Sexism and sexual violence towards medical students

"Sexism and sexual violence impacts what choices I make. What I wear. Where I go. It impacts my perception of my own safety and my trust in others" – Respondent

SURVIVING IN SCRUBS
Tackling misogyny in healthcare

British Medical Association
bma.org.uk

Foreword

Sexism and sexual violence remain pervasive within medical schools. They are deep-rooted within the culture of academia and throughout clinical placements, influencing the day-to-day experiences of students and shaping the future culture of the profession.

Despite consistent calls for change, students are completely forgotten about, with survivors who face distress throughout the rest of their lives continuing to be silenced. Following recent highly publicised and shocking reports of sexism in surgery, we could not even begin to quantify the student experience; something we needed to do to lobby for change.

This report highlights that the problem is not just confined to doctors. It is also prevalent for student doctors, with student doctors encountering sexism and sexual violence from a range of sources, including their peers, university staff, and healthcare professionals during their placements.

We urge medical schools, universities and clinical placement providers to implement the recommendations outlined in this report and commit to building a culture of safety, respect and equity at university and placements – where all students can thrive.

Ria Bansal and **Akshata Valsangkar**
BMA Medical Students Committee Welfare co-chairs 2024-2025

We launched our campaign in 2022 to raise awareness of sexism, sexual harassment and sexual assault perpetrated between healthcare staff. We sought to raise the survivor voice, collecting stories of lived experience submitted anonymously and sharing them online to challenge healthcare authorities to take action on this issue. Very quickly we identified students as a significant proportion of survivors. We recognised this from both our personal lived experiences and those of our friends and colleagues.

Sexism and sexual misconduct is a misuse of power and hierarchy. Those at the lower end of the hierarchy, such as students, are particularly vulnerable. Despite this, data has been lacking across the medical student body in the UK and we fail to see action from organisations responsible for medical students. Recognising this we reached out to the BMA medical students committee and asked them to collaborate with us to produce a survey for the first time quantifying this issue amongst medical students across the UK.

The results show the scale of misogyny and sexual violence affecting medical students perpetrated not only by fellow students but by university and healthcare staff. Silence and dismissal by institutions runs as a theme through this data.

This data could be viewed as disheartening but we see it as a call to action, to ask our medical schools, clinical placement providers and regulators to take action to protect students. These authorities must provide specialist support for survivors, hold perpetrators to account, and ultimately seek to prevent sexism and sexual violence through education and cultural change. Medical students should feel safe to study in an environment free from sexism and sexual violence. We call on all organisations involved with medical education to commit to action to end misogyny and sexual violence.

Dr Becky Cox and **Dr Chelcie Jewitt**
Surviving in Scrubs

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Executive summary

This report exposes the prevalence of sexism and sexual violence being faced by many medical students. This report underlines why immediate action is needed to combat the individual behaviours and systematic failures that are undermining the education and wellbeing of students. This was a self-selective survey with 968 responses.

Respondents shared many deeply troubling testimonies of unacceptable behaviour which they have faced during their time as students. At the most severe end, this included 37 incidents of rape or assault by penetration, 85 cases of sexual assault, 43 cases of drink spiking and 24 cases of stalking.

The report finds failures in institutions to adequately respond to incidents of sexual harassment and assault, resulting in a damaging breakdown in trust between students and the institutions and leaders who should be protecting them. It also reveals an underpinning sexist culture that runs through medical education and the NHS, with 84% of respondents believing sexism to be a problem in medical education.

Key Findings

- A concerning level of sexual violence, including criminal sexual offences, is taking place while medical students are at university. 41% of female respondents had been a target of sexual harassment or sexual assault while at university, as had 19% of male respondents. The incidents are most likely to be perpetrated by fellow students.

- The health and wellbeing of victims need to be prioritised, and there is concern that leaders do not recognise the impact of sexual harassment and assault. The risks of social isolation and ability to participate in education need to be recognised and support measures should be offered.

- There is a lack of clarity on the interface between medical schools, universities and placement providers. This is leaving students with the difficult and stressful task of navigating a complex system when they need to report an incident and/or seek support.

