General Medical Council

Allegations of sexual misconduct: support for employers and Responsible Officers

Introduction

Employers have legal responsibilities, set out in legislation and common law, to protect their employees and others from sexual misconduct in the workplace[1].

In addition, responsible officers (ROs) have key roles in identifying and tackling sexual misconduct as part of their duty to ensure a doctor's fitness to practise. Allegations of sexual misconduct perpetrated by a doctor can be in relation to two types of survivor:

- patients, their partners or family members
- colleagues, including students, and others within and outside medicine

This document focuses on sexual misconduct related to doctors' fitness to practise and is intended to support ROs in preventing, identifying, and responding to allegations both within and outside of clinical settings.

Issues related to sexual misconduct perpetrated by patients, patients' partners, or families are not addressed here.

Good medical practice

Good medical practice addresses issues relating to sexual misconduct and reminds doctors of their responsibilities in this regard in healthcare settings.

It sets out clearly what is expected of doctors in their interactions with patients and with colleagues:

- Doctors must not act in a sexual way towards patients or use their professional position to pursue a sexual or improper emotional relationship with a patient or someone close to them. They must follow our more detailed guidance on *Maintaining personal and professional boundaries*[2].

[1] EHRC Guidance on sexual harassment and harassment at work

[2] *Good medical practice* paragraph 86

- Doctors must not act in a sexual way towards colleagues with the effect or purpose of causing offence, embarrassment, humiliation or distress. What we mean by acting 'in a sexual way' can include – but isn't limited to – verbal or written comments, displaying or sharing images, as well as unwelcome physical contact. They must follow our more detailed guidance on *Maintaining personal and professional boundaries*[3]. Doctors must treat colleagues with kindness, courtesy and respect[4].
- Doctors must act promptly if they think that patient safety or dignity is, or may be, seriously compromised. If they have concerns that a colleague may not be fit to practise and may be putting patients at risk, they must ask for advice from a colleague, their defence body, or us. If they are still concerned, they must report this, in line with their workplace policy and our more detailed guidance on *Raising and acting on concerns about patient safety*[5].
- If doctors witness colleagues behaving inappropriately towards other colleagues in the workplace as described above, they should act, taking account of the specific circumstances. We recognise some people may find it harder than others to speak up but everyone has a responsibility – to themselves and their colleagues – to do something to prevent these behaviours continuing and contributing to a negative, unsafe environment[6].
- If doctors have a formal leadership or management role and they witness – or are made aware of – any of the inappropriate behaviours described above, they must act. They must[7]:
  - make sure such behaviours are adequately addressed
  - make sure people are supported where necessary, and
  - make sure concerns are dealt with promptly, being escalated where necessary.

[3] *Good medical practice* paragraph 57
[4] *Good medical practice* paragraph 48
[5] *Good medical practice* paragraph 75
[6] *Good medical practice* paragraph 58
[7] *Good medical practice* paragraph 59

What is sexual misconduct?

Sexual misconduct is uninvited or unwelcome behaviour of a sexual nature, or which can be reasonably interpreted as sexual, that offends, embarrasses, harms, humiliates or intimidates an individual or group.

Sexual misconduct encompasses elements of harassment, violence and abuse and can be physical, verbal or visual. The motivation is seldom romantic and almost never benign. It's often motivated by a wish to bully and coerce.

It can take place within and across different genders. Cultural or social norms, such as rigid gender roles, can also increase the risk of sexual misconduct.

Although most victims/survivors are women, men also experience sexual misconduct. Sexual misconduct can be perpetrated within, and across, different genders. There is also an issue of intersecting protected characteristics in relation to sexual misconduct and there may be additional concerns for minority ethnic, lesbian, gay, bi, trans and Q+ (LGBTQ+), disabled and younger people where the harassment may be bound up with other forms of discrimination[8].

Sexual misconduct is found in healthcare settings, and is, on occasion, perpetrated by healthcare professionals. There is greater awareness of sexual misconduct after numerous high-profile sexual abuse cases and the rise of awareness of sexual harassment from the #MeToo movement; however, there is more that needs to be done to prevent it from happening and to support those impacted.

Examples of sexual misconduct:

- sexual comments, jokes, innuendo and so-called banter
- displaying sexually graphic pictures, posters or photos
- suggestive looks or leering
- propositions and sexual advances
- making promises in return for sexual favours
- sexual gestures

[8] https://www.unison.org.uk/content/uploads/2020/02/25965-1.pdf

- intrusive questions about a person's private or sex life or a person discussing their own sex life
- sexual posts or contact on social media
- spreading sexual rumours about a person
- sending sexually explicit emails or text messages, and
- unwelcome touching, hugging, massaging or kissing.

