36

Conclusion

Louise Stone and Rosalind H. Searle

In writing this chapter, we realise we have not produced the evidence-based guideline that many would want to see. We remember approaching a senior bureaucrat in Australia and describing what we have tried to achieve. 'I hope it provides solutions', she said, 'and isn't just another collection of complaints'. While the book is not a 'collection of complaints', we have not attempted to provide a solution-focused manual. In the Introduction, we wrote that this book is not a reckoning. It is also not a protocol to support specific action. The reason is simple. We do not believe there is one solution that is universally relevant.

In medicine, we often see simplified 'solutions' proposed to address complex health issues. These 'solutions' don't work, or they only work for the privileged. We did not want to replicate that approach. Instead, we have chosen to explore the complexity of the deeply sociocultural issue of sexual harassment and abuse.

In this conclusion, we have produced several frameworks for jurisdictions and individuals to address this problem in their own culturally relevant way. We present a way of understanding the problem, drawing on the insights included throughout the book. We then outline a health promotion framework, also synthesised from the collective expertise of the authors.

CREATING CULTURAL CHANGE: DIAGNOSING THE PROBLEM

Medical culture is seriously unwell. In psychiatry, one way of understanding illness uses formulations, descriptions of why a person may be ill at this time. Formulations help guide treatment, because they support us to understand the issue in all its complexity. They are often written using the categories of predisposing factors, precipitating factors, perpetuating factors, and protective factors. We can use the same discipline to approach the problem of sexual harassment in medicine, using the insights our contributors have detailed throughout this book. This framework can be adapted to any context, to help institutions understand the most relevant interventions for their particular culture.

Downloaded from https://www.cambridge.org/core. UNIVERSIDAD AUTONOMA METROPOLITANA, on 17 Nov 2026 at 02:45:52, subject to the Cambridge Core terms of use, available at https://www.cambridge.org/core/terms. https://doi.org/10.1017/9781009673037.039

Downloaded from https://www.cambridge.org/core. UNIVERSIDAD AUTONOMA METROPOLITANA, on 17 Nov 2026 at 02:45:52, subject to the Cambridge Core terms of use, available at https://www.cambridge.org/core/terms. https://doi.org/10.1017/9781009673037.039

TABLE 36.1 *Creating a formulation of the problem of sexual harassment in medicine*

	Predisposing factors	Precipitating factors	Perpetuating factors	Protective factors
Cultural issues in society as a whole	Intersectional privilege hierarchies in society Doctors being seen as beyond reproach because of their work ('moral licencing') High prevalence of childhood, adult and intergenerational trauma Weak legal sanctions in the prosecution of sexual assault Rape myths that blame survivors for their own abuse and resultant trauma The high risk of punishment, including public shaming and marginalisation, of those who report	Trauma outside of medicine Reports of sexual harms in the media that reinforce rape myths	Rape myths, that cause targets to be criticised in public, leading to targets being reluctant to report or withdraw their reports. Public support for alleged perpetrators	Improved sexual safety literacy in society Survivor stories and support networks and peer support

TABLE 36.1 *(continued)*

	Predisposing factors	Precipitating factors	Perpetuating factors	Protective factors
Cultural issues within the profession	Hierarchical structures in work and in training making juniors vulnerable Competition with others for career progression Stigma and shame around mental illness The 'theory of beneficial mistreatment', normalising self-sacrifice and feats of human endurance	Lack of challenge from colleagues, including critical failure to speak truth to power	'Intergenerational' trauma of doctors, including exploitation of the workforce Availability and normalisation of use of drugs and alcohol Drinking culture of off-site workshops and conferences Exceptionalism – feeling of being above the law, working in the grey areas between law and policy	Improved sexual safety literacy in medicine Survivor stories and support networks and peer support Senior medical 'champions' and mentors within the profession
Workplace and regulatory harms and limitations	Medical regulatory harms leading doctors to avoid mental health care for fear of de-registration 'Wellbeing washing' – employers offering over-simplified solutions to complex problems 'Performative policies' – which make claims to safety that are not implemented or monitored.	Moral licensing of perpetration because of the reputational good they offer the organisation and individual patients and team members	Institutional dependence on the exploitation of junior medical staff Weak and inconsistent legal sanctions Weak policy implementation, especially early identification and reporting of illegal activities with policy systems that overlap and contradict each other from multiple organisations (e.g.	Effective policy, that integrates with other policy systems and does not act in isolation Time for moderated peer reflection in training Protection for whistleblowers Safe regulatory processes

