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Response of UEMS to the recent publications on Sexual Misconduct in Surgery

This response has been jointly drafted by the Thematic Federation for Equality, Diversity and Inclusivity and the Surgical, Medical and Multi-Disciplinary Sections within UEMS

A recent scientific paper[1] described the widely experienced sexual misconduct in past 5 years with disproportionately more women affected. Its content was shocking. Many females related disturbing and distressing misconduct ranging from inappropriate comments to rape.
In a parallel publication the UK Working Party on Sexual Misconduct in Surgery (WPSMS)[2] published Breaking the Silence - Addressing Sexual Misconduct in Healthcare[3] and Myths and Facts about Sexual Behaviour[4].
Inappropriate sexual behaviour (harassments and assaults) within medicine is not limited to surgery[5] and is not restricted to the United Kingdom[7,8,9]. It is integral to the experience of female doctors across Europe.
Creating a safe working environment for medical workers and consequently supporting patient safety should be a top priority and in the interest of all medical stakeholders.
We need to change that culture from 'everybody knows, but nobody does' to 'everybody knows and everybody does'.
Now that the silence has been broken, the whole profession needs to build on their work. For general measures UEMS supports the recommendations of the UK WPSMS.
To this end, we re-print their recommendations adapted slightly to be appropriate for all UEMS member states.

UEMS suggests as a first step in dealing with this serious problem to acknowledge that it exists and recommends implementing the following actions recommended by the UK WPSMS.

1. ***UEMS recommends for individual help and support for victims of sexual harassments and assaults, the creation of a national confidential support resource***

The victims of these acts are often stigmatized with prejudice and social misunderstanding. Legally the acts should not happen, but the evidence and experience show that they are distressingly common. The creation of a support group/resource consisting of one or more professionals (preferably female in most cases) would offer confidential support.
This resource would be a "safe space" to talk about sensitive issues (via phone, video call or in person, as preferred). The support resource would offer the victims psychological support from experts as well as legal professionals, as needed.
We believe that each country should organise this support system. It could be the responsibility of the national medical associations (NMAs), the national medical chambers or any similar national medical organisations.

2. ***UEMS recommends further Implementation and Investigation***

UEMS encourages accountable organisations to support:

> *1. National Implementation Panel to oversee progress by organisations on the recommendations in this report*

This will also facilitate data collection and report successes and ambitions, ensuring that this work continues for the workforce of the future. It will necessarily develop its own expertise in the process.

> *2. reform of reporting and investigation processes of sexual misconduct in healthcare, to improve safety and confidence in raising concerns and to ensure investigations are external, independent, and fit for purpose*

This is vital to provide safety for those impacted to speak up and to ensure that perpetrators will not continue to act with impunity. Healthcare providers may have a conflict of interest in wishing to preserve an organisation's reputation. Consideration should be given to designating reporters of sexual misconduct as whistle-blowers and affording them protections currently enshrined in whistleblowing law.
A clearer framework across professions within which sanctions are applied will ensure the appropriateness and comparability of outcomes. Consistent referral, expert independent investigation and appropriate judgements will help to restore faith in investigations and result in consequences for perpetrators while deterring others.

3. ***UEMS calls for Policies and Codes of Conduct***

At the time of writing, most healthcare providers do not have these in place.

> 3. *every healthcare provider should have an appropriate, specific and clear Sexual Violence/Sexual Safety Policy in place*

Provision of a template that includes consistent definitions of misconduct, sources of support for those raising concerns and for the accused, reporting processes, thresholds for investigation and

referral arrangements will improve standardisation. While it is noted that a hospital is an independent body.

4. *all healthcare educational bodies and professional associations should have an appropriate, specific and clear Code of Conduct which includes sexual behaviour*

These codes should be signed up to by those who are employed by, study at and belong to these entities, and should apply both within the workplace, and at work-related events such as conferences. A Code of Conduct for educators should include the requirement to report a sexual relationship where there is an educational or supervisory role or a different position of power of one colleague by another. That role should then not be allowed to continue.
Trainees, students, and allied healthcare professionals are particularly vulnerable to sexual violence at work-related events outside the workplace, where boundaries may be blurred, and alcohol may be involved.

