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1. Summary

Sexual assault and harassment within the NHS are part of a culture that idolises macho individualism. Power differentials and hierarchical attitudes are perpetuated by limited access to training opportunities, high competition for postgraduate training posts for doctors and excessive workload. This combination makes it harder for victims and other staff to challenge those behaving badly, especially if it is perceived to affect their own career progression. Sexism is experienced by 91% of women doctors [1]. Patient safety is compromised with poorly functioning teams. Many staff leave. Improving culture requires action on several levels:

1.1. 'Codes of conduct' are needed, including for the public.

1.2. Organisations, especially training organisations, must change processes around reporting and training for all staff, especially managers.

1.3. All staff should be trained and supported to challenge 'minor' poor behaviour with practicalities such as 'active bystander' training, 'call it out', 'call in' and 'cup of coffee conversations'.

1.4. Training organisations should analyse behaviour reports and improve postgraduate training, such as reducing commuting or rotational training, and ensure appraisers and supervisors are appraised.

1.5. The NHS should increase and improve the postgraduate training posts for doctors to reduce excessive competition for posts, rota gaps and excessive workload. Posts for additional staff in support roles should also be funded. The 'broken pipeline' and artificial hurdle of training inaccessibility prevents many women from progressing. This will require funding but delivers better patient care and reduces women doctors leaving the profession.

More detailed recommendations are listed in Section 17.

2. The Medical Women's Federation is the largest organisation of women doctors in the UK. We are a membership organisation and have been supporting women doctors and medical students and campaigning about health issues since 1917. 56% of doctors in postgraduate training are women [2], but the system has not changed to accommodate them, with highly competitive training posts reinforcing poor behaviours by those in power. We know there are huge differences in experiences for women doctors including sexism and sexual harassment. These have catastrophic impacts on their lives and careers. Change has been too limited and too slow. Losing and ignoring this excellent workforce has a huge negative impact on patients and the NHS. This is part of a broader conversation about culture. Other countries and other industries have changed. MWF is absolutely ready to be part of the solution. We would expect to be invited to any forum that can bring change.

3. As President, I am submitting on behalf of the Medical Women's Federation (MWF). I have been a consultant Orthopaedic surgeon for 21 years. I was on the Council of the Royal College of Surgeons of England from 2011 to 2021 and wrote guidance on 'Avoiding Unconscious bias' [3]. I am also a columnist on health issues in the BMJ: https://www.bmj.com/search/advanced/mcnally

4. Our MWF co-Treasurer and our Honorary Secretary, who are both surgeons, published an article on actions to reduce sexual harassment: https://www.bjsacademy.com/sexual-misconduct-in-surgery-calling-it-in-together-we-can-shift-culture. It includes personal testimony about decades of bottom-pinching and lewd comments, especially by senior doctors, and pervading silence as the victims fear for their career if they speak out. It describes how to change. Change should not rely solely on a reporting system. The problem is that the whole culture perpetuates poor

behaviour. Even the language we use in medicine is hierarchical – we talk about junior doctors who work under a consultant. We need to shift the culture. It states that:

4.1. *The practicalities for change of culture require both a top down and bottom up approach.*
4.2. *The examples are just the tip of a much bigger iceberg, the depths of which lie in a sea steeped in patriarchal hierarchy.*
4.3. *Now is the time to shift the culture.*
4.4. *Victims need clear places for support and organisations need to change.*
4.5. *On a practical level we suggest that conversations and invitations to challenge behaviour should be offered at every opportunity, with decorum in theatre and zero tolerance for banter.*
4.6. *Active Bystanders should be supported to make a challenge.*
4.7. *Staff should 'Call it Out' – meaning bringing public attention to an individual, group, or organisation's harmful words or behaviour.*
4.8. *Alternatively, 'calling it in' is an invitation to a one-on-one or small group conversation to bring attention to an individual or group's harmful words or behaviour, including bias, prejudice, microaggressions, discrimination and sexual harassment. This supports the perpetrator to change their behaviour, not ostracising them.*

5. We support the recommendations in the report on sexual harassment: https://www.wpsms.org.uk/, but feel these do not go far enough and will not be successful without wider change to reduce sexism, competition for training posts, over-work and reliance on the current hierarchy for career success.

