

## **Rapid Response:**

### **Why the Cox case is significant for UK medicine**

Dear Editor,

Sexual misconduct in UK medicine is increasingly being placed on the public and policy agenda. This includes publication of the Breaking the Silence (1) and Surviving in Scrubs reports in 2023 (2), as well as the NHS Sexual Safety Charter (3). Regulators are engaged in conversations about how to address and respond to cases of sexual misconduct, and to deliver accountability and justice to those subjected to it. The conviction of former GP Stephen Cox is therefore significant for the British medical community, but not necessarily for the reasons that one might think.

Firstly, in targeting women who were “less likely to complain” on account of their age and background, the particulars of Cox’s case are not exceptional. Doctors who engage in sexual misconduct are more often men, and their victims tend to be young women (4,5), who may also be marginalised by other structural inequalities (for example, having histories of abuse, or psychiatric diagnoses) (6,7). Among doctors, GPs are also particularly over-represented in sexual misconduct cases involving patients (6,8,9). As a GP targeting women who had been in abusive relationships, Cox’s behaviour is therefore entirely consistent with what we know about this group of offenders.

However, what is exceptional about Cox’s case is that he has been criminally convicted for his sexual misconduct. There is limited scholarship examining the relationship between regulatory and criminal justice outcomes in the UK, yet preliminary evidence suggests that fitness to practice sanctions may not be proportionate. In an analysis of General Medical Council cases from 2005-2015, John Martyn Chamberlain demonstrated that only 15% of doctors who had been convicted of a violent or sex offence were referred to a medical tribunal (10). In 2010, Cox himself was initially only suspended from practice for 9 months by the Medical Practitioners Tribunal Service, for his sexual misconduct towards two patients and a medical student in West Sussex.

The Cox case therefore raises important questions. For example, what is the relationship between regulators and the police - how and in what circumstances are cases notified between these two groups? How do victims experience disciplinary or criminal tribunals, and do they find particular mechanisms more “just”? These are just some of the questions that we will be aiming to answer in our Powerful Perpetrators research project, which looks at sexual misconduct amongst high status/high public trust professionals.

In the meantime, addressing sexual misconduct is best tackled by speaking to those who have been subjected to it. Listen, for example, to this anonymous testimony (story number 219) collected for the Surviving in Scrubs campaign, from someone who was sexually assaulted by a colleague (11):

What pains me most now is just how normal I believed it all to be. It was so widely acknowledged and accepted. It was this culture that meant that when a male doctor assaulted me in a much more invasive way, I simply avoided him until he rotated away. It didn’t even occur to me to report it.

Here then are the first steps: we need to unpick the professional and organisational processes and cultures which normalise and therefore permit sexualised behaviour within medicine; and we need to assure those reporting that they will be protected and believed, rather than isolated and silenced. Finally, we encourage regulators and medical leaders to work with researchers to better identify offending professionals and to ensure their disciplinary systems provide effective sanction.

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