The scale of the challenge

Sexual misconduct is found throughout society[9]. Twenty percent of women and four percent of men have experienced some type of sexual assault since the age of 16. However, only 15 percent of cases – one in six - are reported to the police.

Within healthcare settings a survey[10] from April 2021 found that 31% of women and 23% of men doctors experienced unwanted physical conduct in their workplace. Additionally, 56% of women and 28% percent of men doctors received unwanted verbal conduct related to their gender, and 42% of doctors who witnessed or experienced an issue relating to sexism felt they couldn't report it. We do not know the full extent of the issue relating to patients but can assume that it is similarly prevalent; healthcare involves vulnerable people who may be more likely to be abused.

Given the power that doctors can hold and the fears that colleagues and patients might have about the consequences of challenge, it's possible that the proportion of reported incidents is lower in doctor related cases.

Research from the US[11] also shows that sexual misconduct is more likely in environments which are:

- male dominated
- hierarchical
- forgiving of bad behaviour.

[9] https://rapecrisis.org.uk/get-informed/about-sexual-violence/statistics-sexual-violence/
[10] sexism-in-medicine-bma-report.pdf
[11] Cooper, M. The 3 Things That Make Organizations More Prone to Sexual Harassment, The Atlantic, November 27, 2017

Other studies[8] have shown that poor professional boundaries and unchallenged sexual banter can lead to animosity and mistrust between colleagues, which can be a risk to patient safety. They also show how sexual misconduct impacts on other members of the team who are not directly involved by creating an atmosphere of mistrust and uncertainty.

Role of Responsible Officers and employers

Employers and ROs have a critical role in identifying and tackling sexual misconduct and ensuring that they have taken steps to protect patients and their employees.

You should make sure the following principles are in place at your organisation:

- Patients have a right to receive healthcare without fear of abuse
- Doctors, medical students and other health care professionals and employees have rights, enshrined in law, to a workplace free of discrimination, bullying and sexual harassment.

The severity and nature of the misconduct in individual cases will determine the reactive responses that you might take and advice you may wish to seek from expert organisations to help you respond.

Taking a firm and consistent stand on issues of sexual misconduct is also an important part of ROs' fitness to practise role. To ensure that potential harm to patients and colleagues is minimised, it is important that you identify any concern about a doctor's practice as early as possible and take appropriate and timely action where necessary.

This is especially important as serious sexual misconduct, including rape, is usually preceded by a period of inappropriate comments or touching. Instances of sexual misconduct are also seldom isolated; perpetrators often offend repeatedly, and some abuse can last several years. Taking swift and early action can help prevent the misconduct from escalating. It can also help avoid this behaviour from developing into victimisation, bullying, and exclusion of the victims/survivors from the team in which they work, all of which have significant impacts on individuals and can also impact negatively on patient safety and team cultures.

[8] https://www.civilitysaveslives.com/

Sexual misconduct towards patients

In this context, sexual misconduct encompasses a wide range of behaviours and activities. They can, for example, be physical and non-physical, or relate to professional boundaries.

It can include watching patients undress, examining their genitals without wearing gloves, talking about sex and sexual desires, sending sexual messages and pornography, touching, kissing and licking, masturbating, inserting fingers, and penetrative sex.

The patient might be anaesthetised, sedated or fully conscious. Examples of inappropriate behaviour can include doctors offering drugs to somebody who routinely misuses substances in exchange for sex and grooming patients on social media, using Facebook, for example, to build trust and intimacy with patients in the lead up to assault.

Sexual misconduct also encompasses isolated, or repeated, incidents between doctors and patients taking place outside of healthcare settings.

Some victims/survivors are subject to grooming, or may not immediately recognise that certain interactions are abusive. In time, once they realise the interaction is abusive, feelings can turn to guilt, shame and anger. A doctor acting sexually towards a patient is most often misconduct, and therefore serious, except in exceptional circumstances[12].

Sexual misconduct can have wide-ranging effects, including reactions akin to post traumatic stress disorder (PTSD) in which patients fear, distrust or avoid future engagement with doctors, which has an impact on the patient's long-term health. In parallel, patients' experiences of abuse can affect their relationships with family, friends and at work. The effects of sexual abuse continue long after the moment in which it is perpetrated.