6. The Medical Women's Federation recognises the significance of the findings of new research [4] into sexual harassment, sexual assault and rape within the surgical workforce. Over the past five years, 63.3% of female surgeons reported sexual harassment, 29.9% reported sexual assault and 10.9% reported experiencing forced physical contact for career opportunities. Participants reported a lack of faith in regulatory bodies to deal with reports of sexual harassment and assault.

7. Victims of sexual harassment often have long-term consequences to their mental and physical health. In addition, these events could adversely impact careers and prevent women from progressing in their chosen specialty. This is of particular importance within surgical specialties where women remain underrepresented. Sexual harassment and sexism within the workplace could play a significant role in deterring women from completing surgical training. The normalization of such behaviour, which is often excused as 'banter', must end.

8. Ending sexism and supporting parenting:
Sexism is a huge issue. Women doctors are exposed to multiple worse experiences. In some specialties 15% of women leave training [5]. The UK cannot afford to lose this talented group of doctors. Where poor behaviours or a negative culture is permitted, bullying escalates, staff leave and there are data showing patients receive worse care [6]. This is fixable and could change rapidly with changes in culture and processes, training posts and funding.

9. Sexism in medicine – prevalence
The BMA report '*Sexism in medicine'* found 91% of women doctors had experienced sexism since 2019 [1]. The Kennedy review highlighted sexism and 'micro-aggressions' within surgery [7]. The Times reported on sexual harassment [8]. Half those training Less Than Full Time (LTFT) report undermining [9]. Sexual harassment and discrimination are more likely where sexism is tolerated and normalised. Liang describes a 'Tower of Blocks' with any additional poor experience making women doctors leave [10].

10. Sexism - causes:

Sexism is rife and its causes include: some people holding onto a belief in traditional gender roles; unconscious bias meaning that people have assumptions about a person's role; lack of representation in senior roles reinforcing stereotypes; lack of representation creating an imbalance of power and influence; and the gender pay gap may contribute to lower perceived value of women.

Many people struggle to reconcile the two concepts:

10.1 *For women in general*, there is a far greater likelihood of undertaking childcare duties, so difficulties with this and with parenting predominantly affect women. Organisations should modify the environment to allow for general changes to improve parenting for all.

10.2 *For every individual woman doctor*, opportunities should be given that are not stereotyped.

11. What are the areas to tackle to improve women doctors' experience:

11.1 **Culture:** Bad stereotyped career advice, being put off specialties and not being supported within a department.

11.2 **Progression:** Not being supported into higher roles nor listened to when in them.

11.3 **Parenthood:** Training structures that do not acknowledge parenthood and other caring responsibilities: workforce gaps, difficulties with arranging flexible working or training, stigma, commuting and childcare costs/burden falling on women.

11.4 **Sexism:** There are negative assumptions from other staff and from patients.

12. Efforts to reduce sexism and poor behaviours:

When unconscious bias training is optional, the people who most require it are probably the least likely to enrol. Many senior staff do not realise how they are perceived. They can also think they are being kind (benevolent bias) when they confuse general stereotypes with giving individual advice.

Some actions require investigation and sanctions. Unfortunately, reporting can result in a lengthy confidential process with no wider learning. Prevention is also needed. The culture needs to change, so that sexism and personal comments are not tolerated. There should be equality of opportunity. Staff should undergo 'Active Bystander' training and be encouraged to call out poor behaviour. Operating theatres and similar high-stress environments are common places for bad behaviours. The Association of Anaesthetists advise 'declare or distract' in the moment, with follow up 'delay or delegate' discussions as needed [11]. Some staff should be trained in 'vanderbilt cup of coffee' discussions, where a respected colleague has a private discussion with the alleged perpetrator, explaining how they were perceived after an episode of poor behaviour. The Royal Australasian College of Surgeons has an app for this [12] and has shown improvement.

13. Efforts to eliminate sexual harassment:

Sexual harassment is unacceptable. Prevention should include: challenging a sexist culture with allies and active bystanders; and providing clear guidance about what behaviour, jokes or discussion are not acceptable. Other pro-active actions:

13.1 Establish a clear anti-harassment policy

13.2 Encourage reporting

13.3 Provide training

13.4 Prioritize confidentiality

13.5 Respond promptly

13.6 Conduct thorough investigations

13.7 Enforce appropriate sanctions
13.8 Provide support to the victim
13.9 Monitor the workplace and training reports
13.10 Review and update policies.

