

Sexual assault and harassment of doctors, by doctors: a qualitative study

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CONTEXT Although sexual harassment frequently occurs in medical education and medical workplaces, doctors who have been sexually harassed or assaulted by other doctors remain a largely invisible population. This study aimed to identify, using personal accounts, the impact on doctors of sexual harassment and assault by doctors in the workplace.

METHODS This narrative study used in-depth interviews, legal reports and victim impact statements, tracing trajectories from the event's pre-history to its aftermath and impact on professional practice. Participants were six Australian women doctors who had been subjected to one or more non-consensual sexual acts through coercion or intimidation by another doctor in their working environments, within hospital training programmes.

RESULTS All women identified long-term personal and professional impacts of their

experience. Three women had never reported the abuse. The meaning and impact of sexual abuse for the doctors followed a trajectory with discrete phases: prelude, assault, limbo, exposure and aftermath. Discounting the event and its impacts, and returning to the workplace were characterised as 'being professional'. Those who sought legal restitution said it damaged their personal well-being and their standing among fellow doctors.

DISCUSSION Understanding the phases of experience of abuse enables the development of effective interventions for different phases. Interventions to minimise the risk of occurrence of sexual abuse must be distinguished from interventions to increase reporting rates, and interventions to mitigate harm and impact on victims' futures. Idealised notions of professionalism can act as obstacles to doctors responding to sexual abuse.

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 INTRODUCTION

Bullying, discrimination and sexual harassment are common in the medical workplace, with between one-quarter to three-quarters of medical students and junior doctors experiencing harassment.^{1–5} Sexual harassment is more frequent in medical education than in other university faculties or schools, and experienced disproportionately by female students.^{6,7} Most medical students and junior doctors do not formally report the experience, citing concerns about impacts on their careers and distrust of institutional response mechanisms.^{8–12}

Workplace sexual harassment is common, with 21% of Australian workers experiencing sexual harassment, and 13% witnessing it.¹³ Organisations with high levels of sexual harassment often demonstrate an abuse of power by people acting as gatekeepers to career advancement,^{14–16} and an absence of effective pathways to respond to reported abuse.¹⁷ The risk of sexual harassment is increased in hierarchical environments where men outnumber women, organisations are perceived to be tolerant of sexual harassment, or sexism and sexual harassment are modelled by those in authority.¹⁸ Sexual harassment has a high personal impact on victims and a high impact on their careers,^{2,17,19} but the social discourse around sexual abuse continues to perpetuate rape myths, which lead to invalidation of the victims' experiences, self-blame, minimisation of the impact of trauma and under-reporting of sexual abuse.^{20–22} These myths are pervasive and are reinforced in the media,²³ the courts²⁴ and the broader social world.^{13,14,25–28}

Medicine may influence the way sexual abuse occurs and is experienced. Like the military, medicine can be immersive, with residential requirements leading to a blurring of the lines between work and social life.¹³ Career advancement depends upon a mentoring system in which senior doctors have influence over the careers of junior doctors they supervise.¹⁴ The clinical work of medicine is characterised by structured breakdowns in barriers to intimacy, in order for examination of patients to be normalised and socially permissible.^{15,16} Despite the influx of women into medicine, the profession remains strongly gendered, with men dominating in technical and instrumental specialties, such as surgery and intensive care, and in senior positions in academic medicine.^{12,17,18} Whole-of-profession studies into the prevalence of sexual harassment are

lacking, but the evidence to date is strongest in these procedural disciplines.^{8,10,19}

Recommended responses to stop sexual abuse in the workplace include implementing education and prevention programmes, facilitating clear formal and informal reporting pathways, creating greater equity in senior roles, empowering bystanders and facilitating research to drive policy change.^{13,14,28} Training on its own seems to have limited impact on the prevalence of sexual abuse.²⁹

Doctors abused by other doctors constitute an invisible population of victims. There is as yet no evidence of these approaches being successful in the medical workplace. The literature tends to focus on cross-sectional surveys, or descriptions of gender-based harassment,⁵ rather than detailed accounts of the experience and impact of coercive sexual acts by survivors. In the absence of the voices of survivors, preventive policies and reparative interventions risk being ungrounded, generic and ignored.