Misconduct is more likely to happen when a doctor is alone with a patient – but being accompanied is not a fail-safe; it is possible for a doctor to abuse a patient with family and chaperones in rooms. It might not always be clear to a patient, their family member or a chaperone that may have not been appropriately trained whether a procedure is being conducted appropriately, or if it is violating the standard of care; this is heightened in obstetric and gynaecological procedures and breast examinations.

Inappropriate interactions can also take place outside of consultations and formal clinical settings, where no other clinicians or chaperones are present. Once abuse is identified, patients can be troubled by the fear of not knowing exactly what happened. It is important to bear this in

[12] Please refer to our guidance on *Maintaining personal and professional boundaries*

mind and be compassionate and empathic when listening to a patient disclose their experiences of abuse.

Sexual misconduct by a doctor can also be experienced by family members of a patient as well as the patient themselves. Victims/survivors might not raise concerns for various reasons such as (but not limited to) fear of retaliation or victimisation, learning disabilities or cultural norms. The culture we live in can shape how some individuals view issues like sex and gender-based violence which can be normalised, or excused, and perpetuated by attitudes or behaviours. Victims /survivors should be encouraged and supported to step forward.

Sexual misconduct towards colleagues and students

Consensual and reciprocated sexual attraction and relationships between colleagues can and do exist within workplaces and are not sexual misconduct. However, it is important that professional boundaries are maintained, and the undertaking, and/or end, of the relationship has no adverse impact on clinical practice or team environments.

Higher risk factors for consensual relationships between colleagues might include situations with large differences in power levels between colleagues (for example hierarchically across and within specialities and grades) or situations where training and career progression opportunities could be impacted. A power imbalance between the victim and the perpetrator is a common feature in sexual misconduct.

There is also a specific power imbalance between doctors and students in higher education that can place additional pressure on the student not to challenge unwanted sexual behaviours and actions. It can be incredibly difficult to challenge the doctor that they are reliant upon to provide learning opportunities and recommendations.

All sexual misconduct in a workplace is wrong and can impact individuals, teams and patient safety. There is no place for sexual harassment or any form of sexual misconduct in healthcare and doctors have a role in ensuring that the teams they lead and the cultures they influence are safe for patients and colleagues. As such, while tackling sexual harassment in the workplace is a key responsibility for clinical leaders in healthcare settings, the responsibility sits with all doctors.

Where colleagues report sexual misconduct – inappropriate sexual remarks, persistence in asking them out, unwelcome physical contact, for example – it is important that the complaint is taken seriously.

Stopping sexual misconduct in healthcare

Different approaches can be taken. Some focus on identifying individual preparators and taking remedial action.

Others seek to understand what it is that allows sexual misconduct to go unchecked. They communicate repeatedly that sexual misconduct will not be tolerated, and victims/survivors will be supported to step forward. This includes making it clear that calling out poor behaviour, and reporting senior colleagues, will not be career limiting for junior doctors.

Both approaches, implemented in parallel, are effective. However, lasting change comes from taking systemic approaches, changing organisational cultures, and learning from past experiences. You may also find it helpful to refer to guidance documents provided by ACAS, CIPD and Unison which provide practical support around key areas to tackle sexual harassment at work.

Measures to put in place

There are steps that can be taken to encourage reporting and make it as straightforward as possible:

- Ensure local policies addressing different aspects of sexual misconduct are up to date and well publicised to raise awareness amongst patients, employees and students that all incidents are taken seriously.
- Ensure information is easily accessible, clear and gives confidence that reporting misconduct will not lead to less favourable treatment either as a recipient of care or as a colleague.
- Encourage conversations in the workplace. When a culture supports colleagues to speak up, leaders and teams are more comfortable discussing positive and negative behaviour. They are prepared to have difficult conversations and tackle issues.
- Employer liaison advisers (ELAs) can provide information and support in identifying and managing sexual misconduct in healthcare settings.

Use of chaperones

Chaperones can be used in certain types of doctor/patient interactions to reduce the risk of sexual misconduct. In some circumstances, you might consider using chaperones in cases where there is an allegation of sexual misconduct perpetrated by a doctor. A chaperone is defined as a third-party person who is present in consultations and can act as an impartial observer when a doctor is seeing a patient.

Chaperones should usually be health professionals who have been trained on what the role entails and what to observe and monitor[13]. They have the authority and confidence to challenge behaviour that they think is inappropriate or abusive in an appropriate manner, assured that their views will be taken seriously. They should ideally be independent and not employed by, or directly accountable to, the doctor under investigation.