- Respondents do not feel that the sanctions for sexual harassment and assault are sufficient to help stop this behaviour, leading to the view that perpetrators are emboldened to repeat such behaviours. When respondents were asked to identify the most effective action they would like medical schools to take, 60% called for stronger sanctioning for sexual harassment and assault.

- There is a significant problem with reporting and investigation processes and outcomes. The majority of respondents (60%) do not have faith in their medical school's ability to adequately respond to a future incident of sexual harassment or assault. 75% of respondents who reported sexual harassment or sexual assault said they were not really or not at all satisfied with the outcome, and 67% chose not to report. The main reason respondents did not report was a belief that nothing would be done.

- The failure of the NHS and medical schools to tackle sexism on clinical placements risks the continued normalisation of sexism and sexual violence in the NHS. This is exacerbated by the lack of intervention from staff when this behaviour takes place. 69% of female respondents experienced sexism on clinical placements, compared to 16% of male respondents.

- This behaviour is being perpetrated within all the major groups that students are interacting in: students, doctors and patients. The type of actions coming from these different groups does vary. In incidents of sexism, it was primarily doctors that were mentioned but in cases of harassment and assault, it was other students and patients. Where respondents shared the gender of the perpetrator, the overwhelming majority were men.

- Sexist and misogynistic attitudes held by some doctors are leading to unequal educational opportunities, with placement providers and medical schools not doing enough to ensure fair access to high-quality education.

- There can be no presumption that younger generations have more progressive views or a greater understanding of consent. We received examples of students questioning whether women should be in higher education, aggressive responses to rejected sexual advances, and doubts around women's competency.

Recommendations

We recommend the following key actions are urgently implemented to better protect and support medical students. A full list can be found in the conclusion of the report.

- The Government must bring forward legislation that introduces a statutory duty of care on higher education institutions for their students.
- Universities, medical schools and placement providers must provide multiple channels for reporting, including anonymous reporting routes, ensuring students can confidentially disclose incidents without fear of reprisal.
- Medical schools must work together to agree consistent and robust sanctioning guidelines for cases of sexual violence that are sufficient to deter this behaviour from taking place. This must include a review of medical school fitness to practise guidance and ensuring panels are equipped to manage cases of sexual misconduct, preventing weaponisation of these processes to discourage reporting.
- Measures to minimise interactions between the complainant and the accused must be put in place. These measures must prioritise the wellbeing of the complainant, avoid intimidation against them, and prevent any further incidents. This must cover investigations of incidents at medical school and on placement.
- All students should be educated on sexism, misogyny, relationships, consent and sexual violence so that they are fully equipped to recognise, challenge and address these behaviours within academic settings, their own social interactions and their careers in the medical profession.
- Clinical placement providers must monitor teaching standards to ensure sexism in teaching does not take place and that medical students can access equal opportunities, irrespective of their gender.
- Clinical placement providers must provide a safe and inclusive working environment for all students. This should include enforcing professional boundaries and providing medical students the same protections from sexual harassment and sexual violence that their staff receive.
- Placement providers must give all staff involved in educational supervision guidance on how to respond when they witness or are informed about incidents of sexism or sexual violence. This would include how to respond compassionately and how to escalate concerns raised by medical students.
- Medical schools must empower medical students to enter specialties that have notable gender disparities by proactively implementing strategies to dismantle entrenched gender stereotypes and imbalances.

In this report you will find upsetting accounts of behaviour from doctors and students. It is important to remember that the vast majority of doctors and medical students act with integrity and have entered the profession to provide the best quality of care to patients. These doctors and medical students should train and work in a system that is free from sexual violence and gender-based discrimination. This report highlights that we must fix the institutional and cultural problems that are enabling these behaviours.

Introduction

The BMA's medical students committee and Surviving in Scrubs collaborated on a UK-wide survey of medical students about their experiences of sexism and sexual violence. This report contains our survey analysis and recommendations. It sheds light on the difficulties that some medical students face as they navigate both academic and clinical environments where power dynamics, institutional cultures and misogyny may increase their vulnerability to discriminatory and harmful behaviours. Through our recommendations we are amplifying the voices of students on the organisational changes they want to see. This report also includes extracts from hundreds of personal accounts that students have courageously shared with us, which have been vital in expanding the understanding of the nature of incidents and the deep impact they have on people.