In this paper, we aim to outline the experiences of women doctors who have been sexually abused by other doctors in the workplace, to create a narrative model of the journey over time of their experiences of sexual abuse, and to describe the impact of their experiences on their professional lives. We also explore how the constructs of professionalism and gendered relations shaped their experience.

 METHODS

This was a qualitative study using narrative methodology and a critical theory framework. Data included in-depth interviews, legal reports, written reflections and victim impact statements.

Definitions

Research into sexual assault and harassment is complicated by overlapping definitions (Table 1). In this study we use the term *sexual abuse* to denote the experience of one or more non-consensual coercive sexual acts. This includes episodes of assault and episodes of unwanted touching pursued through intimidation.

Participants

The inclusion criteria for this study were doctors who had experienced sexual abuse in the workplace from other doctors. Gender was not specified in recruitment, but all participants were women.

Table 1 Definitions of sexual abuse

Sexual violence: An umbrella term used by the World Health Organisation to describe 'any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic, or otherwise directed, against a person's sexuality using coercion, by any person regardless of their relationship to the survivors/victims, in any setting, including but not limited to home and work.'²² Although all our cases fit this description, we felt the word 'violence' misrepresented the breadth of participant experiences.

Sexual assault: In many jurisdictions, the term 'sexual assault' has a specific legal meaning. We have used the definition of sexual assault given by the Australian Bureau of Statistics in their Crime Victimization Survey as 'an act of a sexual nature carried out against a person's will or without their consent, through the use of physical force, intimidation or coercion and/or involving physical contact. Includes any actual or attempted forced sexual activity such as rape, attempted rape or indecent assault (e.g. being touched inside clothing or intentional rubbing of genitals against the person) and assault with the intent to sexually assault'.³⁴ This definition does not include unwanted touching. Some of our participants experienced abuse that would not be classified as assault.

Rape: The term 'rape' has a specific legal meaning. Generally, rape includes penetration of the genitalia by a penis, object, part of a body or mouth.³⁵ None of our participants' experiences was classified as rape.

Sexual harassment: In Australia, sexual harassment is illegal under the sex discrimination act and applies to employers, educators and providers of goods, services and accommodation.³⁶ In the USA, sexual harassment violates Title VII of the Civil Rights Act of 1964, and applies to employers of more than 15 employees, and employment and labour organisations. Sexual harassment is defined as 'any improper and unwelcome conduct that might reasonably be expected or be perceived to cause offence or humiliation to another person'.³⁷ Because some of our cases involved sexual assault, we did not use the term 'sexual harassment' in the study.

Sexual abuse: 'Sexual abuse' refers to the lived experience of sexual violence, including rape, harassment and assault. We used the term in this study to describe any sexual act that was carried out without a person's consent, through the use of intimidation or coercion. This term encompasses sexual harassment and sexual assault.

Recruitment

Information about the study was disseminated through newsletters, conference presentations and social media groups for doctors. In the initial stage, participants contacted LS, a general practitioner with experience in trauma-informed care, for an informal discussion to confirm they met the inclusion criteria, and to discuss the scope of the interview. This stage could involve multiple telephone calls and e-mail discussions, addressing confidentiality and the potential impact of the interview. In the second stage, participants were provided with detailed written information about the study and invited to identify any further concerns, and whether they wished to proceed. In the third stage, LS met and interviewed each participant at a time and place of their choice.

Ethical concerns

Key ethical concerns of this study were maintenance of confidentiality and the risk of re-traumatisation.¹³ All participants were given a pseudonym, with identifying details changed at their request, and provided with transcripts of their interviews. The risk of re-traumatisation was addressed through sensitive preparation and management of the interview, providing follow-up discussions with the interviewee, and external support provided by doctors' health services briefed on the study. Ethical approval was granted from the ACT Health Human Research Ethics Committee (ETH.11.15.244).