Downloaded from https://www.cambridge.org/core. UNIVERSIDAD AUTONOMA METROPOLITANA, on 17 Nov 2026 at 02:45:52, subject to the Cambridge Core terms of use, available at https://www.cambridge.org/core/terms. https://doi.org/10.1017/9781009673037.039

Downloaded from https://www.cambridge.org/core. UNIVERSIDAD AUTONOMA METROPOLITANA, on 17 Nov 2026 at 02:45:52, subject to the Cambridge Core terms of use, available at https://www.cambridge.org/core/terms. https://doi.org/10.1017/9781009673037.039

	Workplaces and regulatory bodies casting mental health as an individual not a structural issue Using 'resilience' narratives to cast structural failings as individual responsibilities Increasing expectations on doctors with diminishing resources, leading to moral distress and harm		universities, workplaces, medical regulators, etc.) Improvised systems of gathering evidence (delays and not trauma-informed) and unclear or inconsistent reporting structures The high financial and emotional cost of reporting Institutional moral disengagement to discount significance of these events and the trauma they can create Institutional dependence on senior medical leaders leading to protection of senior staff to manage institutional reputation	
Occupational trauma and violence in medical workplaces	Growing levels of workplace aggression and violence from patients and family members Limited acknowledgement of occupational risk in workplaces	Working in unsafe environments that normalise occupational trauma Tolerance of microaggressions in the workplace Tolerance of interprofessional microaggressions in the workplace		Senior medical 'champions' and mentors within the profession Effective support for staff experiencing trauma in the workplace

TABLE 36.1 *(continued)*

	Predisposing factors	Precipitating factors	Perpetuating factors	Protective factors
	Exposure to psychological trauma as part of medical work			Time for moderated peer reflection in training
The structure of medical work	Long working hours impede healthy lifestyles and relationships outside medicine Little time for reflection and self-regulation Professional and social isolation, especially in rural practice Extensive cross-institutional support networks and multi-agency power and privilege hierarchies	Stress and exhaustion (mental and physical) Isolation from friends and family and mitigating social supports and expectations Power and opportunity Residential terms and isolated rotations Lack of diversity and inclusion in leadership	Home–work boundary blurring, e.g. off-site residential training and conferences, on-call provisions Physical intimacy boundary blurring, e.g. social touching taboos need to be renegotiated in medical work – proximity in theatre, emergency departments	Improved sexual safety literacy in medicine Survivor stories and support networks and peer support Senior medical 'champions' and mentors within the profession Doctors' health services Effective policy, that integrates with other policy systems and does not act in isolation Reasonable hours of work
The structure of training	Use of short rotations	Stress and exhaustion (mental and physical)	Relationships between health professionals almost a given	Sexual safety and wellbeing training

Downloaded from https://www.cambridge.org/core. UNIVERSIDAD AUTONOMA METROPOLITANA, on 17 Nov 2026 at 02:45:52, subject to the Cambridge Core terms of use, available at https://www.cambridge.org/core/terms. https://doi.org/10.1017/9781009673037.039