The findings of this report will enable institutions to take more tailored approaches to address these issues, providing insight on the most likely perpetrators of these incidents, the environments they take place in and the flaws in the cultures and systems that are enabling this behaviour.

This report includes the following sections:

- General views on sexism and sexual violence
- Incidents of sexual harassment and assault respondents had witnessed or experienced
- Incidents of sexism respondents had witnessed or experienced
- Perpetrators of sexism and sexual violence
- Reporting
- Impact of sexism and sexual violence on education, health and wellbeing
- Preventative action respondents want to see universities take
- Methodology and terminology

Why did we undertake this survey?

The BMA and Surviving in Scrubs recognised that sexism and sexual violence in medical schools was an issue that needed to be prioritised. The NHS has taken positive steps in recent years to address and prevent the unacceptable levels of sexism and sexual violence experienced by doctors. However, medical students are exposed to the same culture and perpetrators, often in a more vulnerable position. We needed more research to understand their unique experiences on placement.

Students have also brought our attention to incidents of sexism and sexual harassment taking place at university and have sought our support after facing harassment and assault from fellow students. We agreed that a stronger dataset to understand the extent and nature of these behaviours was a crucial step before lobbying for change.

Importantly, we wanted to give medical students the opportunity to share their experiences and inform future policy recommendations with the actions they would like to see from medical schools and universities to prevent sexism and sexual violence.

This report includes direct anonymised quotes from respondents, which may be upsetting to read. If in need of support, the BMA's free and confidential wellbeing support services are available to all doctors and medical students in the UK, regardless of BMA membership.

Context – educational landscape, policy and culture

Institutions and environments students interact with

Universities v medical schools

A key challenge uncovered from this research is a lack of clarity on the interface between medical schools and universities when it comes to responsibility for the care of students. Previous lobbying work undertaken to address sexual violence faced by medical students has understandably focused on medical schools.[1] However, many of the changes that we are calling for will need to be actioned at a university-wide level. This is because higher education institutions as a whole also have a problem with sexual violence.

In January 2025, the Office for Students surveyed all final-year undergraduate students on sexual misconduct. They found that 14% of students who responded had been victims of sexual violence and one in four students had experienced sexual harassment.[2] This approach recognises that medical students live and work alongside other students and university faculty.

Medical schools still have a significant role to play. For example, they have powers when it comes to addressing sexism in teaching and interacting with clinical placement providers and have control over fitness to practise decisions and policies.[3] Medical school staff will also have a significant amount of engagement with students, for example in their roles as tutors.

A note on fitness to practise

Medical students can have fitness to practise concerns raised against them by their educators, clinicians, fellow students or members of the public. In certain cases, this could lead to a fitness to practise investigation or disciplinary process.

The GMC provides guidance to medical schools on managing fitness to practise concerns. However, it has no ability to get involved in individual medical school investigations.[4] The structure of investigations can vary between medical schools and be influenced by the university's wider investigation processes.[5]

1 BMJ, Medical students are urged to tackle sexual misconduct and safeguard students, 24 July 2024
2 Office for Students, OfS publishes new data on the scale of sexual misconduct in English higher education, 25 September 2025
3 General Medical Council and Medical Schools Council, Professional behaviour and fitness to practise: guidance for medical schools and their students, May 2016
4 General Medical Council and Medical Schools Council, Professional behaviour and fitness to practise: guidance for medical schools and their students, May 2016
5 Medical Defence Union (MDU), Zoe Wood, What to expect from a student fitness to practise investigation, 29 February 2024

Clinical placements

Every medical student has to undertake clinical placements. The objective is to learn through supervised practice in the different settings in which they may work in the future. This can include teaching hospitals, private hospitals and clinics, GP practices, community health centres and specialist health services, such as drug and alcohol services. On these placements, they will learn from doctors and other NHS staff and interact with patients.[6] They will have an assigned educational supervisor who is responsible for overseeing their placement experience.