14. Postgraduate training arrangements – Less Than Full Time Training (LTFT)

14.1. Part-time working is possible for those in permanent posts, such as GPs, Consultants, SAS doctors and Locally Employed doctors. Doctors in postgraduate training can apply for Less Than Full Time Training (LTFT) at between 50% and 80% of hours, with reduced pay.

14.2. Women have been in the majority at medical school for 30 years. An immediate increase in training posts is needed to ensure service delivery now and in the future. For example, in Obstetrics and Gynaecology even where there is a full head count, 18% of shifts/hours are unfilled due to doctors on maternity leave or LTFT [13].

14.3. Most doctors, across genders and specialties, want to work 80% of time in the future [14].

14.4. There is still a stigma to working LTFT – 53% of those in LTFT posts reported undermining [9]. Other staff often blame them for rota gaps, or belittle their working hours. These behaviours should be addressed.

14.5. MWF greatly welcomes recent progress in making LTFT postgraduate medical training more available and not requiring a reason. Small additional funding would help reduce current complex negotiations between hospitals, training systems and the doctor.

14.6. It is imperative that more training posts/numbers are made available to staff rotas properly. We need an increase in training posts so that women can take the maternity leave they need and fathers/partners can participate in taking shared parental leave/paternity leave without affecting shift/rota patterns.

15. Workforce issues impacting on all genders and worsening training experience

Many problems are exacerbated by pressures of service provision. There are insufficient doctors, rota gaps and difficulties with many aspects of training. These are worse for a doctor from a minority group, or one who is balancing other issues. There is no spare time to reflect, plan and optimise learning opportunities. Doctors perceive the need to avoid challenging their boss. The NHS relies upon doctors in postgraduate training to provide a service. From historical lengthy on-call rotas, their hours were limited to 56 in 2004 and 48 hour per week in 2009, with no large increase in training post numbers to compensate for this. It would be possible to increase training posts swiftly and cheaply by converting many Locally Employed (LE) doctor posts to training posts. There are now almost as many doctors not in training posts (61,000 in SAS or LE posts) as in training posts (66,000) [2].

The number of training posts is restricted by training bodies. There are competition ratios of 4 applicants per post for many specialities [15].

Doctors, especially in postgraduate training posts, are rostered to shift work and nights, often reducing daytime training opportunities. Physician Associates and similar autonomous 'Medical Associate Practitioner (MAP)' roles that are being developed should be rostered onto out-of-hours cover where present to reduce the burden on doctors as part of a team, rather than displacing doctors from daytime work and educational opportunities.

For many doctors, over half their working hours are spent on duties that do not require a doctor's capabilities, for example administration [16]. This worsens quality of training and delivery of patient care. They are stretched, not getting meal breaks, fatigued and many are burnt out.

16. Other considerations that may assist the business case for action to retain women doctors

16.1. We are losing thousands of talented doctors, who would otherwise be providing 20-30 years' more service.

16.2. Doctors can handle risk and complexity. 21% of the UK population has a long-term medical condition. 19% are over age 65. At age 65, 50% of the population are multi-morbid (with two of more long-term conditions). We need doctors, especially senior dynamic doctors.

16.3. Litigation, claims and complaints in Obstetrics cost twice as much as running the service [17]. Better staffing, eg doctors, can reduce errors.

16.4. Doctors help improve the population's health. Across the UK, more people than ever are leaving work due to ill-health. We cannot afford to lose their taxes and contribute to care costs.

16.5. Patients are more likely to take advice if personalised by a senior clinician who they trust. This allows patients an opportunity for Shared Decision Making (eg doubts about proceeding with an operation) [18]. This reduces unwarranted investigations and interventions. 10-15% of operations have complications. 15% of patients express regret after surgery. Eg 15% of older patients decide against surgery after a consultation with a geriatric-led service. This saves the NHS huge costs (in resources, staff and complaints). We need to retain doctors to do this.

17. Recommendations for reducing poor behaviours and sexism and improving parenthood, especially in surgical training. See explanation article [19]:

17.1. We should consider a 'code of conduct' for patients and visitors. The NHS is an anchor institution and could help to change society. There are parallels with the 'considerate construction' industry or 'Speak up, Interrupt' for sexual misconduct on the railway from the British Transport Police [20].