Reflexivity

The three researchers are all female general practitioners who work in the care of vulnerable persons. All have looked after survivors of sexual assault and are involved in education addressing sexual harassment in medical schools.

Theoretical framework

The critical theory framework incorporated the subjective world of feelings, opinions and attitudes, and the structures and ideologies that shape an individual's experiences and responses.²¹ We focused on 'medical professionalism' as an ideology: a system of normative beliefs and values that a social group uses to explain itself and as a basis for its economic and social power.²² We theorised that sexual abuse at work is associated with the imposition of gendered power relations in a health

sector hierarchy^{14,23} with inadequate horizontal peer supports.²⁴

Interview schedules

The semi-structured interview schedule encompassed early life, medical school, hospital training, the experience of abuse and its aftermath. The interview schedule recognised the fact that interviewees presented their accounts as event-narratives, beginning with the event's pre-history (a precursor period almost always associated with their early medical professional careers), the event, and the narrative reconstruction of the personal consequences of the event. Several interviewees had never discussed the abuse event, whereas others had experienced their narrative being discussed in the media, as a result of court proceedings.

Data collection

Interviews ranged in length from 1 to 4 hours. Two participants were re-interviewed after a period of 18 months at their request. Several participants continued to reflect on their experience in e-mail correspondence, and provided transcripts of court proceedings, victim impact statements, media reports and personal reflections.

Analysis

The analysis was grounded by the theoretical framework.²⁵ We employed paradigmatic narrative analysis,²⁶ in order to produce common taxonomies and categories across the case studies. Each case was analysed as a story in its own right, constructed by the interviewee. The documentary materials (victim impact statements, court transcripts) were elaborations of the same story, and were integrated into the master narrative produced for each case study. We did not include media accounts of the events in our case narratives, as these focused on the perpetrators. The researchers read and re-read the transcripts, and agreed upon the master narrative of each story with its affect-rich accounts of motivations, meanings and consequences. We then triangulated these narratives with the court-tendered documents, where available, and trial accounts.

RESULTS

All participants were sexually abused within 8 years of graduation, when they were still in training, by

men who had professional authority over them. At the time of the interview, the events were between 4 and 25 years in their past. The sexual abuse events included assault (Stephanie, Helena and Kate), harassment involving intimidating sexual advances (Alice and Claire), and harassment involving stalking (Emily) (Table 2).

We developed two intersecting taxonomies: event-narrative time periods (prelude, the assault event, limbo, exposure for those who reported the event, and aftermath) and at each point intersecting taxonomies of 'being professional' (respect for authority, collegiality, service to a higher ideal), being female in a medical context and being junior in a medical hierarchy (Figure 1).

Prelude to the event

Participants described their personal or structural vulnerability to abuse. Two women saw themselves as personally vulnerable because of harassment and abuse as adolescents, which had been discounted by their schools. Others noted structural vulnerabilities posed by the work life of junior doctors. In an environment where women were over-represented among younger doctors, participants noted the everyday sexualising language used about female doctors and the assumption that sex between doctors was 'part of a whole boy's club' culture.

Enforced closeness can occur in long sessions in operating theatres, emotionally intense experiences in traumatic situations and relocation to rural hospital environments. Alice, who was pressured for sex by a more senior doctor, described the structural vulnerability of young doctors:

They're living in hospital accommodation. They're living by themselves ... they don't have anyone to talk to after hours, they can be very isolated and vulnerable. (Alice)

Another form of vulnerability rose from behavioural practices associated with establishing a professional persona. In order to demonstrate collegiality across disciplines and with senior colleagues, young women doctors described how they presented themselves as 'nice', to avoid being seen as domineering or a 'feminazi'.