When medical students enter these environments, we know they are at risk of experiencing sexism and sexual violence. Just like at medical school and universities, these issues remain in the NHS. Since 2024, the NHS staff survey has asked questions about sexual misconduct. The survey found that 1 in every 12 NHS workers had received unwanted sexual approaches from a patient and 1 in 26 from a colleague.[7] The BMA's Sexism in Medicine report also revealed the high levels of sexism in the NHS, with 91% of female doctors saying they had experienced sexism at work.[8] It is unsurprising that the accounts from respondents about their experiences on placement are reflective of the findings from the Sexism in Medicine report.

Protections and student rights concerning sexual harassment and assault – university and employment settings

Duty of care

In the UK, the duty of care that higher education institutions have towards their students is unclear and varies across the four nations. In the case of *University of Bristol v Abrahart* in 2023, the High Court upheld the findings of the county court that no general duty of care by a university towards a student existed in statute or had been established in any previous cases.

Largely driven by parents who have lost their children to suicide while at university, there have been calls for a statutory duty of care, including a petition that led to a Westminster Hall debate.[9] UK governments have resisted any legislative change, arguing a general duty of care to deliver educational and pastoral services to a competent standard are sufficient.[10]

6 NHS Health Careers, Clinical placements for medical students, webpage accessed November 2025
7 NHS, Sexual safety in the NHS: survey results and update on charter implementation, 12 April 2024
8 BMA, Sexism in medicine report, August 2021
9 UK Government and Parliament petitions, Create statutory legal duty of care for students in Higher Education, petition closed 19 March, webpage accessed November 2025
10 UK Government and Parliament petitions, Create statutory legal duty of care for students in Higher Education, petition closed 19 March 2023, webpage accessed November 2025

Legal protections from sexual harassment

The Equality Act 2010 (applicable in England, Wales and Scotland) defines sexual harassment as unwanted conduct of a sexual nature that has the purpose or effect of violating a person's dignity or creating an intimidating, hostile, humiliating or offensive environment.

The Equality Act is applicable in further and higher education settings. The Act also makes it unlawful to treat a student less favourably because they either submit to or reject sexual harassment related to their sex.

In Northern Ireland, there is a series of anti-discrimination laws and protection from harassment, including sexual harassment. This includes the Sex Discrimination Order 1976 where harassment shares the same definition as the Equality Act 2010.

Office for Students regulations on harassment and sexual misconduct

In August 2025, new regulations were introduced by the Office for Students on preventing and addressing harassment and sexual misconduct.[11] The regulations cover the following areas:

- taking steps to proactively protect students from harassment and sexual misconduct
- training for staff and students on their policies
- support for the affected by harassment and sexual misconduct
- how information on sensitive matters is handled
- investigating incidents
- communications of policies relating to harassment and sexual misconduct

Protection from sexual harassment in the workplace

As mentioned, students will be learning in a variety of employment settings. While medical students are not employees, it is worth being aware of these protections. There is current discussion at government level on the extension of employer obligations concerning sexual harassment to learners, interns and volunteers.[12]

11 Office for Students, Prevent and address harassment and sexual misconduct, published January 2020 and updated 1 August 2025
12 Personnel Today, Adam McCulloch, Labour to target sexual harassment of interns and volunteers policy, 9 May 2024

There has been a shift in recent years to rebalance the responsibility to address sexual harassment from victims towards the employer, and to view it through the lens of employer obligations around the health and safety of employees. This has been established by the Worker Protection Act 2023, which places a legal obligation on employers to take 'reasonable steps' to prevent sexual harassment.[13] These obligations will be strengthened in the Employment Rights Act which requires employers to take 'all reasonable steps'. The Equality and Human Rights Commission have guidance on how employers can be compliant.[14]

There is nothing preventing employers from incorporating students when they take necessary preventative steps; this is something the BMA has advocated for. For example, employers should include students in sexual-harassment policies and sexual-harassment risk assessments.

