Introduction

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Sexual harassment in the medical workplace is a complex, multifaceted problem that needs evidence-based solutions. Medicine is, of course, not unique in having to manage this. For decades, consciousness-raising groups have created spaces to find ways to speak the unspeakable, raising awareness of gender-based violence at work and at home, in order for survivors to begin to heal. Hashtags such as such as #MeToo, #MeoQueridoProfesor, and #UtanTystnadsplikt perform this function in a digital landscape, exposing entrenched toxicity across a range of workplaces, and agitating for legislative and political reform in a number of global contexts.

Medicine is not immune to gender-based violence, sexual harassment and toxic workplace culture. While the prevalence of sexual harassment remains difficult to establish, incidents of sexual harm between doctors occur across disciplines, workplaces and sociocultural contexts. Evidence for sexual harassment is gathered in prevalence studies, institutional reports and lived-experience narratives. In this respect, medicine is like many other industries in which the presence, but not prevalence, of occupational sexual harms is well established. (1–3)

In this introduction, we provide a brief overview of the current state of international research around the sexual harassment experienced in the workplace, focusing on medicine. We then outline the structure and approach of this book as an international and interdisciplinary collaborative research anthology on the phenomenon of sexual harassment of doctors, by doctors.

WHAT DO WE MEAN BY 'SEXUAL HARASSMENT'?

Terminology around occupational sexual harm is inconsistent around the world, and has specific meanings in specific contexts (see chapter 4 for an overview of the history of workplace sexual harassment concepts). In this book, we have used the term 'sexual harassment' in its broadest sense, incorporating a range of single or recurring incidents of unwelcome and intrusive sexual conduct by a co-worker or colleague, which cause harm to the person experiencing that behaviour. There are,

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of course, many other terms used in different contexts to describe this behaviour (see Table 0.1). Some have specific legal definitions, and while some imply specific sexual acts (e.g. rape), others reach beyond sexual acts to discrimination and other forms of gender-based 'put downs' (e.g. gender harassment).

We have chosen the term 'sexual harassment' for three key reasons, outlined in the following sub-sections.

TABLE 0.1 *Operationalising 'workplace sexual harassment'*

Terminology	Examples of legal terms and definitions used in the literature	Social science terms and definitions used in the literature requiring more specific differentiation between *sexualised* and *non-sexualised* behaviours in order for us to consider inclusion under 'occupational sexual harms'.
Sexual violence	'any sexual act that is carried out against someone's will. It can be carried out by any person, regardless of their relationship to the victim, in any setting'. Behaviours are categorised as either 'hands on' (i.e. physical) or 'hands off' (i.e. verbal or non-physical and non-verbal). (10) The following term and definition was used in the Belgian study of medical students and registrars by Geldolf et al. (11)	'unwanted sex-related behaviour at work that is appraised by the recipient as offensive, exceeding her resources, or threatening her well-being' and classifies behaviours into three broad categories of 'gender harassment', 'unwanted sexual attention' and 'sexual coercion' (Fitzgerald's Tripartite Model of Sexual Harassment). In this model, 'sexual harassment' acts as an umbrella term for three distinct categories of behaviour, described below. (12)
Sexual harassment	'unwelcome conduct of a sexual nature, in circumstances in which a reasonable person, having regard to all the circumstances, would have anticipated the possibility that the person harassed would be offended, humiliated, or intimidated . . . conduct of a sexual nature includes making a statement of a sexual nature to a person, or in the presence of a person, whether the statement is made orally or in writing' (13)	