	Isolation from the support of friends and family for doctors in training means less support and social stability Iterant worker status of doctors in training whose lack of tenure and standing in the team can make them disposable Over-reliance on subjective assessments for career progression Close personal relationships with mentors who are also supervisors, educators, assessors and employers Patronage systems, where a doctor in training is expected to 'pay' for their learning opportunities	Rapid social change, changing teams frequently and therefore not feeling embedded, mentored and supported in any particular team Vulnerability during early training while taboos around sex and intimacy are restructured 'Sexual banter' can become normalised, raising the risk of grooming Stigma surrounding help-seeking	because of lack of other social opportunities – exploiting boundaries with the vulnerable, e.g. during training Failure of universities to remove medical students identified as having problematic behaviours during the early stages	Oversight of learning environments and safety Interpersonal, teamwork and wellbeing curriculum Teaching trauma and trauma management including vicarious trauma Time for moderated peer reflection in training
Discrimination in medical culture	Male dominant leadership with accumulated privileges for those at the top Inequality of leadership and development	Being isolated due to intersectional disprivilege Experiencing racism and discrimination in the workplace Tolerating microaggressions in training and practice that	Exploitation of international medical graduates to meet workforce needs without adequate support Routine discrimination and harassment from management,	Diverse medical 'champions' and mentors within the profession

Downloaded from https://www.cambridge.org/core. UNIVERSIDAD AUTONOMA METROPOLITANA, on 17 Nov 2026 at 02:45:52, subject to the Cambridge Core terms of use, available at https://www.cambridge.org/core/terms. https://doi.org/10.1017/9781009673037.039

Downloaded from https://www.cambridge.org/core. UNIVERSIDAD AUTONOMA METROPOLITANA, on 17 Nov 2026 at 02:45:52, subject to the Cambridge Core terms of use, available at https://www.cambridge.org/core/terms. https://doi.org/10.1017/9781009673037.039

TABLE 36.1 *(continued)*

	Predisposing factors	Precipitating factors	Perpetuating factors	Protective factors
	opportunities for doctors from diverse backgrounds Women doctors can feel they are in a social 'no man's land' between the doctors and nurses Visa arrangements for international medical staff and students increase vulnerability of international graduates	are not managed effectively or dismissed	staff and patients, normalising abuse	Effective diversity training, recruitment and support Effective management of racist and sexist microaggressions in the workplace
Individual characteristics and experiences	Prior experience of discrimination, harassment and assault Prior experiences of reporting and being silenced or shamed Being in a lower position in the social hierarchy in medicine Economic dependence on medical work (including visa status) Unstable employment Mental illness, burnout and substance misuse	Emotional immaturity Insecurity and rigid thinking Perpetrator moral disengagement from their actions, denying and downplaying their impact	Stigma and shame Personal characteristics like perfectionism that impede reporting	Time for moderated peer reflection in training Access to effective health care for doctors that is appropriate for physical and mental health care needs

CREATING CULTURAL CHANGE: HEALTH PROMOTION

Throughout the book, authors have discussed interventions at all stages of the health promotion hierarchy. A common problem in this field is to attempt to eradicate sexual harassment by using only one solution, targeting one level or stage of the health promotion trajectory. Inevitably, these single solutions will fail.

In the following framework, we attempt to classify the solutions and approaches described in this book into health promotion stages. We will not discuss broader issues outside of medicine, including the structure and function of law, education and other social institutions or the multiple marginalisations experienced by students before and during their training. Broader social risks are described in chapter 8, and issues around gender inequity are well-described in chapter 2. Instead, we will focus on change within medicine.

PRIMARY HEALTH PROMOTION

Primary health promotion is an attractive option, because it works on preventing misconduct occurring at all. Around the world, there have been calls for 'zero tolerance' of sexual harassment, with organisations using primary health promotion strategies to reduce risks, ideally until the issue is completely resolved.

In general, strategies in primary promotion fall into the following categories:

Training for Employees to Ensure Everyone Has a Common Understanding of their Obligations

The start of sexual harassment prevention is making sure all workers can recognise sexual harassment and understand their obligations under law and the organisational policy to prevent it. In some countries, there is no legal precedent for this work, as sexual harassment is not defined in law, which can make this process challenging.

To prevent sexual harm, employers need to provide all workers with clear and consistent information, instruction and training. One of the biggest issues is that different people will have different understandings of what sexual harassment is (see chapter 4) and so may respond, or not respond, to different situations. This is especially the case where staff come from different cultural backgrounds where understanding and tolerance of sexual harassment can diverge.

