Sexual Misconduct In Health And Social Care: Understanding Types Of Abuse And Perpetrators' Moral Mindsets

Report for Professional Standards Authority

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Foreword

Sexual misconduct by a health professional is a relatively rare but devastating act. Most healthcare professionals work with dedication and integrity and are committed to the best possible patient care. However, in some cases healthcare professionals have seriously breached sexual boundaries with patients, carers or colleagues. Some of these have been the subject of national inquiries and investigations in recent years, which have shown the serious harm that can result when healthcare professionals breach sexual boundaries.

In 2009, the Professional Standards Authority published guidance for patients and professionals, with the aim of helping them avoid becoming a victim or a perpetrator respectively. Sadly, through our work reviewing the regulators' fitness to practise decisions, we continue to see distressing instances of sexual misconduct both against patients and colleagues. As a result, we have commissioned research to deepen our understanding of the circumstances in which sexual misconduct occurs.

This latest study by Professor Searle and colleagues illuminates the moral mindsight of perpetrators, as well providing analysis of the types of incidents and activity. It builds on her earlier work with us, *Bad apples? Bad barrels? Or bad cellars? Antecedents and processes of professional misconduct in UK health and social care?*, in which she demonstrated the potential for the academic literature on counterproductive work behaviour to enrich our understanding of why some professionals lose sight of the standards which should govern their everyday work and conduct.

This new study highlights the correlation between sexual misconduct and an imbalance of power - patient versus professional, senior versus junior - and describes the slippery slope that leads from commonplace workplace incivility to patient harm. It provides valuable insights for regulators and service providers seeking to identify and disrupt the circumstances which might give rise to sexual misconduct and tackle them early. We look forward to taking forward further discussion with our colleagues and stakeholders about how we can work together to prevent this particularly damaging form of abuse.

Christine Braithwaite, Director of Standards and Policy, Professional Standards Authority for Health and Social Care

Executive summary

275 fitness to practise cases were examined for three professions, doctors, nurses and midwives, and allied professionals, which included sexual misconduct as a charge. Of these, 232 cases were retained with sexual harassment or abuse a proven issue.

Analysis revealed that the perpetrators for this form of misconduct were predominantly male (88%). There were no female perpetrators in the sample for doctors and they were a minority in the other two groups. Statistically significant differences were found in the types of cases between the genders, with female perpetrators more likely to have single targets and multiple incidents, while the pattern of incidents for male perpetrators was the repeated targeting of many individuals. There were no statistically significant differences found between the different professions regarding the type of incident. Patients were the dominant group targeted by perpetrators (59%), with vulnerable individuals (young, mental health) a statistically significant sub-category (49%). This group was also significantly more likely to be the target in cases involving the repeat offending of the same individual. Further, colleagues were also a more common target (32%).

Workplaces were found to be the dominant location for these types of fitness to practise cases (54%). This is important in terms of the role of contexts in creating and promoting significant wrongdoing, but also in offering a means to more effectively tackle such wrongdoing. Those working in mental health roles (26%) and General Practice (12%) were also common work roles for perpetrators.

An important difference that was identified between the professions was the sanctions they received. Specifically, doctors were statistically more likely to receive a suspension compared to other groups. This is an important issue as such disparities can lead one group to perceive that these actions are less likely to be 'punished', and so creating an ambiguity for perpetrators.

Differences were found between the professions in terms of the mindsets of perpetrators, involving two distinct types of response. First, denial was found to be more significantly used in cases involving multiple targets and incidents, while denial of injury was more associated with cases involving multiple targets in single incidents than would be expected by chance. Statistically significant differences between professions were also found, with doctors more likely to deny injury, while nurses were less likely to deploy this excuse. A second area of difference was the use of key moral disengagement strategies, with a statistically significant focus by perpetrators to reduce their agency in these events through diffusing or displacing responsibility. Critically doctors were found statistically to be less likely to displace their responsibility for events, but along with allied professions were more likely to try and diffuse their responsibility by involving others and external

circumstances as reasons for their actions. In contrast, nurses were less likely to diffuse responsibility. These results reveal how perpetrators seek to explain their actions. They reveal how denial and efforts to reduce their agency are important.

Recommendations to tackle and reduce offending behaviour include greater attention towards awareness raising and training that extends beyond staff. Hot spot organisations can be identified as those with high levels of incivility and also those with excessively long working hours, and locations with higher concentrations of vulnerable users (mental health especially) are priorities. These efforts would remove ambiguity and inform perpetrators, targets but also staff and other bystanders about what is and is not acceptable behaviour in these contexts. Such training should also include how to report such activities. It is further suggested to have a clear policy prohibiting relationships between professionals and their patients/service users during and for a time (12 months) after treatment. A key issue that may require remedial attention is the disparity of sanctions between professions. Changes to create a clearer framework across professions within which sanctions are applied would reduce the ambiguity for perpetrators and would also ensure appropriateness and comparability of sanctions, especially in the case of events with multiple targets and incidents. Finally, it is recommended that more detailed recording is made of perpetrator and target demographics to enable more fine-grained future analysis of these cases.

Introduction

Building on our previous study (Searle, Rice et al. 2017) that examined determinations in FtP cases relating to the registrants of three separate regulators, this study focuses on a distinct group of cases – those involving sexual misconduct[1]. In this introduction, I outline the key theories that pertain to why someone would undertake such behaviour and then outline the present research methods and key results.

Why health is a different context

The relationship between a professional and the patient, or service user, is unique and often intimate due to the types of procedures and treatments involved (Dixon-Woods, Yeung et al. 2011). Those working in professional health and social care roles have a position of unique trust and virtuousness, with the social contract for these services predicated on both trust and confidence (Dixon-Woods et al., 2011). The type of relationship that a professional should have is enshrined in their professions' oaths (e.g. the Hippocratic Oath) and codes of conduct (Merrison 1975). These exhort professionals to aid the sick without causing them further injury or harm. They are placed in a privileged position often seeing someone at their most powerless and vulnerable, placing service users at a distinct disadvantage. Help is being sought from a professional as they perceived as having capacity to help remedy the situation for those suffering. There is therefore a distinct power differentiation between the two parties arising either from the patient's incapacity to intervene (being too ill to be able to respond), or from them trusting the professional and their request, as at best important to their treatment, at worst benign, but definitely not exploitative or causing harm.

The fitness to practise (FtP) cases under investigation in this research are a challenge at a fundamental level to any taken-for-granted notions of a benign professional, and research into such cases offers better understanding and potential means to predict the actions of perpetrators. The purpose of this study is to examine the types of incidents that occur between these three 9professional groups – allied professionals, doctors, and nurses and midwives, and to explore the types of activity and the moral mindset of perpetrators in order to identify more effective means to deter and disrupt those who abuse their positions of care and can cause physical, psychological and emotional harm that can last a life time. This form of misconduct has potentially very severe consequences for regulators as it can spill over to taint reputations beyond the target and perpetrator dyad to affect the trustworthiness of others within the profession, employing

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[1] Sexual misconduct is not merely a feature of registrants of the three separate regulators – this study was confined to these groups

organisations, the confidence of institutions, such as the regulator, and extend to include friends and family members. These are therefore very serious cases with often long-term impacts.

Key theories and explanations

Sexual misconduct involves unwanted sexual attention which comprises "experiences of sexually inappropriate behaviours that are unwanted and unreciprocated by the recipient. This includes such verbal and physical actions as sexually suggestive comments, attempts to establish sexual relationships despite discouragement, and unwanted touching" (Lim and Cortina 2005).

There are three primary elements to sexual harassment, including: gender harassment, which consists of sexual hostility (explicitly sexual verbal and nonverbal behaviours) and sexist hostility (insulting verbal and nonverbal behaviours that are not sexual but are based on gender); unwanted sexual attention (unwelcome, offensive interest of a sexual nature); and sexual coercion (requests for sexual cooperation in return for job benefits) (Gelfand, Fitzgerald et al. 1995, Fitzgerald, Drasgow et al. 1997).

There are five widely accepted theoretical explanations that have been proposed for why sexual abuse occurs. These include: natural–biological (Tangri, Burt et al. 1982) to those focusing on sexual roles (Gutek and Morasch 1982), and those concerning power imbalances such as the socio-cultural (Farley 1978, MacKinnon 1979), those focused on organisational factors (Fitzgerald, Drasgow et al. 1997, Willness, Steel et al. 2007) and then the four-factor theory (O'Hare and O'Donohue 1998). In addition, increasing attention is being made of socio-cognitive factors that may aid understanding of the mindsets of perpetrators (Pryor, Whalen et al. 1997, O'Leary-Kelly, Paetzold et al. 2000, O'Leary-Kelly, Bowes-Sperry et al. 2009). In the next section these main concepts are briefly outlined, commencing with the biological view through to that of socio-cognitive approaches.