Women tread a very fine line, being just nice enough to everybody that you're not a bitch, but not too nice so that you so-called 'invite

Table 2 Characteristics of the participants and the context of the abuse

Pseudonym	Training term at the time of the abuse	Perpetrator	Nature of the abuse	Consequences
Stephanie	Registrar, radiation oncology	Consultant and clinical supervisor	Invited to the perpetrator's home for a tutorial, drugged and sexually assaulted	Perpetrator pleaded guilty in a criminal court, was convicted and was sentenced to serve several years in jail. The sentence was truncated on appeal to 9 months, due to his professional standing and reputation. Stephanie passed her Fellowship examinations, and returned to her profession after a lengthy absence.
Claire	Registrar, neurosurgery	Consultant and clinical supervisor	Propositioned for sex in her supervisor's office after he exposed his genitals.	Perpetrator was fined in a civil court for sexual harassment. He continues to work in the profession in the same institution. Claire passed her Fellowship examinations, but has been unable to secure work in the public hospital sector.
Emily	Registrar, specialty details withheld on request	Consultant and clinical supervisor	Sexually harassed and stalked at work and at home. She describes hundreds of texts, phone calls and e-mails over several months.	Emily reported the incident and was asked to leave the hospital after the internal investigation was complete. The case was settled out of court because she became severely depressed and could not face the trial. She worked for several years as a volunteer while she recovered from depression, but passed her Fellowship examinations. Emily initially struggled to access a professional position, but has now returned to work as a consultant in her chosen specialty.
Helena	Junior doctor, rural rotation	Registrar in the same team	Helena was on a rural rotation, and returning to her quarters after a team dinner when she was held against a wall and sexually touched by her senior registrar. She managed to escape, but continued to work with him for the remainder of her term.	Helena chose not to report her abuse and eventually left the hospital system. She is now a General Practitioner.
Kate	Junior doctor, surgical rotation	Registrar in the same team	Kate was molested by a registrar performing frottage against her while she sutured a wound on the ward	Kate did not report the abuse and left the hospital system. She is now a General Practitioner.
Alice	Junior doctor, accident and emergency	Registrar in the same team	Alice was propositioned for sex during an accident and emergency shift by a senior registrar after a major trauma case.	Alice did not report the abuse and left the hospital system. She works as a General Practitioner.

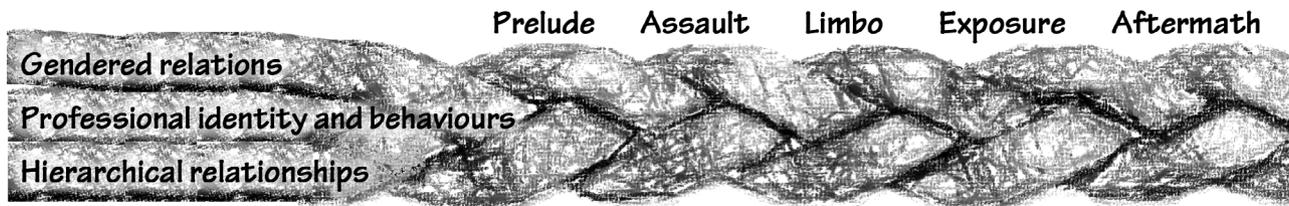


Figure 1 Intersecting taxonomies

inappropriate attention' ... You can't win as a woman. (Emily)

Females and medicine are walking this tightrope between being strong and all those traditional male qualities, making decisions, getting on with it and solving problems. Not creating dramas, I guess being a good girl and then also being approachable and nice to the nursing staff. (Helena)

In the following recollection of a comment made by a senior female colleague, Claire describes the risk of professional elision (being 'crushed like a petal') for young female doctors navigating a path between collegiality and assertiveness.

I was told [by a senior female colleague] if you can't stand the heat, get out of the kitchen ... oh, you'll be crushed like a petal! ... You can't show your femininity without somehow compromising the image that you're supposed to have. (Claire)

This complex negotiation of assertiveness and niceness to establish a professional persona was layered with another professional virtue: respect for medical authority, inculcated through medical school and instantiated through mentoring from senior clinicians. For Claire, 'all her Christmases had come at once' when her eventual abuser singled her out, offering her 'interesting cases' to manage. Stephanie's supervisor, a man of high professional pedigree, complimented her on her skills, telling her he felt 'really safe leaving my patients in your hands'; she was flattered professionally when he offered to mentor her. In retrospect, both Stephanie and Claire viewed these acts of mentorship by their eventual abusers as grooming behaviours.