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TABLE 0.1 *(continued)*

Terminology	Examples of legal terms and definitions used in the literature	Social science terms and definitions used in the literature requiring more specific differentiation between *sexualised* and *non-sexualised* behaviours in order for us to consider inclusion under 'occupational sexual harms'.
	The following term and definition was used in the Australian study of doctors by Stone et al. (14) 'any conduct, comment, gesture, or contact of a sexual nature that is likely to cause offence or humiliation to any employee; or that might, on reasonable grounds, be perceived by that employee as placing a condition of a sexual nature on employment or on any opportunity for training or promotion'. (15)	
	The following term and definition was used in the Canadian study of medical students by Phillips et al. (16) 'unwelcome sexual advances, requests for sexual favours, and other verbal or physical conduct of a sexual nature'. (17)	
	This term and definition was used in the American study of faculty in academic medicine by Carr et al. (18) 'unwanted, sexually determined behaviour that makes a person feel uncomfortable and that violates his or her dignity'. (19)	
	The following term and definition was used in the German study of health care and social workers by Adler et al. (2021) and the German study of physicians in a tertiary referral centre by Jenner, Djermester and Oertelt-Prigione. (2; 20)	

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Terminology	Examples of legal terms and definitions used in the literature	Social science terms and definitions used in the literature requiring more specific differentiation between *sexualised* and *non-sexualised* behaviours in order for us to consider inclusion under 'occupational sexual harms'.
Gender harassment		'does not have sexual cooperation as a goal; instead, it communicates denigrating, demeaning, or hostile attitudes based on gender or sex . . . aiming to put people down and push them out, rather than pull them into sexual activity'. (12)
Unwanted sexual attention		'expressions of sexual interest that are unwelcome, unreciprocated, unpleasant, and sometimes terrifying and traumatising to the target'. (12)
Sexual coercion		'attempts, both explicit and implicit, to make the conditions of employment contingent on sexual cooperation'. (12)

1. *Sexual Harassment Is the Most Generic and Inclusive Term*

This book explores sociocultural and institutional factors that influence the experiences and interpretations of survivors. The breadth of the term 'sexual harassment', as detached from specific legal requirements or definitions, means other terms that are more specific to locations or contexts can also be used. This enables our contributors to utilise the term and definition that is most relevant to their discipline or culture.

For the chapters in Part 3, this term allows for the exploration of culturally specific forms of sexual harassment if any arise, preserving cultural breadth of understanding and interpretation by situating case studies in language appropriate to their context. Furthermore, differences in definitions and terms used by different disciplinary and institutional approaches may play a role in the ways different actors behave and interact; by preserving and juxtaposing their respective terms, potential sources of friction in underlying definitions and principles may be made visible. For this reason, authors in Part 2 may also use terms specific to their discipline and context.

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2. *Sexual Harassment Is Defined by the Survivor*

We have defined the term 'sexual harassment' to reflect the direction of relations under study. It is not a question of what kind of behaviour was perpetrated; sexual harassment is defined by the experience of the survivor or target.

3. *The Term 'Sexual Harassment' Is Culturally Bound*

Medicine has its own culture, and its own cultural norms. The literature on sexual harassment in medicine suggests that doctor-survivors' interpretations of their experiences, their likelihood to report inappropriate behaviour, and their self-assessment of the severity of behaviour they experienced may be influenced by their learned adoption of distorted or permeable boundaries and norms regarding touching and speaking about sex and the body. (2–4)

Put bluntly, medicine requires a breakdown of social taboos around observing and examining bodies. Doctors in training need to acclimatise to these essential features of their profession, and learn how to examine patients in a way that respects their dignity and privacy while still fulfilling their professional roles. This is not a simple task. Doctors in training are understandably (and appropriately) hesitant when first asked to undertake an intimate examination, and require support to perform this examination carefully, sensitively and with appropriate informed consent.

It is not only bodies that trainees learn to explore. Sexual 'talk' is normalised in medicine, not only with patients, but between doctors. It is expected that a patient's sexual concerns, experiences and function will form part of a medical assessment, not only in fields like gynaecology, obstetrics and urology, but also where a disease or its treatment may have an impact on sexual function. For instance, sexuality is an important part of assessment in psychiatry and general practice, where an understanding of sexual function may provide important insights into a patient's biopsychosocial wellbeing. Unfortunately, sexual trauma is also a common experience, and has significant impacts on the health of the body, so discussion of sexual histories is often an important part of medical history taking.