Natural/biological perspectives
Sexual interest theory

This theory contends that sexual abuse occurs in organisations due to sexual interest of the perpetrator in the target (Lengnick-Hall 1995). This positions harassment as an expression of a natural sexual urge, and therefore associated with mate selection evolutionary theory. Inherent in this perspective is that males are more typical perpetrators due to their greater sexual aggression and promiscuity.

Sexual contact hypothesis

This perspective (Gutek, Groff Cohen et al. 1990) is part of the biological explanations and argues that contact or interaction between men and women at work can create a sexualised environment based on the amount of contact individuals have with members of the other gender at

work. Further, this theory suggests that males are more likely to be harassers in such contexts. Studies support this contact perspective revealing that while non-harassing sexual behaviours are undertaken by both males and females in a mixed context, sexual harassment, and sexualisation of the work environment were associated with contact and gender, with male perpetrators dominating.

An important underlying element of sexual abuse concerns an inequality in Power. It offers a longstanding explanation for sexual harassment which arises from a gender power imbalance that favours men who can be sexually coercive and abusive to others (Farley 1978, Cleveland and Kerst 1993, Popovich and Warren 2010). Sexual harassment is the abuse of power to obtain sexual compliance from the target. Inherent to many of these theories is that men are the sexual harassers, yet evidence reflects that women can also be perpetrators (Magley, Waldo et al. 1999).

Sex-role spillover theory

This is one such theory which contends that, where the gender-split in work becomes skewed, sexual harassment can occur due to an inappropriate carryover of pre-existing sex-based expectations and beliefs into a work context (Gutek and Morasch 1982). Therefore, abuse occurs due to behavioural expectations that are irrelevant or inappropriate to work, and more significantly override a perspective of equality amongst peers. In this theory, individuals who do not follow prescribed sex-roles would be open to harassment, while perpetrators would have distinct gender-role beliefs from those of other employees.

Sexist hostility (Glick and Fiske 1996, O'Leary-Kelly, Paetzold et al. 2000) is part of this suite of views that regard sexual harassment as motivated by hostility rather than desire towards the target(s). This theory suggests that targets are more likely to include individuals who do not comply with traditional views of their gendered role, ie. more assertive females or more effeminate men. However, this view lacks attention on female perpetrators.

Socio-cultural theories

This suite of sexual harassment theories consider the wider social and political context in which sexual harassment occurs, and tends to stem mainly from a feminist orientation. These approaches argue that sexual harassment is the logical outcome of gender inequality and sexism that is already present within society and is therefore transferred into a work context. Such actions are motivated by the aforementioned power and hostility, with a desire of men to keep women out of key jobs and economically dependent on them (Farley 1978). Sexual harassment is thus both the antecedent to, and the consequence of, women's inferior position within society (MacKinnon 1979). It is therefore associated with the sexist male ideology of male dominance and male superiority

(Pina, Gannon et al. 2009). In this way, sexual harassment is used to maintain an already present stratification by gender through the emphasising of sex role expectations. While male perpetrators do dominate research, it is argued to be an overtly simplistic explanation for such behaviour (ibid).

Our prior study showed how social and cultural context and social learning could foster copy-cat behaviours by groups of predominantly male perpetrators (Searle, Rice et al. 2017).

Organisational factors.

Research into sexual misconduct has shown the link between organisational violence and sexual abuse (Searle, Rice et al. 2017). Two key elements have been found to be strongly associated with sexual abuse (Willness, Steel et al. 2007). First, local organisational climates are found to play a significant role in fostering such abuse (Fitzgerald, Drasgow et al. 1997, Williams, Fitzgerald et al. 1999). Studies reveal that in such contexts there is an indifference, or lack of attention, paid by management to sexual harassing actions of staff members and as a result perpetrators perceive they will receive little or no punishment for such behaviours, while targets perceive there being little impact from speaking out (Willness, Steel et al. 2007, Pina, Gannon et al. 2009, Pina and Gannon 2012). Therefore contexts where the costs and risks of speaking out are high have greater prevalence of abuse. Similarly, where incivility is rife there are also higher levels of abuse, with the increased probability of multiple victimisations of staff and service users alike (Searle et al, 2017).

A second key factor is gender-job domination, with work places which have dominant roles undertaken predominantly by men associated with greater levels of abuse (Fitzgerald, Hulin et al. 1994).

Extant study has found that training can have a positive impact by raising awareness of what constitutes abuse as well as reducing ambiguity for targets, perpetrators and bystanders (Willness, Steel et al. 2007, Pina and Gannon 2012).

Organisational structure can be a further important predictor of abuse (Willness, Steel et al. 2007). Evidence shows that contexts which promote social integration, and have lower levels of structural differentiation, decentralisation, and formalisation and therefore greater legitimacy have a reduced likelihood of sexual harassment.

Research shows that a significant deterrent to sexual harassment lies in the organisation's formal policies & procedures, which can include written guidelines for behaviour (Willness, Steel et al. 2007). These ease the process of taking out grievances, but also make transparent the processes of investigation, and the enforcement of penalties. Together they comprise the positive use of organisational controls.

A recent new perspective on sexual misconduct that should not be omitted from explanations of sexual misconduct is found in socio-cognitive perspectives.

Socio-cognitive approaches

This suite of explanations is a more recent development that combines cognitive and social factors to explore beliefs, thoughts and attributions that include aspects such as the content, organisation and processing of social information. These approaches differentiate the thinking of sexual abusers from others, and have resulted in developments including the 'likelihood to sexually harass' scale (LSH) (Pryor, Whalen et al. 1997). Extant research findings using this scale have found a different schema may be in operation for men with a high LSH, that has a greater association between power and sex compared to those with low LSH. Studies suggest a lack of awareness by perpetrators that they have behaved in an abusive manner (Fitzgerald 1993). These results suggest an automaticity and lack of consciousness to their power–sex associations, which makes it more challenging to change such behaviours as perpetrators have no frame of references that suggest to them sexual harassment has occurred. Greater levels of denial would be expected.

Goal-directed behaviour is part of this perspective and regards sexual harassment as the output of a decision by the perpetrator to pursue a goal they value (O'Leary-Kelly, Paetzold et al. 2000). Such behaviours are argued to be selected where perpetrators perceive they have a high chance of success and a low chance of punishment. Similar to other forms of aggression these actions can involve the satisfying of a variety of goals, including: emotional, such as the desire to remove a negative affect; retributional, which involves the desire to punish the target for a perceived injustice; or self-presentation, which concerns the desire to establish a desired social image.

Sex-based perspective Berdhal (Berdahl 2007, Berdahl 2007) develops these ideas by looking at a need to punish gender-role deviants, which is abuse based on sex, but she contends with distinct drivers, namely the need to maintain social status as an individual, along with the benefits that are derived from it. As a result Berdahl argues both males and females can be perpetrators. In this way, a soft-spoken male and an uppity female could be targets with perpetrators striving to protect their sex-based social standing.

Moral disengagement

An important strategy that perpetrators use is to cognitively disengage so to morally separate themselves from their actions. Bandura (Bandura 1976, Moore, Detert et al. 2012, Moore 2015) identified eight distinct tactics that are used.

The first set of activities involves the cognitive restructuring of unethical behaviours to make them appear to inflict less harm. These include: *moral justification* (cognitively re-positions the actions of the individual to be seen as in the service of a greater good); *euphemistic labelling* (involves the use of more sanitised language, such as describing victims of war as "collateral damage"); and *advantageous comparison* (compares the current actions with other and more reprehensible behaviour in order to make them appear more innocuous).

A second set of techniques involves efforts to minimise the perpetrator's agency. These include: displacement and diffusion of responsibility, with *displacement of responsibility* identifying and attributing the responsibility for the behaviour to an authority figure who is deemed to have either tacitly condoned or explicitly sanctioned the activity, while *diffusion of responsibility* seeks to disperse responsibility across a group of others.

The final strategy is designed to focus on the target and to reduce the perceived harm or blame them for it. The strategies here include: *dehumanisation* (which position the target of the action to be undeserving of basic human consideration), while *attribution of blame* (involves assigning the blame to the target as some how being responsible for what befell them) and *distortion of consequences* (minimising the severity of the impact of the behaviours).

Four factor theory

The preceding theories have all tended to focus on single or few combined elements, while this last approach – the four factor theory (O'Hare & O'Donohue, 1998) offers a more complex understanding as to why abuse occurs. It builds on prior work to suggest that sexual harassment will occur when four conditions are present. These include: a perpetrator being motivated to harass, which is argued to be driven by a combination of power, control or sexual attraction. Second, the perpetrator needs to overcome their internal moral restraint, which will inhibits these desires. Third, they will also have to overcome specific external organisational restraints, such as their professionalism. Finally, the resistance of their target will need to be overcome. This includes elements such as a lack of assertiveness, or having a lower position in the organisation's hierarchy.