Violence against women and girls in the UK

All of this takes place in the context of an endemic level of gender-based violence and our society's continuing issue with misogyny. It is unsurprising that successive governments have said they will prioritise this issue, yet we have not seen meaningful change. The current Government has committed to halving violence against women and girls in the next 10 years.[15] In 2024 it was reported that, 1 in 4 women have been raped or sexually assaulted, and 1 in 18 men in England and Wales.[16]

13 Worker Protection (Amendment of Equality Act 2010) Act 2023
14 Equality and Human Rights Commission, Sexual harassment and harassment at work: technical guidance, published January 2020 and updated 26 September 2024
15 House of Commons Library, Violence against women and girls in 2025, 27 May 2025
16 Rape Crisis England and Wales, Rape and sexual assault statistics, webpage accessed November 2025

Methodology and terminology

Methodology

The survey was a self-selective qualitative survey, which was open to medical students across the UK. We received 1006 responses; 968 were valid responses. Among the valid responses, 79% were female, 18% were male, 1% were non-binary and 1% self-described.

Medical degrees include compulsory participation in workplaces, which can expose medical students to additional risks of sexism and sexual violence. We asked specific questions about their experiences in workplaces to obtain a detailed understanding of the problems faced and how medical students may need access to specific support to reflect the requirements of the degree.

We separated the questions into experiences at university and experiences on clinical placement. Analysis of the survey showed that certain questions were not interpreted as expected by respondents. When we asked questions on experiences at medical schools and universities, many respondents included their experiences on clinical placements. This resulted in a stronger focus on the free-text responses.

Terminology

Terminology around gender-based violence and discrimination is often changing and can be inconsistent. We provided definitions to survey respondents.

Sexual harassment: behaviour characterised by the making of unwelcome and inappropriate sexual remarks or physical advances in a workplace or other professional or social situation.

Sexual assault: sexual violence or abuse that involves physical contact between the perpetrator and the victim/survivor. This definition is based on the legal definition set out in the Sexual Offences Act 2003 and is used by sexual violence support organisations such as Rape Crisis England and Wales.

Sexual violence: any kind of sexual activity or act (including online) that is unwanted or involves pressure, manipulation, bullying, intimidation, threats, deception or force.

Demographic breakdown and intersectionality

The demographic breakdown of the survey respondents can be found in Appendix.

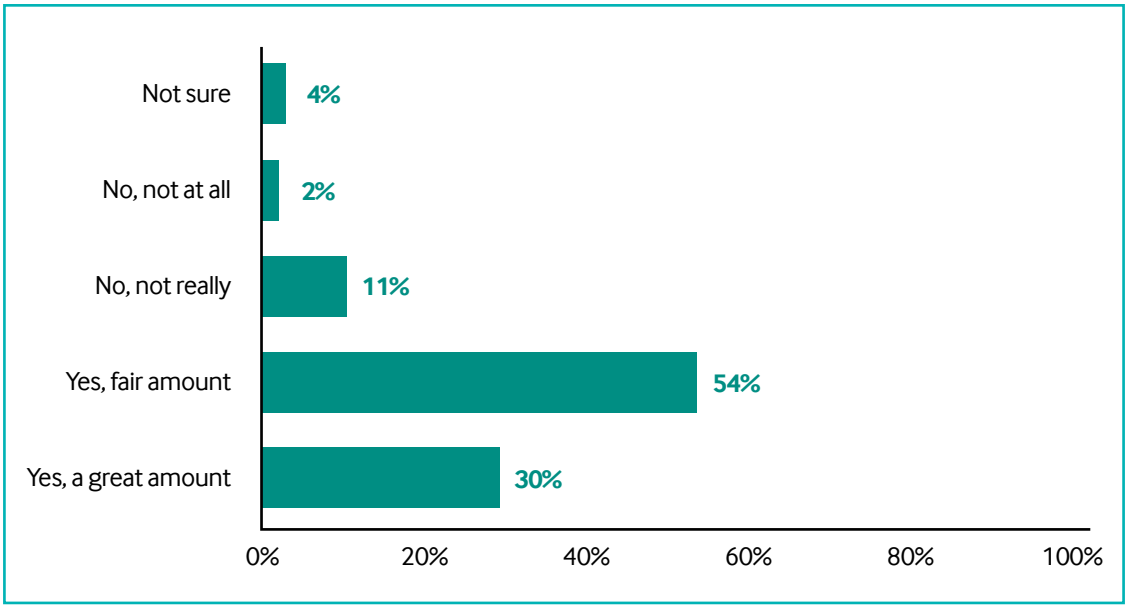
Women were overrepresented in the survey, making up 79% of respondents. This is an expected outcome for a self-selective survey as women are more impacted by sexism and sexual violence. There were significant differences between male and female students across a range of questions.