17.2. All trainers/supervisors and permanent senior staff should be required:

- to understand how to support parents, eg https://www.boa.ac.uk/careers-in-t-o/parenthood-orthopaedics.html.
- to understand unconscious bias [3].
- to understand how to deliver constructive criticism, especially if those returning from parental/etc leave lack confidence, with additional support.
- to understand that everything should be done to assist doctors in postgraduate training to achieve the standards for completion of training, and that some will not fit the traditional image of presenteeism and perfection but will develop on different trajectories.

17.3. All NHS Trusts and managers should:

- provide mandatory Active Bystander training
- understand how to deal with disruptive behaviours, such as: https://www.rcseng.ac.uk/standards-and-research/standards-and-guidance/good-practice-guides/managing-disruptive-behaviours/
- have clarity about how they support new parents - expectations should change (for example, just because clinic always overruns does not make it that Registrar's problem). Eg LeadersPlus toolkit for managers and those returning from parental leave: https://www.leadersplus.org.uk/parental-leave-toolkits/
- consider how to involve other staff – such as demanding a wider focus on 'Respect' as the Royal Australasian College of Surgeons has done. This is not just about fixing the women. Within healthcare, we need more team-working including holding meetings about this issue together across staff groups and explaining the issues and implications.

- have clear processes for reporting of incidents.

17.4. Training programmes should:

- consider how to collect data and ask questions to highlight areas of poor supervision, behaviours or education.
- re-evaluate which training opportunities are more important than others. For example, those in Higher training posts in Orthopaedics gain little from undertaking additional fracture clinics.
- analyse commuting and rotations. There are unnecessary moves to satisfy historical staffing needs. Training aspects should be clear for each post. Placements should be actively managed. An increase in training posts with recruitment would provide some flexibility. A family-friendly approach is needed to training doctors – allowing families to stay together in one place/locally for their training. Structural inequities should change so that women have an equal playing field to progress.

17.5. Colleges, Joint Committee on Surgical Training, General Medical Council, medical schools, regulators and funders should:

- use data on historical instances to identify all those who have had repeated, persistent or concerning negative comments about their behaviour as trainers and undertake targeted re-education of poor behaviour and scrutiny.
- publicise reporting processes (eg phone number for confidential discussion by an organisation).
- collate and respond to reports of poor behaviours.
- demand active bystander training in-person in team groups, especially starting where there have been problems.
- re-train appraisers and staff undertaking Annual Performance Reviews.
- specifically include in GMC appraisals the need to be revalidated as a recognised trainer.

17.6. Specific funding issues should be considered for specific costs:

- to acknowledge that employing organisation (hospitals, Trusts or Boards) incur some fixed cost for each doctor in postgraduate training, even if training LTFT, so extra funding may reduce the negative perceptions of an individual in a part-time role.
- to arrange cover for “in between” times, such as ramping up, ramping down or being supernumerary in a local Trust on a phased return to work.
- to acknowledge that surgery has the longest training and the longest commutes, and that childcare may be required to cover commuting time.
- Craft specialties require many hours of practice.

17.7. Recommendations regarding Shared Parental Leave (SPL):

- SPL should have a use-it-or-lose it element available only to the 2nd parent (usually the father), in order to increase take-up. Countries which have introduced this, eg Iceland, have seen far higher take up of SPL.

17.8. Workforce recommendations

A large increase in training post numbers across multiple specialties is needed to adjust for the numbers of parents of young children and those training LTFT. This would improve training, improve patient care and reduce rota gaps. This could partly be done by converting Locally Employed (LE) doctor posts to training posts and using the untapped talents of SAS doctors as supervisors. Shared parental leave should be encouraged. ‘Over recruitment’ is

needed, with enough recruitment to account for maternity and paternity leave and part time working when planning numbers of training posts.

17.9. Consider how to staff rotas with less reliance on doctors in postgraduate training (eg additional out-of-hours skills for MAPs working within a team).

17.10. Ensure that support staff, such as secretaries or Doctors' Assistants [21], are available to undertake administrative and basic clinical tasks to free up doctors' time.

17.11. Collate and champion examples of good rotas or IT systems that allow self-rostering or reduce doctors' administrative burden.

18. References:

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