Common approaches to this type of health promotion are to mandate educational programmes and to ensure the knowledge is mastered using a variety of assessment tools. In doing so, organisations can guarantee that their employees are informed about sexual harassment, and can define it, but there is no such guarantee that they will recognise it when it occurs in the workplace. These approaches are compliance

Downloaded from https://www.cambridge.org/core. UNIVERSIDAD AUTONOMA METROPOLITANA, on 17 Nov 2026 at 02:45:52, subject to the Cambridge Core terms of use, available at https://www.cambridge.org/core/terms. https://doi.org/10.1017/9781009673037.039

focused and fail to include attention of the informal systems of how such policies will be utilised in situ.

Skill Development to Recognise and Respond to Sexual Harassment

While people may recognise sexual harassment in theory, they may not recognise it in practice. Some of our editors have had experience running scenarios of discrimination and harassment, role-played by professional actors. Even when primed and supported, we have been surprised at how difficult it is for medical students to respond to these situations.

Knowledge of sexual harassment is not the same as the capability to recognise and respond to it in context. There is a clear difference here between knowledge and professional skill. There is a body of research work needed to underpin this form of training to ensure it translates into action in the workplace.

Assessing and Managing Risk

In order to manage issues around sexual harassment in medical workplaces, it is necessary to understand risk. We are still learning about individual and team risk, but initiatives like HOTSPOTS in New Zealand (described in chapter 14) attempt to map risks over time, based on a dynamic analysis of learners' feedback. Using this model, we expect it will become possible to identify high-risk teams, and potentially high-risk individuals. Hopefully, we will also be able to detect and communicate features of highly functional and psychologically safe teams, so these skills can be transmitted to learners and educators in the future.

However, doing this work requires much more granular data about interpersonal behaviour than we have in practice. We trust that education and skills development will create a common language around sexual harassment, and therefore provide more accurate and predictive data. We also expect that further research in this area, particularly ethnographic research, may inform responses to particular workplaces, such as emergency departments, surgical theatres and mental health facilities, where sexual harassment seems to be more common.

Developing Safe Work Policies

Policy development seems to be central to providing a safe workplace. However, it should be recognised that sexual assault has been illegal in most jurisdictions for decades, and yet even extreme forms of abuse, such as rape, continue to occur. There are two important aspects of policy to consider. Firstly, the policies must be known, and this is a question of education. Secondly, they must be accepted, respected and followed. The problem here is that written policies may not reflect

Downloaded from https://www.cambridge.org/core. UNIVERSIDAD AUTONOMA METROPOLITANA, on 17 Nov 2026 at 02:45:52, subject to the Cambridge Core terms of use, available at https://www.cambridge.org/core/terms. https://doi.org/10.1017/9781009673037.039

the hidden rules that are accepted by staff, more commonly described as 'the way we do things around here'.

There is a parallel in urban planning, to describe the way humans (or animals) may create an alternative path to the one created for them. One phrase for these paths is a 'free will way', an unplanned small trail caused by human or animal traffic that shows us where we choose to travel. It is usually the shortest or the most easily navigated route to the destination, the short cut, or preferred route to a destination, and the depth of its surface erosion is often an indicator of the traffic level it receives, relative to the official route. In other words, a free will path reflects 'the way we do things around here'.

Despite building formal policies, laws, and educational materials that look effective, predators continue to use these preferred routes and use cultural, hidden rules that leave survivors abandoned. The work that needs to be done is to understand how these hidden paths have been used, how policies have succeeded (or failed) to meet their objectives, and how inappropriate attitudes and behaviours can be challenged and changed.

Performative policies need to be changed. Employees view workplace policies as genuine when they are motivated by care and concern for employees, and are thoughtfully and consistently implemented. Insincere or inequitable policies can lead employees to question the overall ethics or values of an organisation and trigger a lack of trust. In this way, policies can actually impede reporting. Unfortunately, employees can base their trust in the organisation on the implementation of the entire policy suite. This means that when a hospital claims to value their employees, but continues to expect unpaid overtime from its junior staff, or use other exploitative practices, it undermines trust in their entire policy framework. Over time, such abuse can transform into distrust.