We analysed the findings to identify any differences in experience based on sexual orientation, ethnicity, disability, and religion. There was no evidence that the prevalence or nature of experiences differed based on these characteristics.

Survey Results – respondents' views on sexism and sexual safety

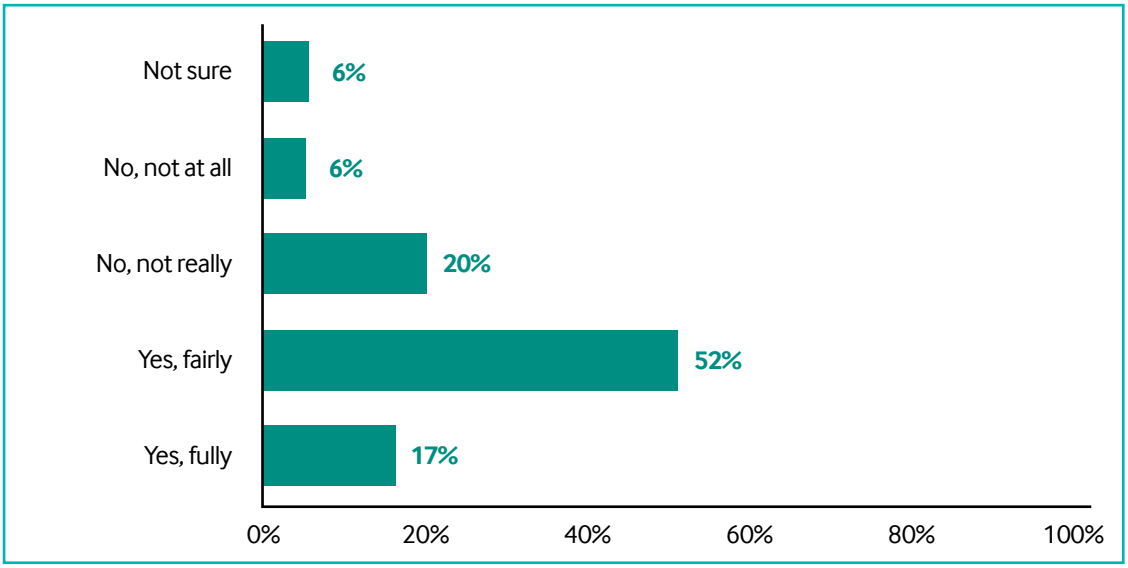
We asked respondents questions to gather their views on sexism. We asked this to understand perceptions in medical education independently of whether respondents had personally experienced sexism or sexual violence.

Do you believe that sexism is a problem in medical education?



84% of respondents believed that sexism was a problem in medical education. There were notable differences in how male and female respondents answered, with 88% of female respondents believing this to be an issue, compared to 67% of male respondents.

Do you believe that your medical school provides a sexually safe environment for students?