Extant research supports this theory, with self-report studies of harassment showing it as falling in workplaces with high levels of workspace privacy, greater knowledge of the complaints procedures, environments which are characterised by greater levels of sex equality, more professionalism, and equal sex-ratios. In reviewing the evidence for the relative strengths of these different factors, the authors conclude that the organisational factors are the most powerful deterrents, with key predictive factors for sexual harassment including poor knowledge about the harassment complaint procedure, lack of professionalism, and prevailing sexist attitudes.

In the next short section the research pertaining to the perpetrator and their characteristics is considered.

Perpetrators

Characteristics.

Research shows that sexual abusers are more likely to be men, and also more senior in the hierarchy than their targets (Pina, Gannon et al. 2009). Further, they are more likely to be married, older and better educated than their targets. Given the diversity of results, it is suggested that socio-demographic profiling of perpetrators may be misleading as these individuals are present in every social strata, type of occupation, and also age categories.

Further research identifies dominant beliefs and perspective from perpetrators. For example, research has identified a link with higher levels of such misbehaviour amongst men who score high on 'likelihood to sexually harass' (LSH). This points to a strong person x context interaction, in which those with higher LSH are found to be more likely to abuse in more favourable contexts.

In terms of personality dimensions of perpetrators, characteristics include higher levels of authoritarianism, lower honesty -humility and a lack of self-monitoring (Pina, Gannon et al. 2009). They also have a range of more anti-social personality characteristics, including a lack of social conscience, lower maturity, and manipulative and exploitative behaviours (ibid). Personality elements found in the endorsement of sexually coercive actions include irresponsibility, lack of social conscience, and the exoneration and legitimisation of incivility and aggression, especially towards women.

Attempts to create perpetrator typologies have differentiated between "public" harassers, who are articulate and approachable, and typically engage in overt, deliberate behaviours that are designed to intimidate or control the target; contrasted with "private" harassers, who are more conservative, and avoid attention, instead using their power to covertly control and access their targets (Lucero et al., 2003).

Some harassers limit their abuse to a small number of victims, while others take advantages of opportunities and pursue targets more widely (Gelfand, Fitzgerald et al. 1995, Fitzgerald, Drasgow et al. 1997, Lucero, Middleton et al. 2003). The latter group is separated into those who are unrelenting in their harassment of a few victims ("persistent pursuers" (Lucero, Middleton et al. 2003) or "hard-core harassers" (Lengnick-Hall 1995), and those with a more inconsistent pattern to their behaviour, operating as the context allows ("exploitive" (Lucero et al., 2003) or "opportunistic"

(Lengnick-Hall, 1995). Studies reflect an increase in the levels of violence against targets over time from those more persistent (Luncero et al., 2003).

A final category is associated with fewer victims and a search for love or affectionate relationships, termed "vulnerable" (Lucero et al., 2003) or "insensitive" (Lengnick-Hall, 1995) harassers. This group is found to be more socially awkward, or lack of social skills to allow them to develop romantic relationships at work.

Responses Perpetrator responses to accusations of sexual misconduct can be categorised in terms of four responses: remedial actions, which comprises the most effective method for minimising observers concerns about abuse – namely denial; followed by excuses, that tend to focus on the external factors which have caused the event; justifications, including arguing that no harm has been done; and concessions, which involves expressions of remorse (O'Leary-Kelly, Bowes-Sperry et al. 2009). Evidence shows that not only does gender influence what is perceived as misconduct (McCord, Joseph et al. 2017), but also the effectiveness of these forms of perpetrator explanation; Specifically, males are found to be more influenced by denial, while concessions has more impact on females.

Despite growing attention on the topic, there remains limited research into perpetrators and their views of their behaviour. This research is therefore of value as it focuses on the accounts of perpetrators for their actions.

Method

a. Context

The Professional Standards Authority for health and social care (PSA) is responsible for protecting the public by overseeing nine statutory bodies that regulate 32 health and social care professions in the UK.[2] These nine regulators have four main functions: registration, quality assurance of higher education, setting standards, and fitness to practise (FtP). FtP is a process for handling complaints about professionals in order to determine whether someone is fit to practise. It is not designed to be a punitive process, although regulatory sanctions may have a punitive effect. FtP charges arise from concerns about any of the four aspects of professionals' behaviour which risk the safety of patients (service users) and undermine the public's confidence in that profession. The most serious of these cases are referred to formal panel hearings. The decisions in these cases are recorded in 'determination documents' which are then passed to the Professional Standards Authority (PSA) who have a statutory responsibility to oversee the cases and the decisions made.

In its database, the PSA applies the category of 'sexual misconduct' where the case includes an allegation of sexual motivation for the registrant's behaviour.

b. Data sample

In this study 275 FtP determinations files[3] from the PSA database[4] were used, comparing cases from three different regulators: the General Medical Council (GMC) (n=94), who regulate medical doctors; the Nursing and Midwifery Council (NMC) (n=119), responsible for nurses and midwives; and the Health and Care Professions Council (HCPC) (n=62), regulating a range of 16 healthcare professions, including clinical psychologists, paramedics, chiropodists, occupational therapists, and social workers. These three groups were selected as they often work together and with the study comparing the similarities and differences in their actions. These cases include an allegation of sexual misconduct.

c. Procedure

Sequential statistical methods were used to systematically examine and compare these three groups of registrants' professional misconduct. For each FtP hearing, the determination document

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[2] 'Further information about the Professional Standards Authority can be found at www.professionalstandards.org.uk'

[3] The determination documents are not the full case files for these cases and so important details which may have influenced outcomes may not have been captured in these documents

[4] The database currently in use by the PSA holds circa 15,000 determinations from all nine regulators, and the sample related to cases that occurred between 2014 and 2016.

was used, which includes incident details and pertaining evidence in a quasi-legal format[5]. The documents vary in the level of detail/evidence and complexity and can include testimony from victims, perpetrators, colleagues, and managers[6]. From these documents details were extracted and then coded cases using two independent coders. The coders were trained first on a sample of cases to ensure they were coding in a consistent manner. Once this was confirmed through reviewing the codes that were applied, they were able to code the rest of the cases separately. The coding include: profession, ethnicity and location of training (GMC data only available), location of incident, type and breadth of target[7](s), frequency of incident(s), resultant sanctions[8][9]. Vulnerable targets were also identified, which included those with mental health issues, or whose age (young or very old) might make them naïve in particular ways toward sexualised behaviour by a health professional.

Further, these cases were examined to identify, where possible, the moral mindset of perpetrators, building on Bandura (Bandura 1976) and other's perspectives (Moore 2015) to code four distinct cognitions (Moore, Detert et al. 2012, Martin, Kish-Gephart et al. 2014): denial (Bullock and Condry 2013, Nunes and Jung 2013), differentiating denial, from that pertaining to the event, injury, and hostile denial; cognitive reconstruction of events, which included moral justification, euphemistic labelling, and advantageous comparison; efforts to minimise perpetrator's agency, through either displacing responsibility, distorting the

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[5] It is acknowledged that a determination is not a comprehensive account of all of the information considered by a panel.

[6] In the case of Arinayagam (Ariyanagam v GMC [2015] EWHC 3848 (Admin)) the Court suggested that a model determination would be one in which the panel set out its conclusions on each of the paragraphs of the charge sheet; provided an adequate summary of the background to the allegation; summarised its view of the witnesses' evidence; commented on the quality of the evidence provided by the registrant; and then explained in some detail why some allegations were found not proved and others were found proven.

[7] Those who are sexually harassed are termed target rather than victim in this report.

[8] The report *Gross negligence manslaughter in healthcare - the report of a rapid policy review* by Professor Sir Norman Williams recommended that 'the [Professional Standards Authority] should review the outcomes of fitness to practise cases relating to similar incidents and circumstances considered by different regulators. This review should seek to determine the extent and reasons for different fitness to practise outcomes in similar cases and, if appropriate, recommend changes to ensure greater consistency'. The Department of Health and Social Care commissioned the Authority to provide a methodology to assess consistency in this regard, for the development of which the Authority contracted with the Research Department of Medical Education, UCL Medical School. The methodology which was the outcome of this work is published on the Professional Standards Authority website: https://www.professionalstandards.org.uk/docs/default-source/publications/developing-a-methodology-to-assess-the-consistency-of-fitness-to-practise-outcomes-2019.pdf?sfvrsn=97c57420_0

[9] In the coding for these sanctions we did not examine differences in standards for that professional group; differences in legislation between regulators; differences in indicative sanctions guidance for each regulator; differences in other guidance or training given to panels on appropriate sanctions; other differences in the regulators' policies or procedures in relation to fitness to practise

consequences, or diffusing responsibility [10]; efforts to change impact or role of the target, which focused on attributing blame to the victim or dehumanising them.