Finally, it should be recognised that policies intersect. A doctor in training who has experienced sexual harassment may report to a number of organisations and disciplines, described throughout Part 2. Inconsistent policies, policies that overlap or contradict each other, and policies that are deeply opaque mean that survivors distrust the process, and do not report.

SECONDARY HEALTH PROMOTION

Survivors of sexual harassment are more likely to come from disprivileged populations. As detailed in chapter 20, international medical graduates are at higher risk. There is little written about secondary health promotion, perhaps because it is quite confronting to consider the cultural prejudice and discrimination behind the choice of doctors likely to be targeted. If we decide to implement a curriculum that assesses and addresses racist behaviour towards international medical graduates, we need to accept that our profession has deep sexist and racist roots, which is uncomfortable. It reveals the wider identities of ingroups and outgroups that maintain wider systems of

Downloaded from https://www.cambridge.org/core. UNIVERSIDAD AUTONOMA METROPOLITANA, on 17 Nov 2026 at 02:45:52, subject to the Cambridge Core terms of use, available at https://www.cambridge.org/core/terms. https://doi.org/10.1017/9781009673037.039

patronage within the profession. Nevertheless, the strategies that work for privileged doctors may not be as effective with those who live with intersecting marginalisations.

The second issue is understanding and responding to high-risk environments. Because our measurements of prevalence are inconsistent, both in definition and methodology, it is difficult to compare learning environments. Strategies successful in an operating theatre, a highly ritualised and formal team environment, may be counterproductive in a community clinic.

Identifying High-Risk Situations

There have been prevalence studies in many medical workplaces across different countries and different contexts. There have also been studies of medicine relative to other health and social care professions that specifically identify the greater frequency of this issue for and within medicine. However, at the time of publication, there have been few high-quality studies that have compared prevalence across contexts using the same methodology and the same criteria.

We know that doctors are at risk of sexual harassment from nurses, carers and patients, as well as colleagues. One of the issues in medicine is that patients may, at times, lack capacity to regulate their behaviour. For instance, surgical patients may behave quite differently while recovering from anaesthetics. Patients with dementia or mental illness may be unable to regulate their behaviour due to illness or disability. Emergency departments can seem quite chaotic, and may have patients who are still under the influence of drugs and alcohol. In these environments, inexperienced doctors can have difficulty distinguishing the sexually aggressive patient from the unwell patient, and may therefore tolerate behaviour that would be unacceptable in other contexts.

Supporting High-Risk Targets

This is a difficult area, because population risks and individual risks are not the same. For instance, certain communities may be particularly intolerant towards doctors of a certain race. Identifying those doctors at risk is difficult. We do know that international medical graduates are at particular risk, and in the training of these doctors to manage expectations of medical practice, there needs to be similar training to help these doctors respond to racism, harassment and discrimination. Racism can also lead to witnesses discounting the experience of International Medical Graduates.

Throughout the book, authors have highlighted the importance of training everybody to respond to inappropriate behaviour. Normalising good bystander behaviour as well as strategies to manage harassment as a target is essential to ensure doctors living with multiple marginalisations are well supported. This is vital to fostering and maintaining trust within these teams and workplaces.

Downloaded from https://www.cambridge.org/core. UNIVERSIDAD AUTONOMA METROPOLITANA, on 17 Nov 2026 at 02:45:52, subject to the Cambridge Core terms of use, available at https://www.cambridge.org/core/terms. https://doi.org/10.1017/9781009673037.039