Doctors in training must therefore learn to 'place' sexually explicit talk and examination within their evolving professional identities, learning when, where and how sexuality can be discussed. It is not surprising that they may have difficulty during this time distinguishing between when sexual talk is culturally appropriate and when it is not. Sexual 'banter' in the tea room, sexualised jokes, inappropriate sexual commentary in the lecture room or operating theatre, and comments on patient's bodies can be seen as 'part of the job' when students encounter them. They may already feel uncomfortable adapting to the breakdowns in intimacy required to do their jobs, and may well not recognise that the breakdowns in intimacy occurring within their teams are inappropriate.

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Our definition of 'sexual harassment' enables us to examine behaviours in sexually non-specific categories, in legal terms such as 'hostile environment sexism' or social science terms such as 'gender harassment', and to include certain forms of sexualised behaviours, while excluding behaviours less relevant to the question of the role of embodied boundaries and norms in medicine (see Table 0.1).

This text uses the term 'workplace sexual harassment' to refer to experiences of harm resulting from single or recurring incidents of unwelcome, intrusive, or inappropriate conduct of a sexual nature by a co-worker or colleague. We use this term to ensure that the focus of the text is on the experience of the survivor, rather than the specific behaviour of the perpetrator. It also enables us to engage with the variety of different legal and social science terms and definitions used in the literature referenced throughout this text.

THE IMPACT OF SEXUAL HARASSMENT

The effects of workplace sexual harassment are varied and have broad reach, impacting survivors, bystanders and colleagues, as well as organisations, clients, and others outside the workplace. Many of these effects have also been observed in medicine. For survivors, sexual harassment is associated with physical, mental, and occupational consequences, (3; 12) including impaired mental health, lower job satisfaction and sense of safety at work, (7) and impaired performance and organisational withdrawal. (12)

Sexual harassment is positively correlated with burnout, depression, and psychosomatic complaints, (2) including chronic back pain, neck pain, and headache, chronic gastrointestinal pain, and cardiovascular symptoms. (20) For bystanders and colleagues, witnessing or having knowledge of sexual harassment between co-workers is associated with negative outcomes similar to those experienced by survivors of direct, targeted harassment. Witnessing workplace sexual harassment predicts greater team and interpersonal conflict, reduced team performance and cohesion, and gradual erosion of general commitment and trust in the organisation. (12; 20) Finally, at the organisational level, sexual harassment incurs medical, economic, and reputational costs due to public perceptions of the organisation failing in their responsibility to protect worker wellbeing and promote a positive moral work environment. (20)

Tolerance of sexual harassment in medicine, however, poses additional risks to the wider community. The associations between workplace sexual harassment (experienced or witnessed) and burnout have concerning implications given the well-documented associations between physician burnout and patients' quality of care. The recidivist nature of workplace sexual harassment means perpetrators rarely remain safe to practice. (21) Sexual harassment is more likely to occur in workplaces with steep hierarchies. Professional, inter-professional and doctor–patient power dynamics in health workplaces pose potential risks to patients, in *addition* to the

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risks posed to bystanders and colleagues of doctor-survivors. As such, while some effects of sexual harassment in medicine appear consistent with other industries, there may also be unique and serious effects, which remain largely unexplored.

UNDERSTANDING THE PREVALENCE OF OCCUPATIONAL SEXUAL HARASSMENT IN THE COMMUNITY

Nearly half a century of literature on occupational sexual harms (12) has equipped policy and management decision-makers with a robust basis on which to develop approaches to primary, secondary, and tertiary prevention. (9) There now exists a wealth of scholarship on the individual and structural factors that increase risk of incidence and the short-term and long-term effects of occupational sexual harms on individuals, organisations, and the wider community. (12)