Results

While 275 cases were coded, 43 of these cases were removed from our analysis as in these cases the facts were not proven in relation to sexual misconduct (although impairment of fitness to practise may have been found on other grounds). Therefore 232 proven cases are the focus of this study. The final confirmed cases data set included 81 doctors, 101 nurses and 50 allied professionals. The results are presented in two levels. First an overview of the results are provided and then a more detailed examination based on the types of misconduct.

Overview of sexual misconduct

Perpetrator Gender. As with our prior study (Searle, Rice et al. 2017), there are clear gender differences in the perpetrators of sexual misconduct, with males (88%) more likely to be perpetrators. No differences were found in perpetrator gender by profession, with 100% of the doctor case perpetrators being male, while 84% of Allied Professionals and 80% of the Nurse cases are undertaken by males.

In terms of professions to which perpetrators belong, 35% of the cases are doctors, 22% allied professional and 44% nurses. There are no midwives in the nurse sample. While statistically there is no significant difference between these results, given that the number of registrants are far higher for nurses and midwives, it is clear that there is an overrepresentation of this form of misconduct amongst doctors. This would be in line with prior research that indicates those in positions of authority and higher in organisational hierarchies are more likely to be perpetrators (Willness, Steel et al. 2007, Pina, Gannon et al. 2009).

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[10] See page 12 Moral disengagement section for further details of these categories.

Figure 1: Gender of perpetrators by profession (overall %)
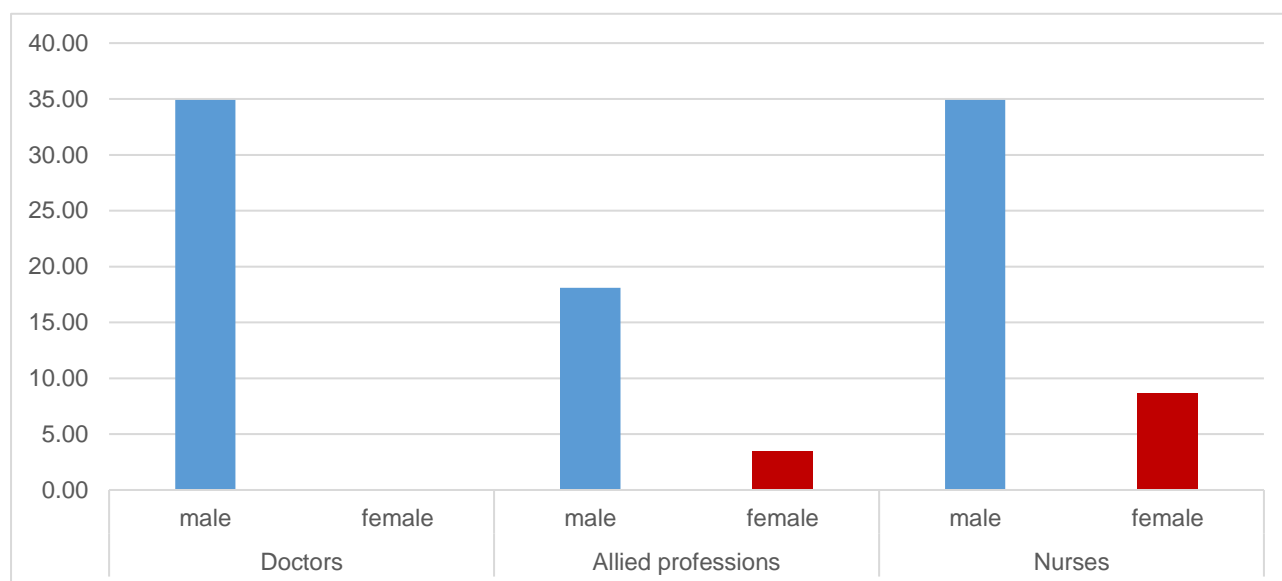
Ethnicity. As only the GMC supplied ethnicity data for their 75 cases, it is not possible to examine the role of ethnicity by profession in these cases.

Target. The targets for sexual misconduct are predominantly patients, with 59% of cases including this group, and they dominate as a target for all professions (see figure 2). Gender differences were found between perpetrators with 82% of male perpetrators cases targeting someone who was vulnerable. Critically, in analysing the type of patients 49% of all cases (32% of doctor cases, 24% of Allied Professionals, and 44% nurse cases involve vulnerable patients, ie someone who is younger, infirm, or with mental health issues). The targeting of vulnerable groups is clearly found in prior studies (Willness, Steel et al. 2007, Pina, Gannon et al. 2009). The next most frequent group to be targeted are colleagues, which are found in 32% of the cases.

As there is no systematic recording of the targets' gender, ethnicity or power (patient/colleague and level), it is not possible to test out any of the theories regarding perpetrator-target differences. This is a significant omission that will hamper further progress on researching this type of FtP charge.

Figure 2: Targets of sexual misconduct by profession
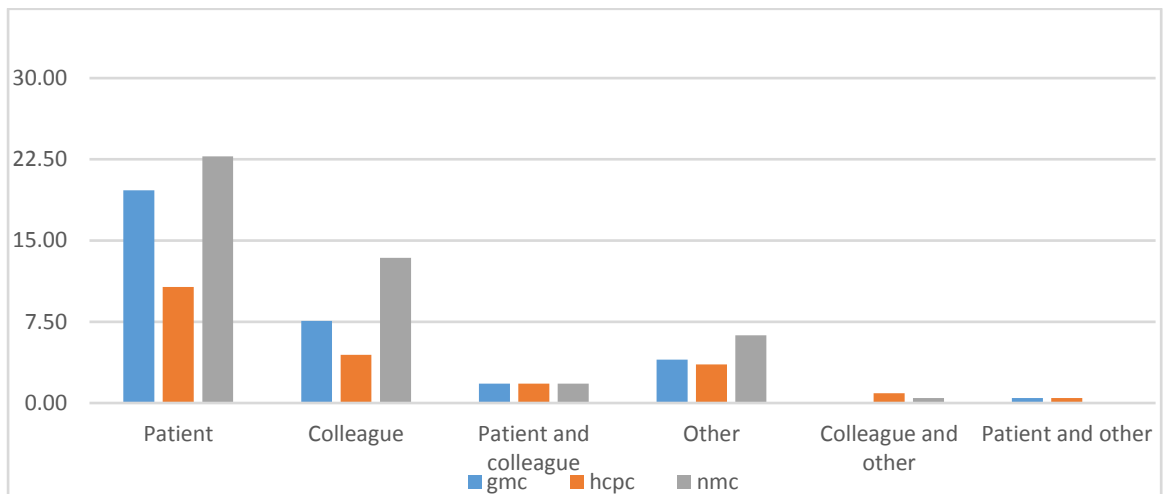
Location. There are interesting differences in the locations of these events by profession (See figure 3). Over half (54%) of these cases occurred within a workplace, and it is the dominant location for each profession. Outside work [11]is a slightly less important alternative (34%), but near parity is found for nurse cases (workplaces 20% compared to outside work 18%). In comparing professions, cases involving doctors are more likely to occur within the workplace, while those involving nurses can involve either the workplace or outside work locations. There were no significant differences found between professions.

Figure 3: Location of sexual misconduct by profession (% overall)
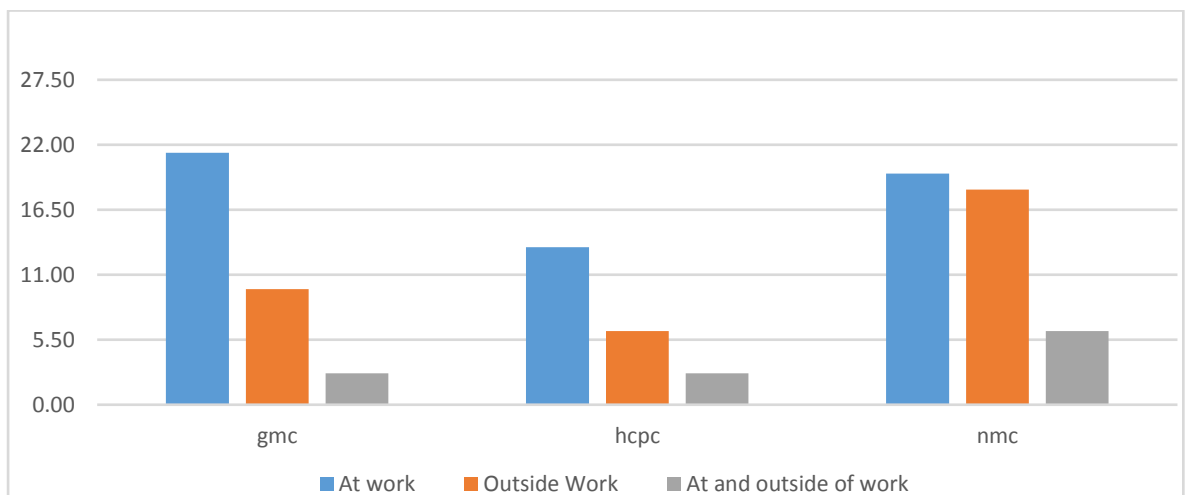
Job roles are an important defining feature with mental health (psychiatry and nursing) over represented (26% of all cases) and also those working in general practice (12%).