Assault

All participants described compartmentalising or discounting the experience. When a registrar

standing behind her in a ward cubicle subjected Kate to frottage, she silently continued suturing the wound of an oblivious patient. When a much-liked senior clinician propositioned and stalked her, Emily 'went into a numb mode'.

I remember wondering whether his behaviour was normal and if there was something wrong with me. I had difficulty believing that his behaviour was actually real ... Sometimes I felt like I was going mad and this made me feel even more unconfident and uncertain about myself.

Helena, who was held against a wall and assaulted after a team dinner, dampened down her feelings about the event for years.

I had pushed it away ... then I got those feelings again back and remembered what it was like and I clarified in my head that it was something that he did wrong rather than me overreacting.

Recognising that they were personally vulnerable in a professional setting was deeply unsettling. Alice stated that as someone from a 'reasonably feminist family', she was 'aware of issues that might come up, but I didn't ever believe it would really happen to me'. Stephanie described the fact that her supervisor intentionally immobilised her with benzodiazepines before assaulting her (at a meeting intended to be about mentoring) as one of the triggers for pressing charges. Years later, she still felt 'the same rage, shame, and desire to just disappear'.

Limbo

After the abuse, the interviewees entered a period of elective or enforced silence, during which they considered their course of action. Reporting the event(s) involved facing the risk of harm, personally and to careers. Some also saw reporting as acting against the ideal of professionalism.

A professional doctor is supposed to get on well with all the team, deal with anything that

happens more internally rather than escalate it to an external, be able to I guess deflect everything like that, or diffuse it ... Probably internalise it more. Otherwise you are just feeble minded, being silly, hysterical or not cut out for medicine. (Helena)

At this point, women often found that their peers withdrew collegiality. Claire commented that even though she was taking calls from lawyers 'in the middle of operating' none of her colleagues offered support: 'they were just pretending nothing was happening'. After Emily disclosed her experience to her supervisor, she was asked to leave the hospital and prevented from attending educational sessions or accessing educational resources. Emily felt the roles became reversed: she was seen as the perpetrator and the perpetrator became the victim. The silencing and banishment from her workplace 'reduced me into an enigma, and has depersonalised me'.

Stephanie, whose case went to a criminal court, had a more positive experience. In her case, the professional attribute of collegiality protected her. Her friends and immediate colleagues were supportive, and her two bosses 'handled it all extremely well ... taking the initiative and taking it one step further, when I couldn't do it, helped'.

Her decision to pursue criminal charges was also driven by her own view of professionalism. For Stephanie, 'the drugging changed everything'. She had driven home after the assault, unaware that she was unsafe to drive. The perpetrator had not only endangered her own well-being, but had also placed the public at risk.

I went through a big grieving process, because I thought I might have to leave the whole medical profession. But I couldn't live with the guilt of somebody else being hurt ... The reason I went into medicine is to help people, and it's not just inside a hospital or in your clinical room ... I think as doctors we have a duty to protect each other and patients and it's a core thing that I can't negotiate. (Stephanie)

Exposure

The women who chose to report the abuse faced exposure at some point. After the organisational silence while the internal, civil or criminal cases were being set up, they became notorious. Interviewees expressed shame about the abuse itself.

Once they were exposed there was the added shame of having broken a code of collegiality.

For me, the shame was ... firstly, the fact that it happened to me, and that it should have been something that I should have been able to prevent, and I didn't do it. So I guess that's sort of same shame that most victims feel. And I feel that link is just the fear of being labelled a troublemaker. (Stephanie)

Many of their peers discounted the abuse itself. Emily, who was sexually harassed and stalked over months, was told she had misunderstood someone who 'simply wanted friendship'. She was asked to withdraw her complaint, because 'everyone [was] very upset' by her behaviour. Claire's decision to file charges in a civil court against her supervisor led to peers telling her she was 'creating trouble'.

Emily attributes her colleagues' disbelief to reluctance to acknowledge that sexual abuse can happen in the medical workplace.