Social science literature on workplace sexual harassment largely conceptualises sexually harmful behaviours as underpinned by relations of power and gender within specific workplaces, industries, and society as a whole. (1; 12; 22) The forms of workplace sexual harassment with the highest prevalence tend to be described under categories such as 'gender harassment' or 'hostile environment sexism'. These harms reinforce the perpetrators' privileged position in the existing social hierarchy by expressing and reaffirming dominance over the target, or targets, of the 'put-down'. (12) More severe forms of direct sexual harms, such as attempts by a perpetrator to leverage a survivor's employment in order to coerce them to perform sex acts, rarely occur without this form of a pervasive, often ambient environment of sexual harassment. (12)

The origins of sexual harassment advocacy in women's advocacy spaces, as well as pervasive misconceptions of sexual harassment as being motivated by sexuality, rather than domination or power, have contributed to a research and policy environment that often neglects to examine the roles and experiences of men. (12) While men comprise the overwhelming majority of perpetrators, men can also be bystanders or survivors. (1; 5; 12) The misplaced belief that sexuality is a key motivator of sexually harmful behaviour similarly contributes to pervasive under-examination of other demographic groups and factors. This is a serious oversight. The central role of power and hierarchy in sexual harms are perhaps most visible in the role of marginalisation. Intersectional axes of marginalisation are not limited to gender. (1; 12) Race/ethnicity and migration status, age, trans and gender diversity and sexuality, disability, and low occupational status are all predictive of higher rates of victimisation (1) and unique types of victimisation (such as racialised sexual harassment). (12; 23)

Beyond the traits of survivors, there are other individual factors which play a role in occupational sexual harms. Different perpetrators may have different goals, which tend to affect the severity, type, duration, frequency of incidents and range of targets. Perpetrator motivations can involve factors such as personal investment in rigid gender

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roles or hostile sexism. (12; 21) Survivors will often experience the same behaviour in a workplace more than once, and often on a continual basis over an extended period of time. (1) The likelihood of bystanders to interrupt sexual harms, confront the perpetrator, talk with the survivor, or formally report the incident is also somewhat related to individual factors, such as personal investment in rape myths and belief that sexual harms are 'serious'. (24)

Notably, however, each of these person-level factors are related to broader organisational or sociocultural factors. For example, organisations perceived to have weak sanctions against sexual harms tend to report greater perpetration. (12) Survivors are less likely to report if they believe there will be few or no consequences to the perpetrator, if reporting increases their personal or occupational risk, or if they form the expectation that they will be disbelieved. (1) It is also an unfortunate reality that the process of reporting causes additional trauma for many survivors, particularly in courts (27) and regulatory bodies. (28)

At the societal level, the legislative and regulatory landscape shapes social norms around the management of sexual harms, facilitates reparation and occupational rehabilitation for survivors, and protects others from repeat perpetrators. Unfortunately, fifty countries worldwide still lack any legal protections against sexual harassment in employment, (25) and where such protections do exist, navigation of formal reporting and complaints systems can often be complex and re-traumatising. (12) At the organisational level, it is also not uncommon for survivors to have no information regarding the outcome of their complaint or to experience negative consequences. Perpetrators of occupational sexual harms may continue to work with few, if any, consequences for their conduct. (1) Therefore, reluctance to formally report incidents is often founded on realistic assessments of cultural or organisational tolerance of occupational sexual harms.

Structural or systemic factors are much stronger risk factors for occupational sexual harms than person-level factors. (12) Industries which are male-dominated tend to have higher risks of sexual harms. This includes organisations with steep hierarchical organisational structures, more male workers, a masculine workplace culture and over-representation of men in senior leadership. (12) Workplaces characterised by 'masculinity contest cultures', where disdain for personal relationships and boasts of strength and stamina are prized, also demonstrate higher prevalence. (12)

UNDERSTANDING THE PREVALENCE AND EXPERIENCE OF SEXUAL HARMS IN MEDICINE

Prevalence studies have been conducted in a range of different professional and cultural contexts, with the majority of studies emerging from the USA and Europe and, more recently, Australia. Fnais et al. conducted an international meta-analysis in 2014, demonstrating that 59.4% of medical trainees had experienced at least one form of harassment or discrimination during their training, with 33% experiencing