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[11] Outside work denotes the event occurring in an external to work location, such as a patient's home or a park, etc.

Sanction. A further area of statistically significant difference is the sanction types received by professions (see figure 4). In comparing across the three professions, a Fisher's exact test showed profession was significantly associated with sanction, (26, N = 232) = 47.72, p = .000. Post hoc tests revealed that doctors' sexual misconduct was more likely to receive a suspension (37 cases 16% of the total cases, 46% of doctor cases, compared to nurses 18 cases, 7.83% of total cases, 18% of nurse cases). By contrast 62% of nurses found to have sexual misconduct charged were struck off, while 33% of doctors received this sanction. Doctors and suspension was the only group in which outcomes differed to a statistically significant level.

Figure 4: Sanction by Profession (%)
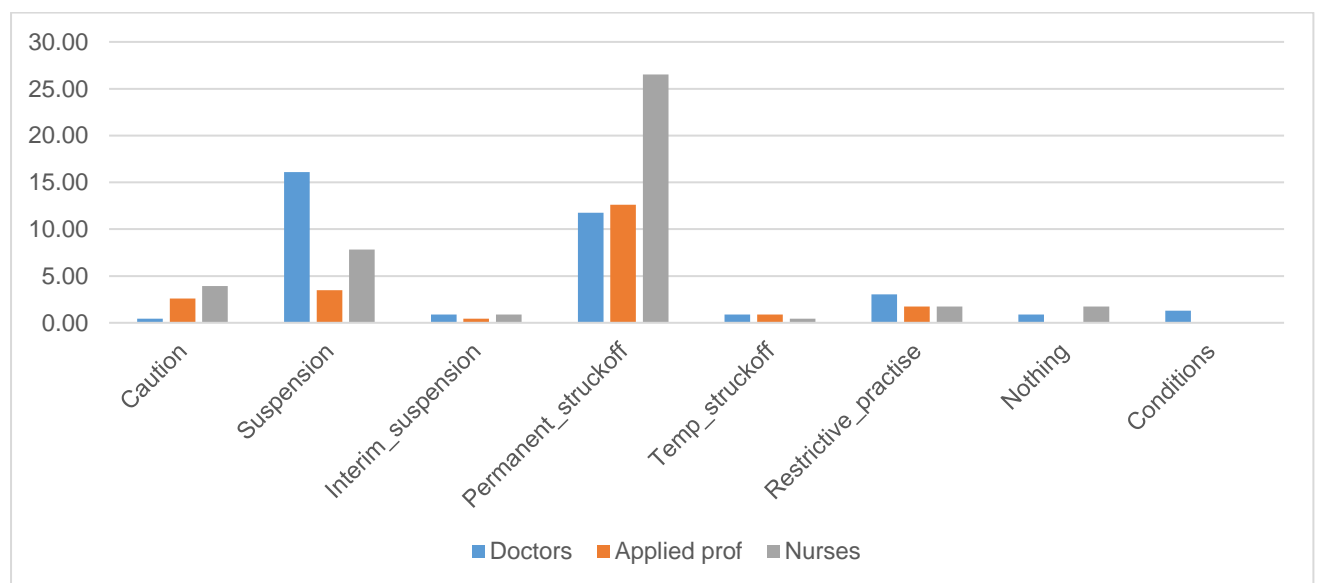
Moral mindset. Turning now to the moral mindset of perpetrators, the dominant responses of perpetrators are denial (34%) and efforts to reduce or eliminate the perceived distress caused to the target (34%), followed by constructing events (18%) and then efforts to reduce perpetrator agency (14%) (See figure 5).

Figure 5: Perpetrator mindset by profession
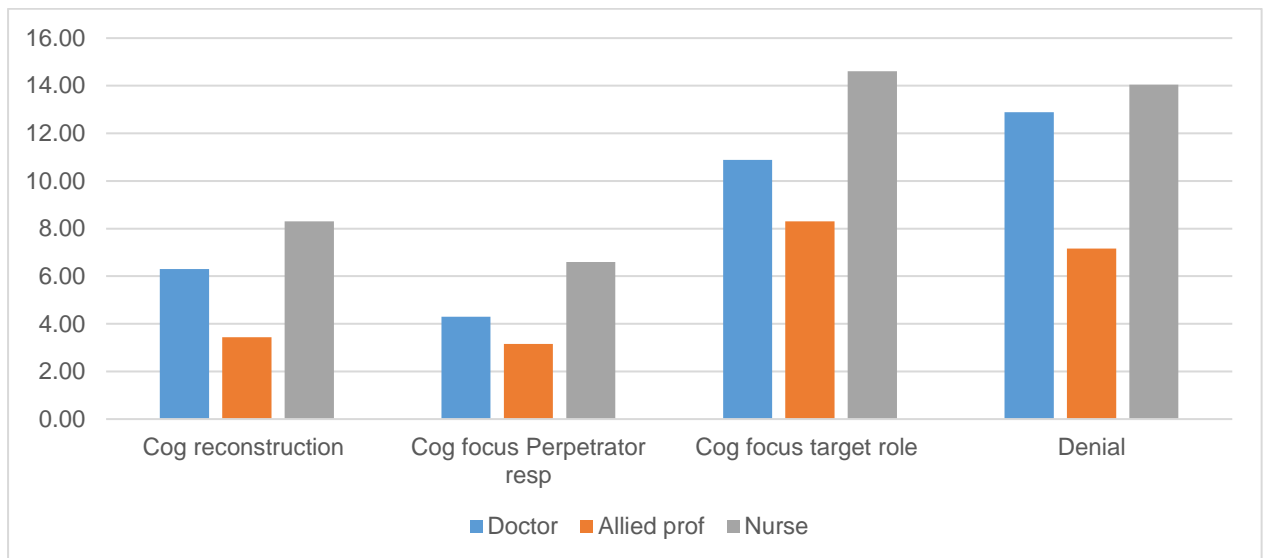
More detailed breakdown of these different categories (see figure 6) shows the domination of denial as a key cognitive strategy (24%), followed by strategies to focus on the harm, with distortion of consequences found in 15% of cases, and blaming the target in 13%. Euphemistic labelling is also a more typical response (10%). There are some important differences between these three professions (see figure 6). Differences are found with doctors and nurses preferring the distorting the consequences of their actions, and to try and provide some moral justification for their action. Nurses were found to be more likely to distance themselves from their actions through the use of euphemistic terms. Nurses also try to displace responsibility onto authority figures, which links to concerns about difference in the sanctions for perpetrators (Figure 4). In contrast doctors try to diffuse responsibility amongst peers; they also try to dehumanise their targets, which is a concern as this can be linked to increased levels of violence and aggression in these misbehaviours. Attempts to attribute blame to the target are common across all and more typical in a colleague-target situation.

In terms of denial doctors are statistically more likely to deny they have caused injury, while both nurses and doctors deny the event itself has occurred.