These things happen ... in a hospital in a bright office. I mean, it's not a dark alley ... The stories that we tell are not the 'right' story. We can't believe that somebody in that position would actually be like that ... Unfortunately, now I see the world in quite a different way (Emily)

Even when the abuse was acknowledged, collegial support was still offered to the perpetrator. Although Stephanie's perpetrator pleaded guilty to sexual assault, he was able to furnish the court with many character testimonials written by senior colleagues.

Aftermath

In the aftermath of the experience, all participants battled to reassert their professional identities. The three women who did not report their experiences changed career paths to become general practitioners, working outside hospitals. Emily and Claire struggled to find work in their chosen fields, with supervisors providing poor performance ratings.

The recovery of professional ground could also be occasioned by champions. When Emily eventually found a position, years after she had reported her abuser for stalking, she was not initially welcomed by some doctors in her workplace.

Later on, I found out that many of them didn't want me to come. They had a meeting and said, we don't want Emily because she's a devious person. But the head [of that department] said, You do not know what the truth is, and we have to offer this girl a chance, and you will just deal with this ... [One other specialist] stood up for me and said, you ... shouldn't have opinions about something you know nothing about. (Emily)

Although all participants are still working as doctors, most struggle, years later, with the personal and interpersonal impact of sexual abuse. A few participants found their relationships with their partners collapsed. The financial cost of legal fees and the loss of work was significant. Several commented on how exhausting it was to face the trauma every day.

You're just so tired all of the time, because of this emotional energy that's expended, that you just almost don't have the energy to fix your life or change anything ... You've got to be a survivor, and being a survivor takes a lot of energy, and it means that other things in your life suffer. (Emily)

During Stephanie's court case she was never named or photographed in the media, in accordance with the law governing sexual assault cases in that jurisdiction. This public silence, coupled with notoriety among her peers, placed her in an odd position of extended limbo.

I'm dealing with the remnants of PTSD now I think. It's just that I've been so quiet and reserved ... for a long time. So to break out of that is really quite difficult. Like last week ... when I received the news [that the perpetrator had launched an appeal against the length of his sentence] then I just had trouble speaking for the rest of the week. I mean I was stuttering and that was really frustrating. (Stephanie)

Participants lost their faith in medicine, their mentors and the law. The betrayal of individuals and institutions changed their world view, and affected their identity as women and as doctors. Emily stated that her 'rose-coloured goggles' had come off; Stephanie saw 'my whole belief system collapse', in the wake of the abuse (see Appendix S1 for Stephanie's victim impact statement).

Several participants stated that they had become profoundly different women. Stephanie describes this very clearly in her victim impact statement: 'the impact of the assault has been profound in many ways and continues to affect me daily. I have lost so much and my life is heading a very different path to where I had imagined' (see Stephanie's Victim Impact Statement in Appendix S1). Alice agreed that the impact of abuse can be extensive. 'If we are going to manage this', said Alice, 'we need a curriculum of recovery.'

DISCUSSION

'Being professional' operated as a two-edged sword for the survivors in this study. Although certain tenets of professionalism may have made them more vulnerable to abuse, and to not reporting it, for others, professionalism acted as a touchstone to report the event: the 'duty to protect each other'.

Participants ignored or discounted the behaviour of perpetrators because they did not wish to appear 'unprofessional', that is, to break the codes of disciplinary collegiality and loyalty. Some participants were censured by colleagues and senior women; others were asked to leave the hospital because their reporting of a doctor had upset other doctors. If we are to shift this view of professionalism, we need to highlight ways of responding to members of a professional team who allege abuse, particularly in the difficult time of 'limbo' before the cases are resolved.

However, collegiality can also be a force for recovery and reintegration into the profession. Belonging to a professional community functioned as an important resource for the women in this study who maintained their professional career. Mentoring, including deliberate support to help victims reestablish their careers, is needed to manage the aftermath of this sort of trauma: the 'curriculum of recovery' that Alice mentions.