Managing High-Risk Perpetrators

There is little written about perpetrators in medicine. Researchers from the University of Melbourne have analysed risks to identify the higher risk from repeat perpetrators in doctors and thus the value of distinct sanction. (1) Professor Searle's work suggests there may be a difference between the predator, who chooses medicine to access targets, and the doctor whose behaviour becomes disordered over time. (2) While there is little written about early identification of high-risk individuals and the effectiveness of remediation, we have seen in multiple chapters of this book that perpetrators are rarely removed from the medical workforce, resulting in escalating scale and frequency of sexual assault. This is one area where more research is needed, to better understand not only how to exclude potential perpetrators from the medical workforce, through selection and assessment processes (see chapter 14), but also how medical culture supports and enables sexual harassment and abuse. Senior medical staff may lead a very socially restrictive life, with extensive work commitments precluding the development and maintenance of personal and social support. The rates of alcohol abuse, mental illness and death by suicide are disproportionately higher in doctors, and we are yet to acknowledge and understand how medicine as a culture can actually drive professional misconduct. This is a difficult, but necessary, area to research.

TERTIARY HEALTH PROMOTION

Unfortunately, it is unlikely that sexual harassment will be eradicated from the workplace altogether, so it is essential that organisations have the systems and processes in place to better identify issues, and to reduce the further trauma from the reporting process. Although it is obviously important to communicate the process clearly, it is also critical to make the process trauma-informed. As discussed in chapter 35, trauma-informed processes are essential. In the case of reporting, the following strategies may be helpful.

- Establish a trustworthy and capable team for reporting and to support those involved in these processes. Conflicts of interest should be prevented.
- Develop trauma-informed investigation processes that facilitate collection of best-evidence and do not re-traumatise survivors and witnesses through re-tellings. Separate interviewing of survivors, witnesses and alleged perpetrators and provide trauma-informed support for all participants during and after the process.
- Clarify the process and its components for the survivor(s), alleged perpetrator and witnesses to clarify expectations (including what will and will not be included, and terms used). Communicate potential costs, and potential outcomes.
- Create organisational communication strategies to communicate outcomes to the people and teams involved.

Downloaded from https://www.cambridge.org/core. UNIVERSIDAD AUTONOMA METROPOLITANA, on 17 Nov 2026 at 02:45:52, subject to the Cambridge Core terms of use, available at https://www.cambridge.org/core/terms. https://doi.org/10.1017/9781009673037.039

- Design trauma-informed approaches that facilitate recovery through restoring the agency and control of survivors. Strategies should include setting the time and place of any meetings, and setting clear tasks to achieve at each meeting in collaboration with survivors. The survivor should be allowed to exit the meeting if they need to do so.

Reducing Reporting Barriers and Streamlining the Processes of Reporting

Strategies in this area involve writing processes that are clear and understood. It is important to get multiple stakeholders to identify gaps, and omission and conflicts in these process, or confusing content. This includes seeking advice from survivors, who may identify barriers to reporting. It also should include ongoing monitoring and review of policies and their review to ensure information contained is accurate and current. Organisations should ensure when and how other organisations may be involved in reporting, to ensure survivors are not confused by intersecting and contradictory policies. There should be a well-informed support person available who can advise on these processes. Ideally, this person should not be involved in teaching or management, to avoid potential conflicts and enable the survivor to consider their options independently. Whether the survivor chooses to report or not, they should be offered independent support. The process should minimise re-tellings by the survivor.

Communicating Investigation Outcomes to the Workforce

It is necessary to balance transparency and confidentiality. De-identified information should be released in a way that respects confidentiality, but ensure the workforce understands that allegations of sexual harassment are taken seriously and that there are consequences. These controls and provision of information are critical to maintaining trust.

Analysing Critical Incidents

Throughout the book, we have seen examples where policies and processes can be harmful. Policies have failed, and processes have been unexpectedly ineffective. One particular challenge is when a survivor withdraws their report.

Throughout this process, there are usually multiple, consecutive failures. The harassment has not been prevented and it may have not been recognised or reported by the survivor or the bystanders. When reports have been received, the process may not produce a satisfactory outcome. Because these processes are so complex, it is essential that they be examined carefully with a view to improving policy and process. There are, of course, processes to examine clinical failures in medicine, and a similar root cause analysis can be followed.