Figure 6: Details of Moral disengagement strategies of perpetrators by profession[12]
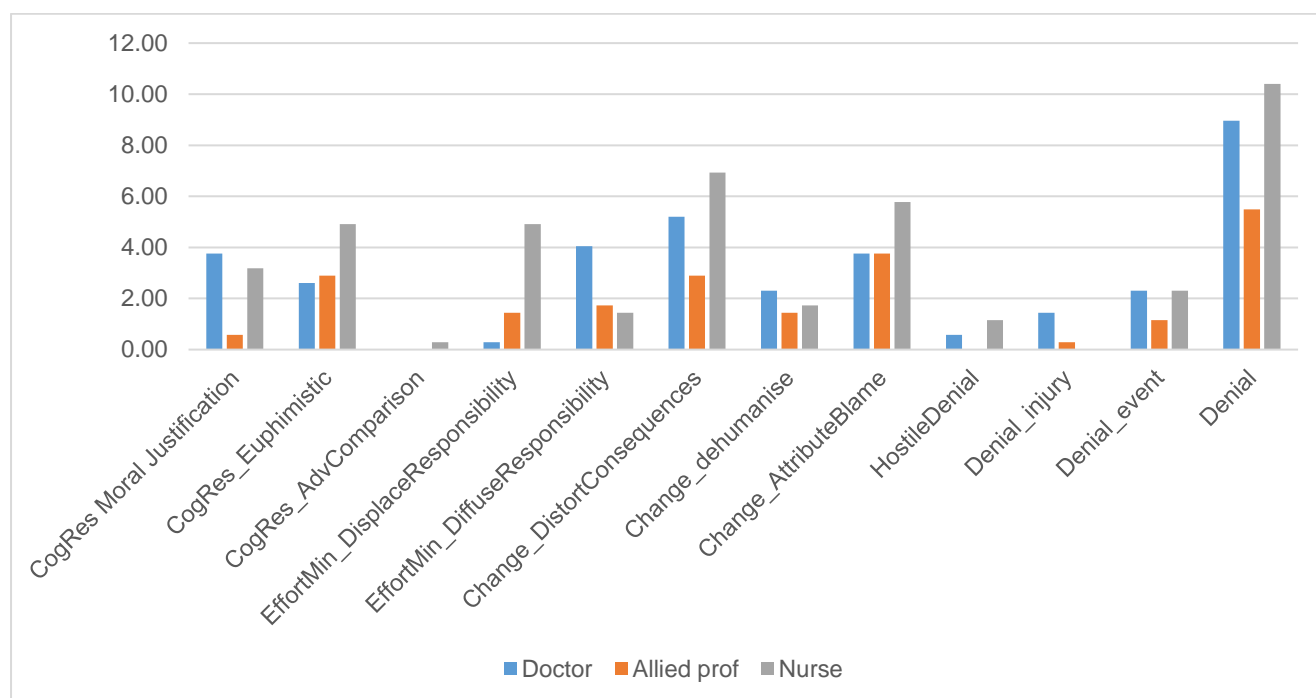
Statistical analysis comparing professions and their use of distinct types of these moral mindset shows statistically significant differences (Fisher's exact test (2, $N = 215^8$) = 12.69, $p < .001$. (Cramer's V = 5% shared variance)). Specifically, significant divergence is found in cognitive efforts to alter the perpetrator's agency. There are two key areas of difference, namely doctor perpetrators are less likely than expected to try and displace their responsibility, while this type of excuse is more commonly used by nurse perpetrators. Second, significant differences were found in perpetrator's efforts to minimise their action by diffusing responsibility (Fisher's exact test (2, $N = 215^{13}$) = 8.44, $p = .012$. (Cramer's V = 4% shared variance)). Post-hoc tests indicated doctor and allied professional professionals were more likely to undertake such behaviour, while nurse professionals displayed it less than would be expected under the null hypothesis.

In looking in more detail at denial behaviours, statistically significant differences are found in denial of injury between professions (Fisher's exact test (2, $N = 215^8$) = 6.77, $p = .013$. (Cramer's V = 3% shared variance). Post-hoc tests reveal doctors as more likely to deny injury, while this is less likely amongst nurses. No significant differences were found here for allied professionals.

Different types of events are now explored to consider whether there are professions differ in the severity of misconduct and its outcomes.

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[12] See page 12 moral disengagement for further details on the differences between these categories
[13] This is a lower N as there was insufficient data in all of the cases to code for moral disengagement.

Event types

Results here indicate that sexual misconduct events should not be treated as similar, instead some important areas of differences are evident if these events are dichotomised using target breadth and frequency of misconduct data.

Perpetrator

Profession differences. Results show that within professions, doctors' sexual misconduct is associated with all four types of event (see figure 7), however, they are more likely to undertake either single target and events (32%) or multiple event and multiple target (45%) incidents. Analysis of both doctors and allied professional cases reveals multiple incidents – multiple target cases (45% and 40% respectively) as the dominant category. By contrast, the actions of nurses show a greater tendency towards single events and incidents (39%), or single target but multiple events (35%). A Chi Square test of independence found no significant association between profession and event type.

Figure 7: Profession by event type
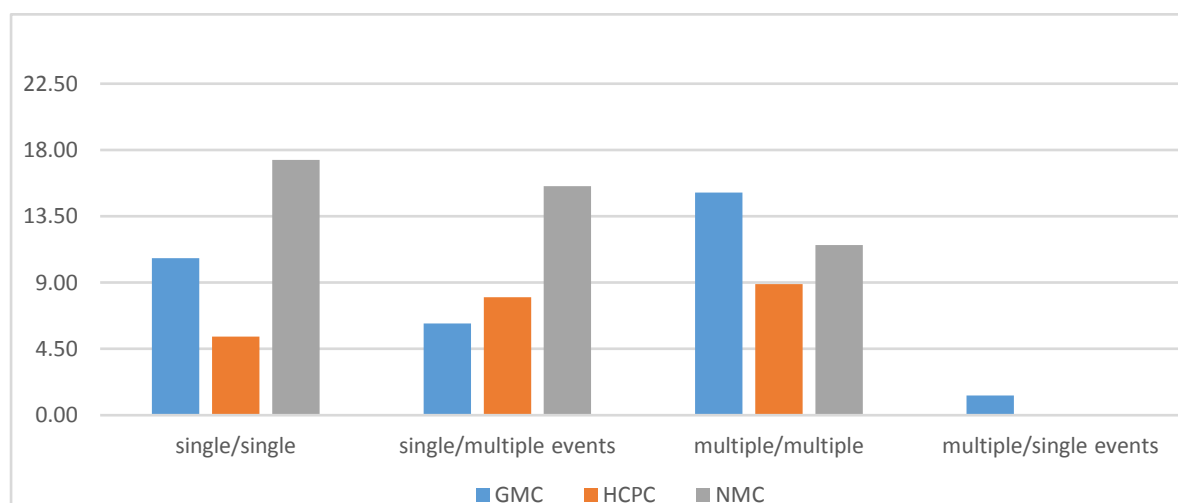
Gender. In contrast, statistically significant differences were found between sexual misconduct and gender (see figure 8). A Chi Square test of independence indicates males as being more associated with cases involving multiple targets and events, while single targets and multiple events are more associated with women (df = 2, N = 225[14], X2 = 10.589, p = .020) (see figure 8). There are some further differences to gender by profession, with 95% of female nurse perpetrator cases involving a single target, while for male nurses there is little difference in the frequency by % between the three types of activities (each is in the 30s%).

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[14] This figure is lower than the 232 of the total data set as it was not possible to code all of the event types based on the FTP hearings information contained in determinations

Figure 8: Gender by event (overall %)
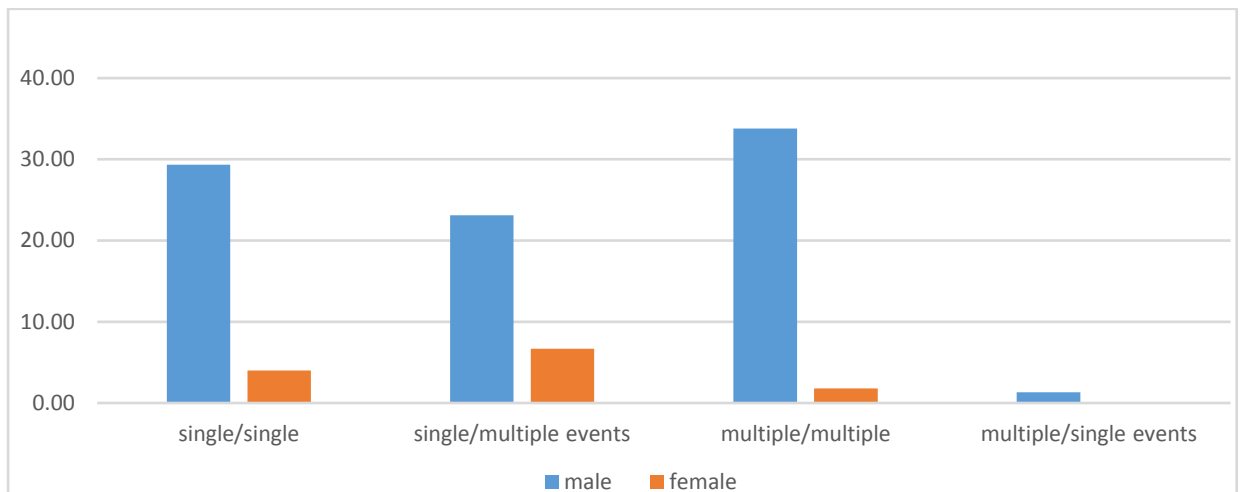
In looking at over represented job roles some further differences in event type emerge by gender. For example, male GPs are likely to be more involved with multiple instances, either against multiple targets (43% of these cases) or repeat incidence with the same individual (36% of these cases). In contrast gender differences amongst nurse perpetrators working within mental health shows for the 12 female cases 91% are repeat events against the same individual, while the 41 male cases show similar in 59% of the cases and 27% multiple events with multiple targets.

