Powerful Perpetrators

Doctors and sexual misconduct: A summary of the literature

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Powerful Perpetrators is a five-year project (2023-2028) looking at sexual misconduct and abuse perpetrated by professionals, and the regulatory and administrative justice mechanisms used to investigate and sanction their behaviour. The project team are Dr Natasha Mulvihill (principal investigator); Dr Nathan Birdsall; Dr Emma Yapp and Dr Hannah K. Richards. More information is available at: www.powerfulperpetrators.org

Stage 1 of the project (May 2024 to October 2024) involved searching and synthesising the available literature on professional sexual misconduct. This work is collated in the following open access briefings:

- Yapp, E., Birdsall, N., Mulvihill, N., and Richards, H. 2024. *Doctors and sexual misconduct: A summary of the literature*. Bristol, UK: University of Bristol.
- Richards, H., Yapp, E., Mulvihill, N., and Birdsall, N. 2024. *The legal profession and sexual misconduct: A summary of the literature.* Bristol, UK: University of Bristol.
- Richards, H., Yapp, E., Mulvihill, N., and Birdsall, N. 2024. *The military and sexual misconduct: A summary of the literature*. Bristol, UK: University of Bristol.
- Birdsall, N., Mulvihill, N., Richards, H., and Yapp, E. 2024. *The police and sexual misconduct: A summary of the literature*. Bristol, UK: University of Bristol.
- Mulvihill, N., Richards, H., Yapp, E., and Birdsall, N. 2024. *Politicians and sexual misconduct: A summary of the literature*. Bristol, UK: University of Bristol.
- Mulvihill, N., Richards, H., Yapp, E., and Birdsall, N. 2024. *Religious leaders and sexual misconduct: A summary of the literature*. Bristol, UK: University of Bristol.
- Richards, H., Yapp, E., Birdsall, N., and Mulvihill, N., 2024. *Professionals (general) and sexual misconduct: A summary of the literature*. Bristol, UK: University of Bristol.

The briefings and our 'literature summary interactive tool' to compare our findings for each profession is available on our website: www.powerfulperpetrators.org/publications

What is the nature and extent of sexual misconduct and abuse by doctors in the UK and internationally?

It is complicated to estimate the extent of sexual misconduct amongst doctors, due to difficulties with administrative data (1). Self-report surveys indicate that 38-52% doctors report knowing a colleague who has been sexually involved with a patient (2). Two per cent of patients report inappropriate sexual behaviour from doctors (3), although only a third of those will report it (4). There is also evidence that doctors act in sexually inappropriate ways to colleagues: 91% female doctors report experiencing sexism at work in the past two years (5); and 3.8% NHS employees report experiencing inappropriate sexual behaviour from colleagues in the past year alone (6). Sexual misconduct cost the NHS a total of £4 million between the years 2018 and 2023 (7).

Sometimes referred to as "sex in the forbidden zone" (8), there are problems with consent given the inherent power dynamic and single-sided dependence between patient and physician (9). Sexual assault by doctors also incurs specific harms, as it can result in individuals avoiding crucial medical care. Legal scholar Jenni Millbank provided a particularly striking case study from the Australian context, in which "Debbie" was raped by her doctor at age 14 in 1978; he drugged and raped her twice more in the subsequent year. Forty years later, Hoong Pan Sze-Tho pled guilty to sexually assaulting Debbie and another patient, but in the time that had ensued between his crimes and his conviction, Debbie had harboured an understandable fear of doctors, and therefore avoided consultations while pregnant. This resulted in her giving birth prematurely three times, and losing three sons (10).

What administrative justice mechanisms do medical regulators currently have in place to respond to sexual misconduct and abuse by their members?

In the UK, when a complaint of sexual misconduct against a doctor is raised, the General Medical Council's (GMC) case examiners conduct an initial week-long investigation known as "triage". If they find that the concern is serious, this will lead to a longer GMC investigation, and potentially, a trial at the Medical Practitioners Tribunal Service (MPTS), adjudicated by a combination of medical and lay members. These trials are adversarial in nature, and enact the civil standard of proof (balance of probabilities) rather than the criminal one (beyond all reasonable doubt) (11). However, there is evidence to suggest that only 15% of those criminally convicted for violent and sex offences make it to the tribunal stage, and doctors are rarely "struck off" for sexual misconduct (12–15). Further, even for those who have been "erased" from the medical register, they can apply for restoration after five years have elapsed, though any prior findings of fitness to practice will remain on the searchable medical register.

In the UK, how do (a) perpetrator characteristics; (b) victim characteristics; and (c) the context of sexual misconduct and abuse, compare across doctors?

The characteristics of sexual misconduct amongst doctors are consistent across the international literature. Perpetrators are more likely to be older, more senior men (1,10,12,13,16–35,35,36), and victims are likely to be younger women (1,5,17,20,23,24,26,27,29,37), often those who are referred to in the literature as "vulnerable": they may have psychiatric diagnoses, or histories of abuse (12,19,25–27,32,34). In some cases, vulnerability is induced by drugging (20,27). Physicians who are more likely to act in sexually inappropriate ways with patients tend to be those who visit patients in their homes, or who are left alone with patients. This includes psychiatrists, obstetricians, gynaecologists, and GPs (12,13,19,21,25,26,28–30,38–46). A separate but notable site for sexual misconduct is in the operating room (5,16).

How do social relations of power operate and intersect with context and opportunity at the (a) individual (b) organisational-professional and (c) socio-cultural level, to account for the perpetration of sexual misconduct and abuse by doctors?

Doctors are perceived by patients as benevolent, competent, and in possession of moral integrity (21). As such, it can be difficult to "speak out" about sexually inappropriate behaviour from doctors, especially when conducted under the guise of a medical examination (47). In addition, doctors have access to patients' medical records, and may edit these to imply that the patient is an unreliable witness, as a "pre-emptive strike" (19). Medicine is also an historically hetero-masculine, hierarchical, and sexist institution, which breeds problematic cultures that are conducive to sexual violence (5,16,20,21,35,48–52). Within the field of psychiatry, for example, there is a history of sexual interventions being conducted by doctors under the guise of "treatment" for hysteria, or sexual "dysfunction" (53).

How effectively do current administrative justice mechanisms (a) sanction past sexual misconduct and abuse and (b) seek to deter future sexual misconduct and abuse by doctors?

There are numerous problems with the administrative justice procedures for sanctioning sexual misconduct amongst doctors. From failures to investigate (10,48), to failures to sanction and record sexual misconduct (12–14), there is attrition at every step of the administrative justice process (1,4,9,14,15,21,54). In this sense, this literature reflects research on sexual violence cases more broadly. Rape myths and psychiatric evidence are regularly deployed to discredit experiences of sexual violence (14); patients are represented as seductive (55); and cases with multiple victims are more likely to be successful (19,26). In addition, the treatment of sexual violence by the judicial processes is highly medicalised and individualised, focusing on a doctor's ability to show "insight", "remorse", and preferably, "rehabilitation" (10,19,21,56–60). This is highly problematic, as sexual violence literature more broadly demonstrates that it is not an "individual" and "treatable" problem, but one that is instantiated within wider dynamics of power (61–63).

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