Current systems of reporting are opaque, involving intersecting roles of hospitals, Medical Defence Organisations, Colleges, the courts and Medical Boards, and the consequences for reporters personally and professionally can be severe.¹⁰ Reporting also reinforces women's roles as victims, and victims remain vulnerable. Instead, women may take on the responsibility for the abuse. 'Misunderstanding' or 'inviting' inappropriate

behaviour at least enables the person to retain a sense of personal agency.

There may be a role for a senior ombudsman in the colleges. In the aftermath of their abuse, several interviewees benefited from supportive action by senior professionals outside their immediate workplace. Most of the women described their experience as so out of their normal experience as to appear unreal: as Emily says, there is a sense of 'not being in the right story'. Having an unbiased witness within the profession who can hear the story and validate the experience of victims is essential.

Some of the abusive events occurred in public, or were well known within the victims' departments. In these cases, the bystanders were also members of the professional community, and may be wary of the personal impacts of whistleblowing.³⁰ Bystanders may enact 'betrayal blindness',²⁸ whereby they unconsciously fail to recognise abuse, to avoid consequences for social relationships. They may also be truly unaware of the trauma occasioned by the abuse. In our study, bystanders and colleagues compounded the trauma, particularly in the exposure stage when they questioned the reality of the abuse. Bystanders have a critical role in mentoring and protecting the victims, and managing the behaviour of the perpetrators, relieving the victims of some of the burden of managing the perpetrators and the environment in which they thrive.

Although there is little in the medical literature to guide a policy response to sexual abuse, we agree with McDonald et al.,^{29,31} who propose a time-based framework to manage workplace sexual harassment. Reducing the risk of harm in the prelude involves a change in medical culture to promote gender equity. This includes evidence-based education around what constitutes abuse, and rehearsal around how to respond, although education alone may not be sufficient.²⁴ In the assault phase, we recognise the importance of clear and transparent policies and lines of reporting. To counteract the hidden curriculum of professionalism that emphasises compliance and silence, and seems to operate despite policy and legal frameworks that espouse 'zero tolerance', policies should be overt, enforced and regularly reviewed.

Victims need independent senior doctors who are able to guide them through their decision making, including helping them decide whether the behaviour they experienced is abusive. Managers

need continued support to understand their legal and organisational obligations, and the human impact of trauma. During limbo, victims need ongoing support from external, independent mentors, who are able to help them negotiate systems of reporting, and importantly, their position in the workplace and training programmes. Exposure requires management of the broader team, to prevent re-traumatisation and victimisation from colleagues. Senior staff need to manage teams that may have a strong emotional response to the situation, particularly when the alleged perpetrator and victim are well known, or part of the same clinical team. Finally, in the aftermath, victims need their own health care and career mentorship to support recovery. All these interventions need to be evaluated to ensure they remain evidence informed and effective.

This is one of the first qualitative studies of doctors who have been sexually abused by doctors in the medical workplace, exploring lived experiences and recovery journeys. Although the sample size is small, this is common in much victimology research, reflecting the challenges of recruitment in hidden populations. This sample demonstrates information power, following the principles of Malterud et al.^{32,33} (Appendix S2). As with any narrative study, the accounts are retrospective personal narratives, and reflect years of reflection on the event and its impact. Further research should extend this work, particularly including male victims of abuse, same-sex predation and the experience of gender and culturally diverse doctors who have experienced sexual assault and harassment.

CONCLUSION

If we are to manage the impact of doctors' sexual abuse of junior doctors, we need to support all stages of the trauma and recovery trajectory. We need to continue to prevent sexual abuse and work to reduce the power differentials that make abuse possible in the medical workplace. We also need to have better policies and processes in place to ensure effective support of survivors when sexual abuse occurs. Finally, survivors need restorative justice: a mechanism to reintegrate them into the professional institutions that have deeply betrayed their trust.

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SUPPORTING INFORMATION

Additional Supporting Information may be found in the online version of this article:

Appendix S1. Victim impact statement: Stephanie.

Appendix S2. Sample size and knowledge power.

Appendix S3. Extended methods.

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