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Introduction

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Sexual harassment in medicine is a common, global problem hiding in plain sight. (1–3) It is difficult to detect, measure and eradicate, (4; 5) partly because there is a complex web of medical organisations involved in managing the doctors involved. Multiple organisations are responsible for responding to harassment, but individual policies and processes are often opaque, complex and partial. (6) Survivors describe reporting mechanisms that are difficult to navigate, and many survivors experience considerable harm arising from the reporting process. (6; 7) Few feel there was significant benefit to reporting sexual harm. (8)

The United Nations Chief Executives Board, in its report on victim-centred approaches to sexual harassment, discusses the importance of giving victim-survivors choice and agency. The report suggests 'engaging with a victim/survivor in a way that respects their rights, needs, wishes and dignity, protects them from retaliation, re-traumatization and discrimination, keeps them informed, and supported'. It emphasises the importance of respect for the victim's/survivor's dignity, focusing on empowering the survivors, and therefore enabling them to choose the way they respond to abuse. (9)

Survivors may have one or more goals when managing harassment. Some will seek justice, wanting to expose the perpetrator's behaviour and hold them publicly accountable for their misconduct. Others will want to ensure colleagues are safe from the perpetrator's behaviour and will be keen to ensure they protect more vulnerable colleagues in the future. Some will simply want a chance to heal. Although some countries, including Australia, emphasise the positive duty to report, this approach fails to recognise the impact of reporting to survivors, and does not recognise the importance of choice for survivors trying to regain confidence and a sense of agency.

STRUCTURE

In this part, we examine the multiple disciplines involved in the prevention and management of sexual harassment and describe common dilemmas faced by the

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organisations tasked with managing harassment in the medical workplace. Every organisation has strengths and capacities, but they also have limitations in their ability to manage sexual harassment. In this part, we have asked experts to analyse the problem from within their discipline, and describe the strengths and limitations of their organisational approach.

In the first chapter, Searle examines the psychological evidence behind sexual harassment, and abuse and discusses some of the dilemmas. While sexual harassment clearly causes harms to employees and clients, exposing sexual harassment can cause reputational damage and reduce trust in the organisation. There is also evidence that the reporting process can be highly traumatic for survivors. The perpetrator is likely to be more senior than the survivor, and may well be a high-profile asset for the organisation. The survivor is likely to be a more junior and more temporary employee with less notional value to the workplace. This power differential makes management particularly difficult, as the perpetrator may not be easy to replace. There is also a fine balance needed between openness and transparency, protecting the survivor from re-traumatisation and victimisation when their name becomes known in association with the harassment.

The chapter on law examines some of the barriers to justice and fairness in legal systems. As a barrister, Freckelton brings his detailed understanding of the cultural and structural barriers to reporting through legal channels. He uses three case studies from Australia to illustrate the challenges of reporting sexual harm through criminal and civil courts and tribunals, recognising how the system itself causes harm to survivors. He describes how legal processes may fail, so that despite the personal and professional risks a complainant endures, the outcome may not prevent future harm, or deter the perpetrator from future misconduct.

Ringin presents her work on human rights organisations, discussing their achievements and limitations. Although human rights frameworks have led to standard setting across the world, they offer little to an individual in terms of timely redress. However, the value of human rights work lies in collective advocacy. Common data, language and criteria enable grassroots organisations to agitate for collective rights at a local and national level. Over time, human rights principles can drive changes in legislation, so that workers can be protected under law.

Health professionals, including doctors, are in a unique position because they may be accountable to a medical regulator as well as to local legislation. Medical regulators exist to set and maintain professional standards, so that the public are protected from health professionals who demonstrate practice that puts the public at risk. With sexual harassment, there are different regulatory standards around the world, and in chapter 13, Reid uses her leadership of the International Association of Medical Regulatory Authorities (IAMRA) to highlight the common key processes of medical regulation agencies internationally and the significant differences between

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them. Medical regulators hold an important role in disciplining practitioners whose behaviour does not explicitly meet the legal threshold required for consideration in local courts. However, the differences between agencies and jurisdictions can mean it is difficult for a survivor to clearly understand and utilise these processes effectively.

Chapter 14, on medical education, highlights several major limitations for survivors who are still doctors in training. The steep professional hierarchy and the blurring of roles in teaching and supervision mean learners may be very dependent on their senior colleagues for career progression. This means that doctors in training may be reluctant to report sexual harassment due to concerns about the impact on their careers. In addition, workplace-based learning means doctors in training may be managed under two distinct policy frameworks: one at the workplace and one with the institution who oversees their learning. This can mean that survivors may have difficulty understanding their options when attempting to report abuse. They may also choose to avoid reporting simply because they move between teams relatively rapidly, and so may choose to endure the abuse and 'move on' rather than begin a lengthy reporting process that will last longer than their placement. Finally, the chapter explores the challenges of identifying, remediating, and, if necessary, removing doctors in training from the profession.

Hastings-Truelove and Flynn outline some of the challenges faced by doctors when they seek therapy. Apart from the obvious blurring of boundaries when seeking therapy inside a community that causes harm, there are defence mechanisms used by doctors that can impede the ability of survivors to seek and engage in therapy at all. In this chapter, the authors explore strategies to encourage survivors to seek care, and to overcome the stigma and shame that often accompanies trauma.

Finally, Roberts and Ahluwalia use their experience in the UK to explore how each of these disciplines can be integrated to ensure that survivors are able to access care showing how organisations can draw on multidisciplinary approaches to prevention and management. This chapter discusses an integrated and holistic approach to preventing, responding to and managing sexual abuse of doctors, focusing on organisational as well as individual factors. Using a case study, they explore how different organisations can work together to achieve better outcomes in prevention and management.

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