How many more will be abused before we act on sexual violence in healthcare?

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Failures to record, investigate, and act on cases of sexual harassment and abuse in healthcare have enabled perpetrators, but three sanctioning mechanisms can help tackle this, writes Rosalind Searle

A new investigation by The BMJ and The Guardian provides further evidence of the prevalence of serious sexual violation and assaults in the UK's National Health Service (NHS) [1]. The investigation offers some explanation of why sexual harassment and abuse remain enduring concerns due to lack of sexual safety policies in many organisations, including failures to actually record and then investigate such cases. Collecting and recording data is central to organisational understanding of this phenomena (2). This investigation highlights failures to take sexual violence seriously, and to value gaining a more sophisticated understanding of three distinct sanction mechanisms - self, social, and legal sanctions - that are required to reduce these violations in workplaces and society.

Sexual harassment and abuse do not occur in isolation. Our previous research has associated these behaviours with workplaces that are already hotspots for bullying and harassment from both patients and staff (3). Perpetrators act on these aggressive, goal-directed behaviours for their own satisfaction and to enhance *their* feelings of power and control, with little or no regard for targets (4). Research shows it is habitual, once started it is difficult for the individual to self-reflect and control the behaviour (5,6-7). It often progresses with perpetrators testing out how others react to their transgressive activities and if their behaviour is tolerated in that environment. They use cognitive reframing and behavioural strategies to overcome their inhibitions, denying or downplaying the consequences of their behaviours (8,9).

Perpetrators select locations for privacy and access to suitable targets – especially people who are vulnerable, powerless, or may be considered an unreliable witness. Jimmy Savile's crimes showed the attraction and vulnerabilities of healthcare workplaces to abusers (10), they can allow people to move around largely unchallenged by both staff and the visiting public.

Perpetrators are found to use specific career choices such as agency or locum work to improve their access to targets (10). Some workplaces and professions, notably mental health, are a hotspot for perpetrators as the include a wide range of professions including psychiatry, nursing, and psychology(11–13), and there are also significant issues within family medicine (14), and obstetrics and gynaecology (15), although this varies by profession and access. There is value in focusing on such locations to ensure data are gathered especially since this investigation suggests inconsistent data provision despite evidence of these hotspots.

Given that perpetrators' self-regulation is impaired, two other mechanisms should be used to help deter and prevent them (8). Social sanction is an important means of inhibiting perpetrators – but only if the perpetrator fears the negative reactions of others. Considering ongoing issues of recruitment and retention in health workforces, fewer staff reduces the means to notice other's abusive behaviours and then have capacity to intervene (8). As perpetrators often hide their activities, there may be only subtle clues available to realise something is not quite right.

More insidiously, perpetrators can deliberately subvert workplace norms and culture, often relying on ambiguity (8). For example, they may only make sexualised comments to junior female staff,

masking it as a joke to make it easier to disregard. Yet what is occurring is boundary shifting, desensitisation of bystanders and targets, and reduction of social sanctioning (8).

Clear policies of sexual safety and mandatory staff training on them are important in re-establishing social boundaries, reducing the ambiguity of what is acceptable behaviour by staff and patients, and to raise awareness about reporting. In order for those who are experiencing sexual harassment and violence to feel confident about reporting requires confidence that senior and responsible role holders are willing to listen and act their concerns. Yet such roles are often held by perpetrators, or those more focused on protecting the organisation (16). Building a trusted organisation requires controls specifically the application of sanctions (17), demonstrating justice for abuse targets and that safeguarding of staff and service users is a priority. The current investigation indicates what could be interpreted as a wilful disengagement manifest in the failure of controls to detect or prevent sexual abuse. Not collecting data on sexual harassment and violence does not change its occurrence – rather suggest the organisation is incompetent and lacking in goodwill intentions.

Effective legal sanctions and punishments are the final means to inhibit perpetrators (8). This investigation again shows their shortcomings, with inconsistent and inadequate recording making early detection impossible, and inconsistent sanctions opening up further ambiguity. Early evidence of sexual transgression is often discounted (18). These failures fuel perpetrators' moral disengagement, sense of exceptionalism (8), and greenlights abuse (9,19). They pervert justice and support for targets. Downplaying incidents of sexual abuse, especially those perpetrated by patients, reduces staff wellbeing, job satisfaction and workplace safety, and increases staff intentions to quit the workplace and profession (20–22). The culture of silence that follows involves the decline of moral, financial, and care quality in the organisation and the erosion of public trust, greenlighting abusive activities to perpetrators (23,24).

2022 saw the highest level of sexual violence reporting in the UK. When these events occur at work they actively undermine the safety and integrity of that workplace. Specific sexual harassment and violence policies need to be developed and utilised (2) if we are to have the means of changing the lives of perpetrators, targets and bystanders.

No conflict of interest

1. Link to investigation

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