely to share

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TABLE 16.3 *Illustrative case study*

May is a twenty-nine-year-old registrar in obstetrics and gynaecology, working in a major teaching hospital in London. She is the only daughter in her family and immigrated to the UK as a young child from Singapore. Her parents have high expectations of her, and she has worked hard all her life, with academic scholarships and extracurricular achievements in music. She graduated with honours and decided on a career in obstetrics and gynaecology after her clinical rotation in this discipline as a student.

Although she has a good academic record, May has had some difficulty as a foundation doctor. She is slight and softly spoken, and somewhat anxious, and she has found it difficult to assert herself in clinical teams, often staying back late to ensure things are done well. She admits she has always been a perfectionist. May had a long-standing relationship with another medical student at university, but she broke up with her boyfriend when she decided he was 'too controlling'.

This is her first term as a registrar in the Obstetrics and Gynaecology team. She has found the term very difficult, as she sees the other registrars as 'more extroverted and definitely more competent' than her, and she has had trouble maintaining her confidence. In addition, there have been some interpersonal issues with the midwives on the wards.

One of the consultants on her team is a highly respected senior obstetrician, with a reputation as an excellent gynaecological surgeon. However, she has been feeling increasingly uncomfortable with his behaviour and his comments recently. At first, she felt singled out as he was very encouraging, and commented that 'he always felt safe leaving his patients in her hands' because she 'went above and beyond to care for them'. He seemed interested in her as a person, and asked her about her family, and her support system. However, his remarks have become more personal, with comments about her appearance, with a recent comment 'your ex-boyfriend doesn't know what he's missing out on'. He invited her out for dinner one night when she was working late, and although she declined, he has continued to ask her again and text her after work so she can 'meet him for drinks'. Because she feels isolated in the team, she hasn't felt able to disclose this to her fellow registrars, but she became increasingly anxious about seeing him at work. At one point, she was sure he followed her home.

Last month, he was assisting in theatre on a gynaecological operation, and he insisted she suture one of the incisions. He stood behind her, giving her instructions, and she could feel his erect penis rubbing against her back. She was aware that there were other members of the team in theatre, and felt she couldn't say anything, so she finished the operation and then left the hospital, telling administration team members that she was unwell. She has not been back to work since.

May has had escalating anxiety whenever she thinks about work and has nightmares about this consultant. She is also experiencing insomnia and has lost 5 kg because she has 'no appetite'. She has been avoiding seeing her friends and family. May finally consulted her GP, who encouraged her to seek further help. She knows she 'should' report this but feels too 'ashamed' to do so. She is afraid this will mean the end of her career.

personal information if this is likely to act as a barrier to a closer relationship with the person they are grooming (e.g. if they are married). Perpetrators are likely to use their position of power and 'good standing' to encourage communication with a potential victim, and to encourage trust within the relationship, which sadly may then be

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abused. In this case the perpetrator holds a position of power clinically and as a potential career mentor. This case also exemplifies another risk for abuse – opportunity and use of 'tools' within their career armoury to abuse. In this case the physical opportunity of proximity to operate, under the guise of assistance for learning a practical procedure, was used, and particularly when the victim could not 'escape' at the time without abandoning the patient procedure or calling for help when in an area surrounded by colleagues of the well-respected consultant.

This case also highlights several elements in relation to the victim. Elements referenced in this case include the victim's junior status (and resulting power imbalance), gender, and lack of formal or informal support networks – all risk factors that may have reduced her likelihood of 'speaking out'. In addition, her described lack of confidence, 'less extrovert' personality and possibly a tendency to feel ashamed instead of feeling affronted further add to the risk of not reporting the first signs of breaking through normal professional boundaries. This book, in examining abuse of doctors by doctors, highlights that this is a truly global phenomenon, sadly, and that such issues need addressing worldwide. It may be the case that working in an environment that is not your country of origin further increases feelings of disempowerment and leads to underreporting. In addition, there may be differences in cultural tendencies to report sexual infringements, which this book explores. The word 'ashamed' is used in this case and may be relevant in this context.

In terms of management of this case through an integrated lens, it is appropriate that a holistic approach be taken. The victim may have chosen the person to whom they wish to disclose carefully, and sensitive handling of this discussion is paramount. The person to whom they disclose may feel shock, sometimes initial disbelief, and also a feeling of intense urgency to act or react. Working collaboratively with the victim to gain permission to draw in an appropriate case manager, so that a productive relationship can be formed, is very important in reducing the traumatic impact on the reporting junior doctor. The importance of judging pace of any stepwise support and investigation at the rate accepted by and appropriate for the victim is also critical.

Personal preferences in terms of communication style and interventions should be considered. For example, some victims will feel empowered by knowing that such abuse is not uncommon and that there are systems and services to offer support. Underreporting emphasises that other victims can feel a real lack of confidence, but signalling that there is progress with increasing numbers of victims speaking up can help. Some victims will not be motivated by systems factors, and this should also be respected.

All victims should be offered the chance to address their individual experience and narrative with highly skilled services. As highlighted in the case, a range of physical and psychological ill health can result from such abuse, and appropriate medical care from the trainee's GP, occupational health, or specialist services such as the practitioner health programme would be offered. In this case May has clear

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physical and psychological symptoms of anxiety and depression, leading to a break down in ability to cope or attend work. Victims need to be informed about their options, including the appropriate bodies that could be involved in the investigation of their abuse (e.g. employers, legal systems, etc.), the likely manner in which investigation could occur, and the possible outcomes for each potential course of action.

It is critical that victims build back confidence in themselves, and also the systems which should support them, with factually correct and appropriate information. Any fears or needs around the victim's educational and career journey should then also be addressed. Interventions would need to match the trainee's needs and personal situation as well as their wishes. This may range from sick leave during investigation, treatment and recovery, through to adjusting the place of work depending on the teams or perpetrator implicated in the abuse. Understanding context and the doctor's wishes around the full range of complex issues will be central to assisting in the doctor's next steps following the trauma.

CONCLUSION

In this chapter we describe principles around integrated management of sexual harassment and abuse to ensure that the consequences of abuse (physical, psychological, educational and social) are acknowledged, and victims are supported to safety and healing. It is also increasingly recognised that such abuse takes place in organisational and social contexts and that policy and practice are required for effective prevention. We must also acknowledge that abuse of doctors by doctors is a sub-set of a much larger issue – abuse of individuals based on differences in power and social status.

Education and training have an important role to play in recognising and preventing abuse. Awareness raising (12) as well as bystander training has been recommended, (5) and can help organisational culture to recognise the inappropriateness of sexual harassment and abuse in the workplace. There is much potential here to help empower doctors at an early stage to identify inappropriate behaviour before outright abuse or attack occurs. Clearly all staff should feel empowered to take positive action, so men and women play an incredibly important role in assisting with this remit, and in giving the target a voice if they do not feel sufficiently empowered to report alone.

Our review of the literature with a particular context of the doctor in training suggests that much further research is needed if we are to have a better understanding of the drivers and motivations of perpetrators as well as the most effective strategies for preventing such abuse, or rehabilitating perpetrators. Such information will be critical for teams managing the needs of victim and perpetrator. Finally, ensuring that workplaces facilitate speaking out and the culture is one of investigating and acting on any reports of abuse is paramount. (6) The organisation holding

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formal guidance and policies on appropriate behaviours (31) must accept the responsibility of leading cultural change by consistently addressing reports of misconduct if they are to be effective in this most fundamental arena of staff safety and wellbeing.

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