Downloaded from https://www.cambridge.org/core. UNIVERSIDAD AUTONOMA METROPOLITANA, on 17 Nov 2026 at 02:45:52, subject to the Cambridge Core terms of use, available at https://www.cambridge.org/core/terms. https://doi.org/10.1017/9781009673037.039

Providing Rehabilitation for Survivors

For the survivor, there is the difficult decision to remain within the culture that harmed them, to change speciality, or to exit the profession entirely. The loss of doctors to the profession when they are unable to re-enter the workforce has received little attention. Medical training is an extraordinary investment of resources, not only for the survivor, but also for patients and the community. Survivors who have invested heavily in their professional identities feel lost and isolated when they are no longer able to practice. They not only lose the capacity to work, they also lose the collegiality of their peers. These derailed careers also have consequences for employers, impacting their equality and inclusion policies, and efforts to attract and retain more women and those who live with intersectional disprivilege into medicine. It is important that rehabilitation emphasises the repair of wider relationships that will have been damaged in these cases and their subsequent reporting processes. This wider group might include both colleagues and patients.

Given that sexual harassment and sexual abuse constitute a failure of governance, it should be a collegiate responsibility to help the survivor regain as much function as possible. If they return to the workplace, re-entry is challenging. The workplace may seem the same, but the survivor may be changed. As Dr Dominique Lee wrote in chapter 18 'When I went back to work, I found myself hugging the walls because the floor no longer felt safe'. There will also be others for whom her treatment makes this a distrusted workplace.

QUATERNARY HEALTH PROMOTION

Quaternary health promotion focuses on reducing the harm associated with reporting. Re-traumatisation is a common consequence when reporting involves multiple retellings in a variety of settings that may or may not feel safe to the survivor. In the 1970s, an Australian judge famously described women who reported rape as 'heroines of fortitude'. In doing so, he recognised the courage it took to survive the trauma of reporting.

Managing Privacy and Confidentiality

Exposure, loss of anonymity and gossip are all painful, especially when the case is high profile and the media is involved. The people involved in any investigation should know who has been informed about the case, and who has not. Communication needs to be carefully managed, and the workforce needs to be reminded of their obligations to respect the confidentiality of the people involved. Workers' rights to confidentiality should be protected.

Downloaded from https://www.cambridge.org/core. UNIVERSIDAD AUTONOMA METROPOLITANA, on 17 Nov 2026 at 02:45:52, subject to the Cambridge Core terms of use, available at https://www.cambridge.org/core/terms. https://doi.org/10.1017/9781009673037.039

Reducing Victimisation

When survivors report, their team can easily 'take sides', expressing their support for either the survivor or the perpetrator. The siding with individuals can create further betrayal, and damage other relationships. If the media becomes involved, both parties are harmed through the airing of opinions, and the judgments of others, including those they thought were colleagues or friends. Survivors can experience inappropriate interpersonal communications in their team, including gossip, bullying and further harassment, which limits their capacity to focus, including on their work. It is essential that teams around the survivor and the alleged perpetrator are monitored to ensure each is protected from this form of harm.

There is a particular type of victimisation which involves the adversarial nature of investigations. We are aware of survivors who have reported to regulatory bodies, and have been unable to withdraw from the process when it became deeply traumatic. Regulatory bodies need to ensure they have clear processes to manage 'victim whisteblowers'. When mandatory reporting for professional misconduct is required, it is unacceptable to force a survivor to report their perpetrator when the report itself causes deep harm. This is a complex problem, but mandatory reporting should not override a survivor's health and wellbeing.

Reducing Re-traumatisation

Although it is critical that reporting processes establish essential facts, it is also important to minimise discussion of the harassment to what is necessary to achieve outcomes. Multiple, unnecessary re-tellings can deepen trauma.

Restoring Safe Culture

The principles of restorative justice include preventing further harm by working with those involved to set relations right. All people impacted by the wrongdoing – survivors, perpetrators, witnesses, patients and community members – have a voice in the justice process. However, in order to make this process work, we need to actively repair trust and create safe spaces to have difficult conversations, where people can share freely without judgment.