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sexual harassment. (26) Since then, there have been a series of studies in a variety of contexts that reinforce our understanding of sexual harms between doctors. A national survey of faculty in academic medicine in the USA found 30.4% of women and 4.2% of men personally encountered 'unwanted sexual comments, attentions, or advances by a superior colleague'. (27) Another study of physicians at a tertiary referral centre in Germany found 76.12% of women and 61.59% of men experienced sexual harassment, and while transgender, intersex, and non-binary participants were too few for statistical testing, all reported experiences of sexual harassment. Colleagues were named as perpetrators in 80.3% of all incidents, and superiors in 18% of all incidents. (20) A study of surgical trainees, International Medical Graduates (IMGs), and fellows, commissioned by the Royal Australasian College of Surgeons, found 7% of participants had experienced sexual harassment, with prevalence as low as 3% in orthopaedic surgery and as high as 13% in ophthalmology; surgical consultants were reported as the perpetrator in 75.7% of sexual harassment incidents, and in only 30.1% of cases of sexual harassment where a formal report was made did the behaviour cease. (28)

Scholarship in this space has expanded in the past decade to explore sexual harms of doctors by doctors in different cultural and professional contexts, finding prevalence as low as 2.4% (8) and as high as 73%, (7) in stages of medical careers from undergraduate (29) to retirement. (29) This wide variation in prevalence is partly due to methodological and cultural differences between studies, particularly regarding the ways that occupational sexual harms are defined by researchers, participants, and their respective legislative or regulatory landscapes (see Table 0.1). We explore the challenge of defining prevalence in greater depth in the first part of this book.

Given the challenges of defining prevalence, including low reporting rates and inconsistent definitions, it is important to explore other forms of evidence.

WHY THIS TEXT AT THIS TIME?

While it is encouraging that the past decade has brought with it an expansion of scholarship on the prevalence of sexual harms, and the development of a number of novel interventions, the need for a 'process-oriented understanding' of occupational sexual harms in medicine remains largely unresolved. (22) This book builds on the approach of the editors' pilot study (14) to address this need, by exploring the individual and structural factors that influence the ways doctors experience, interpret, and understand sexual harms by other doctors.

We aim to investigate the nature of the relationship between contextual factors and survivors' behaviours, decisions, and interpretations after being sexually harmed, by juxtaposing the approaches and understandings of the issue in different cultural contexts and with different actors in the medical, legal, and regulatory landscape. With this work, we begin mapping the landscape of these neglected areas of inquiry, to better equip future policy and management scholars to develop

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tailored, evidence-based, and effective approaches to primary, secondary, and tertiary prevention strategies, particularly in the area of occupational rehabilitation.

This book adopts a hypothesis-generating approach consistent with qualitative methodologies. This approach facilitates the articulation, expansion, and development of models to map the interactions that influence occupational sexual harms in medicine, in such a way as to enable and support future empirical study of specific factors. Our primary hypothesis for the book as a whole, therefore, was broad: that sexual harms of doctors by doctors occurs in a range of cultural and institutional contexts, and that this phenomenon is deeply shaped by social dimensions and a complex interplay of factors both internal and external to the social dimensions of the medical workplace.

WHY FOCUS ON DOCTORS?

This text restricts its focus on sexual harms between doctors, and largely avoids examining students or other actors in the medical workplace. While we accept that doctors work in teams with many other health professionals, we chose to examine the issue within the profession rather than look at the broader cultural context around this profession. This restriction serves four key purposes.

1. *Focusing on Medicine Enables a Deep Dive into a Narrow Field*

Restricting our focus to one profession facilitates a broad-ranging exploration of the institutional and sociocultural factors that, directly and by interacting with one another, exert complex and nuanced influence on the experiences of doctors who have been sexually harmed by other doctors.