Ethnicity. Examining the association between ethnicity of doctors by event type did not indicate statistically significant results. However, the graph (figure 9) below indicates some patterns emerging for different ethnic groups, with Asian and Asian British doctors found in all four types of event, while black African and British doctors are more commonly associated with multiple targets single events. In contrast, white doctors are associated more with single targets and single events and not at all with multiple targets and single events.

Figure 9: Doctor only ethnicity by event type (just Doctor cases)
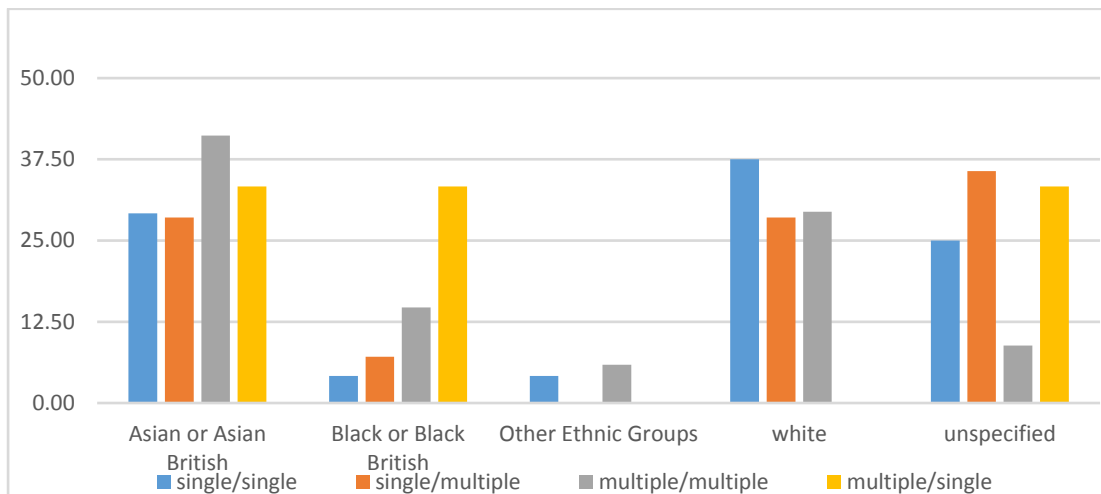
Location. Further analysis reveals important differences in events by location (see figure 10), with multiple targets and events more likely to occur in the workplace (24%). Single targets and events are equally likely to occur within or outside work.

Figure 10: Events by location (overall%)

Sanction. In relation to the sanctions by type of incident, no differences were found across the professions against the perpetrator. This is surprising as it would be expected to see more severe sanctions in the form of permanent removal from the registers associated with the more concerning multiple event and multiple incident cases.

Targets. The targets for this type of misconduct vary by incident type, with patients overrepresented in single incident types (42%), while colleagues are more likely to dominate multiple incident-multiple target events (see figure 11).

Figure 11: Target by event type
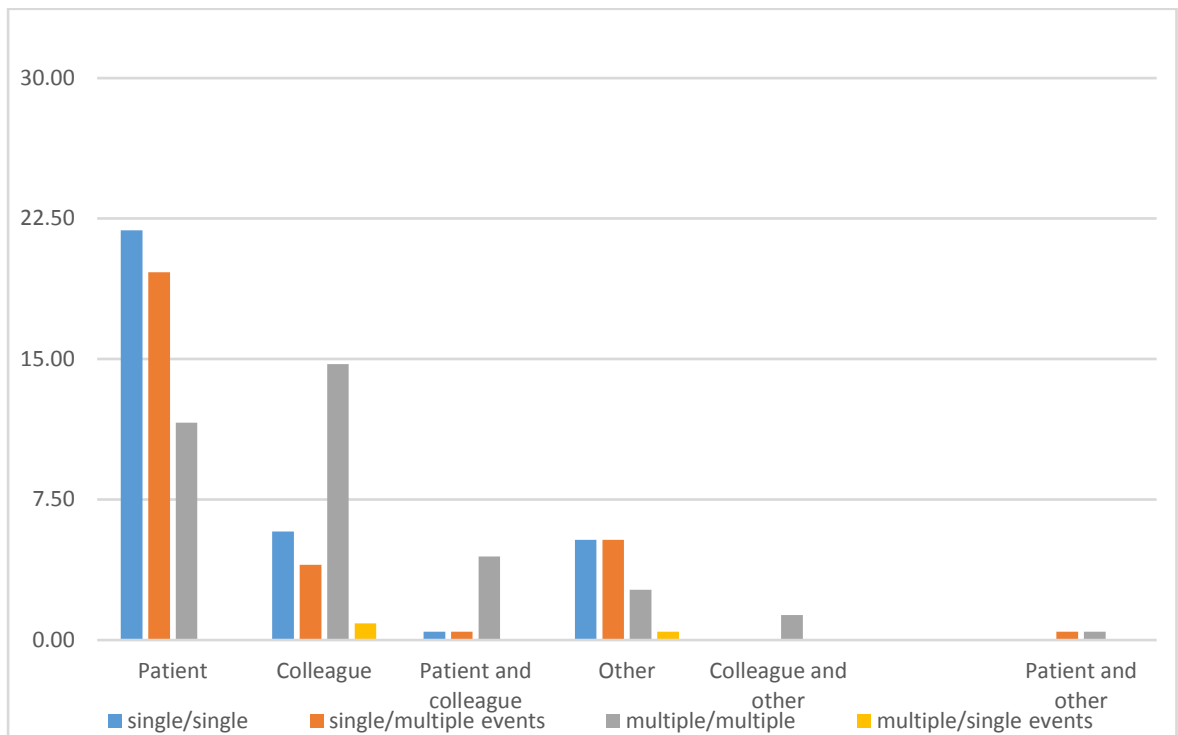
A further statistically significant distinction is found between vulnerable patients and event type (Fisher's exact test (3, N = 216[15]) = 10.31, p = .010. (Cramer's V = 5% shared variance)). Post-hoc analysis shows that vulnerable patients are more prevalent in single target and multiple incidence cases, while they are less likely in multiple/multiple cases. This suggests that vulnerable targets are more likely to be targeted in a systematic way for ongoing abuse. However, as is clear in figures 10 and 11, vulnerable patients are a significant patient group that perpetrators' target.

Figure 11: Frequency of events involving vulnerable patients (%)

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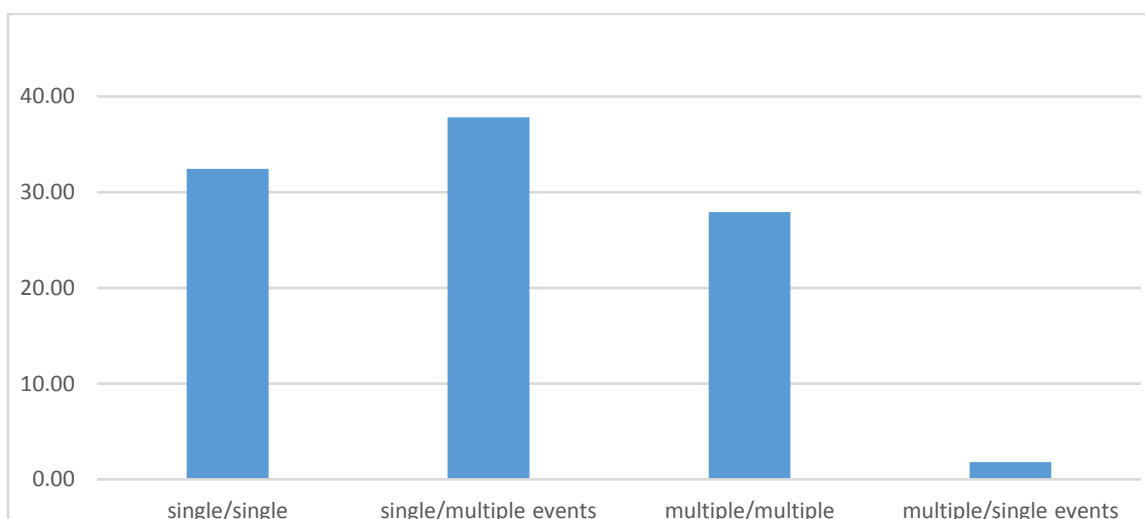
[15] There was incomplete information to allow all 232 to be coded for target type.

Further analysis reveals the locations for these repeat offending incidents for vulnerable patients and service users (see table 1). From this it is clear that locations vary by profession, with GP surgeries appear as a doctor-only event location, while hospitals and mental health facilities are more frequent[16] for all professions.