FINAL WORDS

Doctors are committed to healing, and deeply familiar with complexity. Within the profession, there are many who are expert at deconstructing complex problems on a micro, meso and macro level. The profession should be able to tackle this problem within their own culture the way medical error was tackled in the past, creating safe spaces to honestly and openly deconstruct a problem and proffer potential solutions,

Downloaded from https://www.cambridge.org/core. UNIVERSIDAD AUTONOMA METROPOLITANA, on 17 Nov 2026 at 02:45:52, subject to the Cambridge Core terms of use, available at https://www.cambridge.org/core/terms. https://doi.org/10.1017/9781009673037.039

setting aside defensiveness, blame and stigma. Doctors should be able to understand the trajectory of trauma, from the prelude that predisposes a doctor in training to abuse, to the restorative justice that sees a survivor return as a valued member of the profession they love. In doing so, they should draw from the expertise of many others, including experts in law, social science, therapy, management, and many others.

This book has presented a range of initiatives that are occurring across the world, at all levels. Internationally, the Sustainable Development Goals championed by the United Nations are driving gender equity, reducing the gendered hierarchies in place in most cultures and most workplaces. Although some countries have no legal sanctions for sexual harassment, increasingly, countries are improving their legal approaches to sexual trauma, and many are specifically targeting sexual harassment in the workplace. Medical organisations are recognising the cost of sexual harassment and abuse in the workplace, and beginning to address barriers to reporting, including the need to ensure there is a positive duty to create and maintain psychologically safe and trauma-informed workplaces. Finally, and perhaps most importantly, the stigma and shame experienced by survivors is breaking down, with many doctors openly discussing their experiences. Doctors' health has finally become a topic for discussion in the profession, although many are still wary of acknowledging their issues and seeking help.

The editors have attempted to synthesise the breadth of trauma and healing that is occurring across the world. The book could not be a comprehensive representation of all experiences, but it does attempt to show how diverse experience can be. Like good qualitative research, the findings are not generalisable, but they are transferable to other settings, other professions and other cultures.

This book is not a reckoning, but it does create an opportunity to advance healing, safety and restorative justice. Medicine needs to recognise the issue and to seek to heal itself. While doctors understand trauma, and healing, they are not the only profession to face the problem of sexual harassment and abuse, but of all the professions, they are best placed to manage it most effectively using the skills deployed every day in clinical work. As a profession, medicine has done its best work when it has provided moral and cultural leadership. Facing this problem frankly and openly is part of that leadership.

As editors, we hope this book will provide the framework for other cultures, professions and jurisdictions to address their own 'dirty little secrets'. It is time to stop performative policy, the type that offers simple solutions to complex problems. There is no value in another compulsory workshop, aspirational statement or media campaign. Instead, we hope this book enables the reader to engage meaningfully with the interpersonal, interdisciplinary and international complexities of workplace sexual safety.

Sexual trauma should never be the price a doctor pays to work in the medical profession.

Downloaded from https://www.cambridge.org/core. UNIVERSIDAD AUTONOMA METROPOLITANA, on 17 Nov 2026 at 02:45:52, subject to the Cambridge Core terms of use, available at https://www.cambridge.org/core/terms. https://doi.org/10.1017/9781009673037.039

REFERENCES

1. Bismark MM, Spittal MJ, Gurrin LC, Ward M, Studdert DM. Identification of doctors at risk of recurrent complaints: a national study of healthcare complaints in Australia. BMJ quality & safety. 2013;22(7):532.
2. Searle R. Sexual misconduct in health and social care: understanding types of abuse and perpetrators' moral mindsets: report for Professional Standards Authority: University of Glasgow; September 2019.

Downloaded from https://www.cambridge.org/core. UNIVERSIDAD AUTONOMA METROPOLITANA, on 17 Nov 2026 at 02:45:52, subject to the Cambridge Core terms of use, available at https://www.cambridge.org/core/terms. https://doi.org/10.1017/9781009673037.039