5. *accountable organisations and professional associations should support and enact relevant pledges and charters. Where appropriate, the BMA Sexism Pledge and the NHSE Sexual Safety Charter might offer guidance*

Changing the culture in healthcare is vital, and these frameworks are an important step in that process.

4. UEMS asks those responsible for the ongoing education of the healthcare workforce to:

6. *integrate learning in recognising and taking appropriate action on sexual misconduct and other forms of inappropriate behaviour at all stages of a career in healthcare*

Scientific data show that men report witnessing sexual misconduct far less frequently than women do. Education and raising awareness are required to change attitudes to respect the experience of those targeted. It would dismantle the endemic sexual misconduct occurring within the healthcare workplace. Actually, much is trivialised by the prevailing culture.

7. *ensure active bystander, unconscious bias and awareness-raising training for all members of the healthcare team, with specific reference to dealing with incidents of sexual misconduct*

Active bystander training, awareness raising, and unconscious bias (including bias reduction strategies and bias mitigation strategies) should be part of training for all members of the healthcare team, with specific reference to dealing with incidents of sexual misconduct. Active bystander training equips individuals with strategies to challenge poor behaviour, including sexual misconduct that they may witness.

8. *ensure all those involved in receiving reports of and/or investigating sexual misconduct have received specific validated education including learning from previous cases and have appropriate expertise, including critical competencies*

Many who have spoken out or have given their stories experienced a woeful lack of expertise by those who investigated their report of being sexually harassed, assaulted, or raped. Current reporting mechanisms are insufficiently clear and poorly trusted.
There is wide variation in the competency of those carrying out investigations. In many countries within the police force, Sexual Offences Liaison Officers (e.g. in the UK) act as first responders. There should be clear criteria for involving the police where a crime may have been committed.

5. UEMS calls upon accountable organisations with regard to their Culture and Performance

9. to include sexual misconduct towards colleagues in the reform of healthcare regulators' professional guidance

Other healthcare regulators should follow the example set by the UK General Medical Council in this matter. This recommendation should also apply to any future regulatory body of healthcare managers and should include the duty to appropriately deal with concerns raised.

10. engagement of all stakeholders with the Implementation Panel (as described above) to report progress and to share data and expertise

It is the responsibility of all of us within healthcare to solve this problem with a zero-tolerance approach.

11. the agreement of standards for the management of reported incidents of sexual misconduct and scheduled prospective auditing of performance by organisations against those standards

There should be on-going independent audit of all sexual misconduct cases of which healthcare organisations and professional regulators are made aware. This should be included as a standing agenda item in organisations' leadership team meetings and a standard reporting item to the Implementation Panel. This will provide data on progress, identify outliers and encourage cultural change.

12. the inclusion in hospital, NMA or other healthcare organisations of questions on workforce satisfaction specifically about how adequately those organisations deal with sexual misconduct

Current healthcare workforce evaluations of the adequacy of dealing with sexual misconduct are poor. It is the responsibility of these organisations to improve, and we suggest that they regularly collect data on this to inform them of their own progress. There is vast opportunity to gather data to inform future progress through staff enquiry.

13. an equality, diversity and inclusivity promoting strategy to improve the representation of women (and other underrepresented groups) in local and national leadership roles, and across all specialities and workforce groups in healthcare

While women remain under-represented in these spaces, cultural change of the magnitude required to make a difference is a significant challenge. A lack of diversity in areas of healthcare is a major contributor to the prevalence of sexual misconduct. Its existence may be one of the underlying reasons why many women do not choose for a specific specialty.

6. UEMS strongly suggests to improve methods of Data Collection

14. Improvement or implementation of appraisal/assessment/end of placement or employment feedback systems for staff and students to include questions on their own and others' behaviours regarding sexual misconduct and safety

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