We recognise the importance of exploring workplace sexual harassment between professions or within other health care professions, particularly with respect to high rates of sexual harms in nursing (8; 30; 31) However, certain features of medicine, such as the terms of employment, position in the occupational hierarchy, the competitive nature of training and increasing public expectations, are not specific to medicine, but may be different in nursing and allied health professions. We expect that some personality features common in doctors, such as perfectionism, independence and objectivity, may also influence behaviour.

Focusing on a narrow occupational field prevents this text from replicating the general lack of clarity and specificity that characterises much of the current research in this sphere. Many prevalence studies relevant to this text were not specific in differentiating between perpetrators who are doctors and perpetrators who belong to other professions in the medical workplace. However, there is some evidence that doctors who experience sexual harassment tend to be distinct from others in the medical workplace regarding the demographic clusters who tend to be targeted, the behaviours they tend to experience, the rates at which they experience those

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behaviours, and the types of perpetrators who target them. Furthermore, doctor-perpetrators appear to use different types of behaviour in different proportions than other perpetrators in the medical workplace. (4; 31; 32) They also utilise different strategies to protect themselves from formal reporting or punishment than perpetrators in other health care professions. (33) By defining a more specific relationship between the survivor and perpetrator, we control for factors that may operate solely within, or solely between, professions (such as lateral and informal hierarchies of power), which may influence the ways that a doctor experiences occupational sexual harms.

2. *Focusing on Medicine Enables This Text to Lay the Groundwork for Future Study*

Cultural change requires a deep understanding of the problem as it is situated within its own unique context. The literature reveals a wealth of institutional and cultural challenges within medicine that increase the risk of occupational sexual harms becoming pervasive, and complicate attempts at primary, secondary, and tertiary prevention. Individuals encounter these challenges from the beginning of their medical training, including a 'hidden curriculum' of an intensely gendered and hierarchical medical culture (11), and the vulnerabilities resulting from the combination of steep power differentials within medical career and training pathways, (4; 11; 20; 34) hierarchical relations with different professions in the medical workplace, (9; 22) and the fear of retaliation against educational and career opportunities in an already highly competitive environment. (9; 35)

3. *Medicine Has Its own (Sub)Cultures which Differ from the Cultures of Other Professions that Share Health Workplaces*

Medicine as a profession shares the features of other high risk professions, including 'boasts of strength and stamina', competition and, for some, 'disdain for personal relationships'. (12; 22) Overwork is often normalised, and there is active and passive disrespect for the tasks of child-rearing or maintaining intimate family relationships in many disciplines. (9; 12) These characteristics do not solely manifest in lateral expressions between peers; they are implicitly, and often explicitly, endorsed both in teaching and by employing organisations themselves. For example, working long hours in small groups in new, unfamiliar environments can facilitate the breakdown of social barriers between doctors during training and early career, (9) yet active implementation of these practices is considered fundamental to medical work and is extremely commonplace.

Implicit, more passive forms of endorsement are visible in environments which tolerate toxic teaching and working behaviours and environments. The 'theory of beneficial mistreatment', common in most hierarchical professions, lauds overwork

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and feats of endurance, to 'toughen up' their trainees. Entrenched beliefs in the necessity of 'building resilience' in trainees, or that medicine entails inherently toxic workplaces, enable educators and supervisors, senior doctors, and health care institutions to ignore or downplay the impact of the problematic behaviours that increase risk of sexual harm. The normalisation of workplace violence in health care is more explicit with regard to patient-perpetrators. There is an extent to which doctors are trained to expect sexual and non-sexual verbal and physical abuse from patients or patients' companions as an occupational hazard. This is often framed as an inherent risk of the emotionally charged experiences or clinical conditions of patients, and a less experienced doctor may well lay the responsibility of the patient's behaviour on their illness or emotional state. (4; 35) Similarly, the sexually charged nature of some kinds of work physicians conduct means normal taboos around intimacy are broken down in this workplace. (11) Education around these issues often focuses on patients or patients' companions as perpetrators (rather than colleagues or superiors), and this is the context where de-escalation training occurs. (2; 20)

4. *This Text Aims to Provide Useful and Specific Primary, Secondary, Tertiary and Quaternary Health Promotion Strategies to Improve Sexual Safety for Doctors*