Table 1: Locations of vulnerable patient single target – repeated incidence (% by overall)

	Doctors	Allied Professionals	Nurses	Overall
Hospital	4.76	4.76	28.57	38.10
Outside Work	4.76	7.14	9.52	21.43
Mental Health	4.76	2.38	4.76	11.90
Local Authority	0.00	7.14	2.38	9.52
Gp Surgery	7.14	0.00	0.00	7.14
Ambulance Trust	0.00	4.76	0.00	4.76
Care Home	2.38	0.00	0.00	2.38
Private Consulting Rooms	0.00	0.00	2.38	2.38
Unknown	2.38	0.00	0.00	2.38

Moral mindsets. In looking at how perpetrators talk about their actions, statistical differences were found between the professions and the type of events. A Fisher's exact test of independence showed two aspects of denial as areas of divergence ((df = 3, N = 217[8]), = 9.35 p = .016. (Cramer's V = 4% shared variance)). Specifically, post-hoc tests indicated that denial was more associated with multiple target and multiple event types of incident than would be expected under the null hypothesis, and observed significantly less than expected in single target and multiple event types. Further, denial of injury was also significantly associated with event type (Fisher's exact test (3, N = 217[8]) = 7.70, p = .048. (Cramer's V = 8% shared variance)). Here post-hoc analysis found denial of injury occurred more in multiple target and single event type of incidence.

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[16] It should be noted that some of the hospital locations may include mental health units

Discussion

The results of the varying analysis reveal some important commonalities and differences between these professions. First, these FtP cases typically include patients, therefore they have a greater potential to undermine trust and confidence in both these professions, and the various institutions. Further, vulnerable patients are found to be an important target for perpetrators from all professions especially those involving repeat offences, with the same individuals repeatedly targeted. In addition, these events are more likely to occur within a work place, with further investigation showing hospitals and mental health units as more frequent workplaces for sexual abuse (see table 1) (see Searle, et al. 2017). Mental health roles are also over represented in terms of job roles of perpetrators. Further, mental health contexts are likely to include greater levels of aggression and also boundary management failures due to the types of patient issues. As a result it may be a more important location in which to have clearer policy about relationships, as a means of protecting both staff and patients.

Our prior PSA study identified an association between this type of abuse and locations that had other significant elements – notably long working hours that would be likely to deplete individuals' ego resources, but also contexts with increased levels of incivility and physical violence (Searle, et al. 2017). This suggests that more preventative work could be done to identify potential hot spots for such misconduct, and so to intervene before sexual abuse occurs.

Strikingly, vulnerable patients are a feature of all events (see figure 10), and therefore solutions which focus on protecting this group need to be better utilised. Our previous study identified the staff training as an important factor in reducing incidents of sexual abuse (Searle et al, 2017), therefore extending awareness raising training to include patients and service users may be of value. Further preventative efforts could make better use of NHS staff survey results, especially those with greater numbers of vulnerable patients, such as mental health units. Supervision is an additional tool that could be used for those working in these contexts. Further, our evidence shows that perpetrators of sexual abuse are found to also have problems with maintaining professional boundaries (see Searle et al, 2017). Therefore, formal policies might be used to make it clear that personal relationships are not acceptable with patients and service users. Such an approach has been applied in Ottawa with a ban of relationships within 12 months of being a patient. The use of policies is found to be a useful tool in reducing ambiguity, and is therefore valuable in protecting vulnerable targets. Such control systems enhance protection to this vulnerable group in a variety of ways; they make all stakeholders aware that this is not acceptable behaviour in a health and social care context. Second, they can deter perpetrators by imposing external boundaries, and also make

this clear to bystanders that include other staff members and the public. They can also inform and raise awareness amongst targets themselves.

It is sadly not possible to investigate further the types of target, as there is no formal recording of the gender and other details of targets to allow assessment of whether it is hostility or attraction that might be a driver for such activities. It is strongly advised that greater attention is paid to give greater granularity to targets and from this allow more insight to be developed to aid both detection and deterrence.

Second, there are clear professional differences between perpetrators. For example, doctor cases are all male perpetrators, and more likely to be either single target incident events, or multiple targets and events cases. Further differences were evident in the cognitions of perpetrators; doctors are more likely to deny injury in their actions, and specifically in multiple targets and events cases to deny the event occurred. These two forms of denial may be indicative of perpetrators' lack of insight into the consequences of their actions, but they are also a strategy for reducing attention. Further, doctors are also found to more frequently try to reduce their agency in these events by diffusing their responsibility for their actions far more than found in nurses. Training that includes awareness raising about what constitutes sexual harassment and abuse would be an important tool here. Supervisions are also important especially for those in general practice.

It is noticeable that in relation to the sanctions applied to doctors, suspensions were found more frequently than would be expected statistically compared with other groups. No difference in sanctions is found for repeat offenders. If this form of abuse is regarded as a goal-directed behaviour, and one that involves lack of adherence to boundaries, then any signals of a reduced level of sanction for this professional group is very concerning. It may lead some to feel that they can evade the consequences of their actions. It also is likely to impact on perceptions of natural justice, especially as doctors are more likely to deny injury has been caused by their actions. There needs to be more attention to understanding the parity of sanction across professions, especially for repeat offenders[17].

Nurses, by contrast, are found to include both male and female perpetrators. Female perpetrators were more frequently associated with single targets and multiple events, while males had more frequent targets. This female pattern may be indicative of an attempt to have a relationship with their target; indeed our previous study (Searle et al 2017) identified some female nurses as a potential target rather than the perpetrator in these cases. Again without details of the

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[17] This term refers to those who undertake multiple incidents of sexual misconduct against either the same target or a number of targets

targets' gender and other information, it is not possible to make more nuanced explanations for this grievous behaviour. It does suggest very different modus operandi and detection between these different gendered perpetrators. In addition those working in mental health are overrepresented as a perpetrator group, suggesting the importance of looking at specific training provision as well as improved supervision.

In terms of cognitive differences again a clear area is the changing of perpetrators' agency, with nurses found to be more likely to try and displace responsibility for their actions than doctors, but less likely to diffuse responsibility. A frequent defence used is not understanding local context (see Searle et al, 2017). This indicates cultural differences that could be challenged and removed through training and raising awareness as to what constitutes unacceptable physical contact in a UK context. It is striking that in contrast to doctors, nurses appeared far less likely to deny injury to their targets from such action.

There were very little differences found for allied professions, with the exception of cognitive aspects. Like doctors, they are more likely to use tactics that were designed to minimise their agency, specially they were more likely to diffuse responsibility for their actions. Again training would be an important tool here to challenge such views.

Recommendations

Given that workplaces are the dominant context for this form of misconduct, greater attention needs to be paid to awareness raising, supervision and training within work as a means of deterring perpetrators, but also improving understanding amongst bystanders, which includes other staff members, service users and the public. Research shows bystander training to be an important tool in reducing incidents.

A further recommendation is to have clearer policy about relationships and their appropriateness between professionals and patients in the workplace. Ambiguity would be reduced through clear guidelines about the appropriateness of patient/service user and staff relationships, and serve to protect both professionals and targets. This is especially important in known hotspots, such as hospitals, mental health and GP surgeries (see table 1). Further research is recommended into mental health roles and workplaces to understand better whether these workplaces attracted more perpetrators, or whether they denude the moral compasses more quickly of those working within them.

The apparent disparity of sanctions between different professions is a further source of ambiguity and concern as to its wider signalling for perpetrators. The more frequent use of suspension for doctors relative to the other two groups may not be appropriate as extant research shows their relative higher social status and place within organisational hierarchies makes this profession more likely to be perpetrators; empirical findings here confirm doctors as relatively over-represented in this form of professional misconduct, and also no statistical difference between sanctions for those undertaking multiple incidents. The perception of disparity of sanctions between the different professions can send an ambiguous message to perpetrators suggesting to them relative leniency for their actions; this is especially concerning given that these forms of misconduct are goal-directed behaviours, with perpetrators weighing up the costs and benefits. Perceived leniency may encourage others to perceive that they will be treated less severely by their regulators. Greater scrutiny should be given to the detection and removal of professionals undertaking repeated offences from the workforce[18].

Dehumanising of targets is more likely to occur for those in a different group to a perpetrator, and is more common to doctor cases, therefore it is important that attention is paid to the recording and reporting of demographics for both perpetrators and targets. It was only possible to obtain ethnicity data from the doctor cases pertaining to the perpetrators. Given the efforts our

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[18] See footnote 8.

results show, that perpetrators go on to reduce their agency, plus the frequency of the excuse of 'being from a different culture', it is important that further research can investigate these issues. More critically recent cases of sexual abuse have shown ethnicity to be a factor, and therefore it is important that registrants' ethnicity is formally recorded. Further examination of this form of misconduct would be significantly enhanced through formal recording of the ethnicity, gender, seniority and other key information, such as sexual orientation of perpetrators and targets.

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