Using chaperones is not always possible, practical or effective, especially if serious misconduct - such as indecent assault, sexual assault, rape or other criminal offending - is alleged, or if the doctor is subject to allegations from more than one patient. There have been occasions where doctors have assaulted patients despite their presence.

Chaperones should not be used:

- where the police have laid charges
- where there is a history of deliberate non-compliance with chaperone conditions or other restrictions on practice
- where there are concerns that a doctor asked a chaperone to leave the room during an intimate examination or exhibited sexually indicated behaviour towards patients in the presence of a chaperone
- in the context of psychotherapeutic practice such as by psychiatrists, due to the highly personal and confidential nature of therapy and where the presence of a chaperone would therefore be highly intrusive
- where there may be a possible pattern of behaviour in relation to a doctor engaging or seeking to engage in a sexual or improper emotional relationship with patients. This is because chaperones may not be effective in protecting patients from this type of behaviour by doctors, since most contact of this nature is likely to occur in unchaperoned time, outside a consultation.

On occasion, more restrictive measures are used to protect patients while allegations are investigated, such as greater use of gender-based prohibitions or prohibitions relating to patient contact, or suspension from practice.

[13] Please refer to our more detailed guidance on *Intimate examinations and chaperones* for more information

When the police are involved

Employers and ROs should notify the police immediately and cooperate with them fully in their investigation if they have reasonable belief that a criminal act may have taken place. Where children are involved, this would also include considering any safeguarding actions required including notifying social services.

Whilst steps should be taken to protect colleagues and patients by putting protective measures in place, it is important that nothing is done by ROs that could compromise any criminal investigation underway.

Further considerations that may help you tackle sexual misconduct

- What protocols and policies are in place locally? Have they been reviewed recently? Who has overall responsibility for keeping them up to date?
- What is being done to make clear the seriousness of sexual harassment? How are key messages communicated to doctors, students, other colleagues, patients, and their families?
- How are you assured that victims/survivors have confidence that their concerns are taken seriously? Have you audited reported cases and identified patterns or significant systemic issues?
- Have you assured victims/survivors, through your communications with patients and colleagues, that reporting sexual abuse will not affect the quality of care they receive or limit their career?
- What are your processes for reporting? How are they publicised? Are they well known and understood? How do you know?
- Are you able to help victims/survivors disclose their abuse and access support services?
- Are you able to support doctors against whom allegations are made to access mental health support?
- What do you know about potential barriers to reporting? How do you know what the barriers are? What steps have you taken to remove those barriers?
- What feedback has been received in relation to completed cases? What changes to your processes and approaches have been made as a result? How do you communicate these changes to doctors, students, other colleagues, patients, and their families?

- How can you and other medical leaders initiate discussions? What are the best ways of beginning these discussions? How often will you refresh information for doctors, students, other colleagues, patients, and their families?

Help and support

Help and support are available for anyone affected by sexual misconduct in the workplace.

Raising concerns about a colleague

- Our outreach advisers can provide information and support in identifying and managing sexual misconduct in the workplace. See *Who can help in your area?*
- Our ethical hub pages on *Speaking up* provide advice and tools to help you follow the processes set out in our guidance, as well as a list of organisations who can support you.

Advice helplines

Rape Crisis England and Wales, Rape Crisis Scotland and Rape Crisis NI provide free, private emotional support, information and signposting by phone or email.

NHS advice on help after rape and assault provide advice on what to do, the services that can help and how to support people.

Rights of Women provide free and confidential legal advice to women and girls through their sexual harassment at work helpline.

SurvivorsUK operate a free, private national online helpline for men and boys.

GALOP offer a free, confidential and independent helpline for anyone in the UK who is LGBT+ and who has experienced sexual assault, violence or abuse. They will also provide assistance to friends, family members and professionals who are supporting LGBT+ victims of abuse.

NHS social care support gives free, private support to people that have experienced different forms of abuse.

NIA rape crisis gives free, private specialist support to women and girls who experienced any form of sexual violence at any time in their lives.

Victim Support England and Wales, Victim Support Scotland and Victim Support Northern Ireland provide free and confidential specialist help.

Independent sexual violence advisors (ISVAs) work with adults and children who have experienced sexual violence and their families. ISVAs can be accessed without talking to the police, through sexual assault referral centres (SARCs). SARCs have specially trained doctors, nurses and support workers on hand 24 hours a day, offering medical, practical and emotional

support to anyone who has been raped, sexually assaulted or abused. Find a local sexual assault referral centre.

Case studies

You can find case studies relating to sexual misconduct on our website, to support you in putting the above advice into practice.