While doctors may receive de-escalation training for managing sexual harms by patients or their companions, (2; 20) equivalent de-escalation training where perpetrators are modelled as colleagues tends to be less common. We expect that the primary health promotion strategies to understand and prevent workplace sexual harassment are situated within the culture of the profession, including the context where junior members are dependent on their senior colleagues for career progression. Identifying environments and individuals at higher risk depends on understanding the contexts in which working and learning occurs, and we expect this is likely to be dependent on the roles a health professional plays, and the context of their employment arrangements and responsibilities. The harms that occur and strategies for their mitigation also affect the trauma they experience and the way they are prepared to seek and receive help.

STRUCTURE

This book is divided into four parts, reflecting four general directions we may look to learn from when exploring sexual harms of doctors by doctors.

Part 1, titled *Context*, provides a brief holistic introduction to the issue of sexual harms in a broadly international scope. It contains chapters that draw on expertise from social science disciplines to provide theoretical context regarding the ways that gender, medicine, and marginalisation and power operate and interact.

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Part 2, titled *Learning from Interdisciplinary Perspectives*, is comprised of chapters exploring the approaches of, and dilemmas faced by, different institutional actors a doctor may encounter when formally reporting an experience of sexual harassment by another doctor. In this part, we explore evidence from a variety of disciplines, including medical regulation, medical education, organisational behaviour, law, human rights and therapy. This part concludes with a chapter from London, where the health system includes an organisation that integrates these perspectives.

Part 3, titled *Learning from International Perspectives*, presents qualitative case study analyses from fifteen countries around the world. In this part, we focus on a different type of evidence, using lived experience narratives as a form of in-depth case history with expert interpretation. We already see lived-experience narrative evidence from a series of retellings in mainstream, academic and social media. Social media movements, such as #TimesUp from the USA, #UtanTystnadsplikt from Sweden, #MeoQueridoProfesor from Brazil, and #Sex4Grades from Nigeria, document lived-experience cases occurring around the world. By engaging with the problem of sexual harms in medicine in their own unique contexts, authors in part three provide multiple perspectives on the experience or survivors and the response of the profession. They provide contextually relevant interpretation of experience from their own unique contexts, reflecting on the ways in which their context shapes and responds to this sexual harassment. In this respect, they support decades of scholarly efforts to explore and articulate the social and cultural dimensions of occupational sexual harms. (5; 9; 22; 24)

Each chapter includes a brief description of the cultural context in which the study takes place, a case study loosely following the methodology of Stone, Phillips and Douglas (2019), (14) and a reflective essay that uses the case study and context to guide analysis and reflection on that nation's achievements, failures, barriers, and potential new directions for occupational sexual harms management.

The final part, titled *Looking to the Future*, describes the vision, approaches, successes and failures of advocacy in this space. It includes theories from gender studies and political sciences, and explores the role of advocates in grassroots organising, non-government organisations, leadership within organisations and institutions, and doctors in training aiming to improve the professional culture of the next generation of doctors. Finally, we examine the future of therapy in mitigating the harms experienced by survivors.

CONCLUSION

This book is not a reckoning. It is not an album of anecdotes, nor is it an instructional textbook to guide policy-making and implementation. It is an attempt, made by a growing community of practice, to map the boundaries of a developing field of study. It reflects decades of growing awareness of the ubiquity of workplace sexual harms, and a recognition that effective prevention, intervention, and outcome

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management can only be achieved when we begin to acknowledge and attempt to understand how occupational sexual harms occur and the extent of their effects.

We draw on the history within medicine of struggling with its enculturated issues with gender, power, and marginalisation in order to authentically embody the altruistic and egalitarian values that characterise the medical profession when it is operating at its best. By making visible the individual and structural complexities of sexual harms of doctors by doctors, this book guides decision makers towards more nuanced, more targeted, and ultimately more effective policy and management approaches to the prevention, detection, and management of workplace sexual harassment in medicine.

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