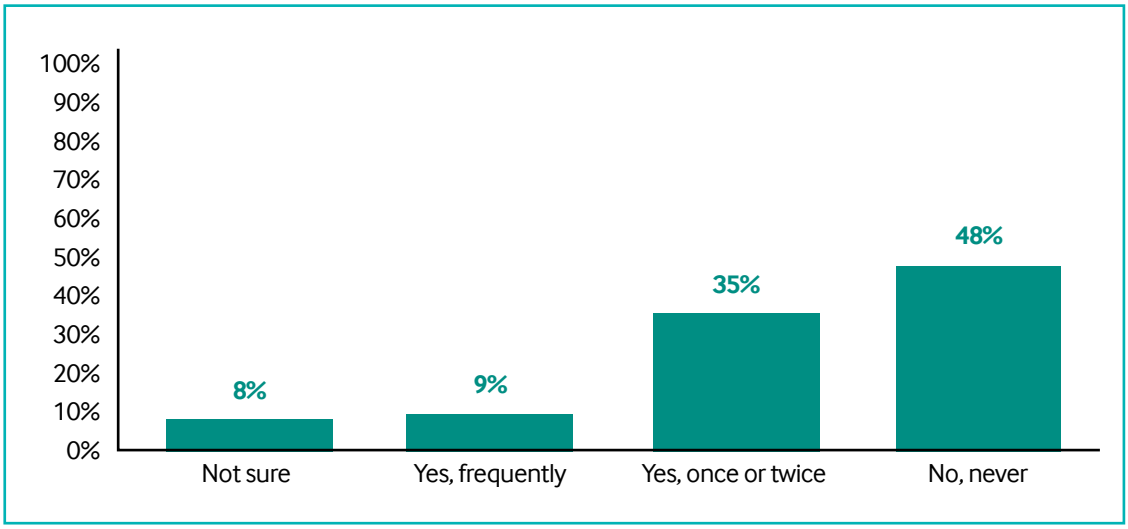


68% of respondents believed that their medical school provided a sexually safe environment for students. Male respondents were slightly more likely to have a positive response to this question, with 71% saying yes to this, compared to 68% of female respondents.

Sexual harassment and assault

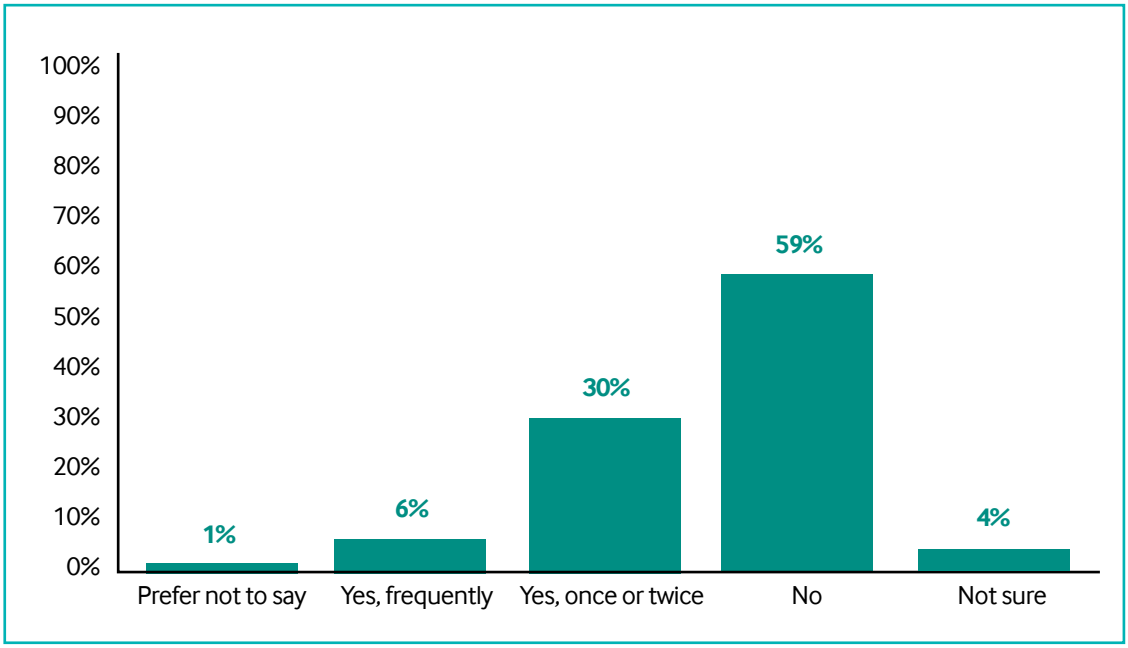
37% of respondents had been a target of sexual harassment or sexual assault at university, including at social or extracurricular events. There was a significant gender difference with women being twice as likely to experience these behaviours (41% v 19%).

Have you personally witnessed sexual harassment or sexual assault at university, including social or extracurricular activities?



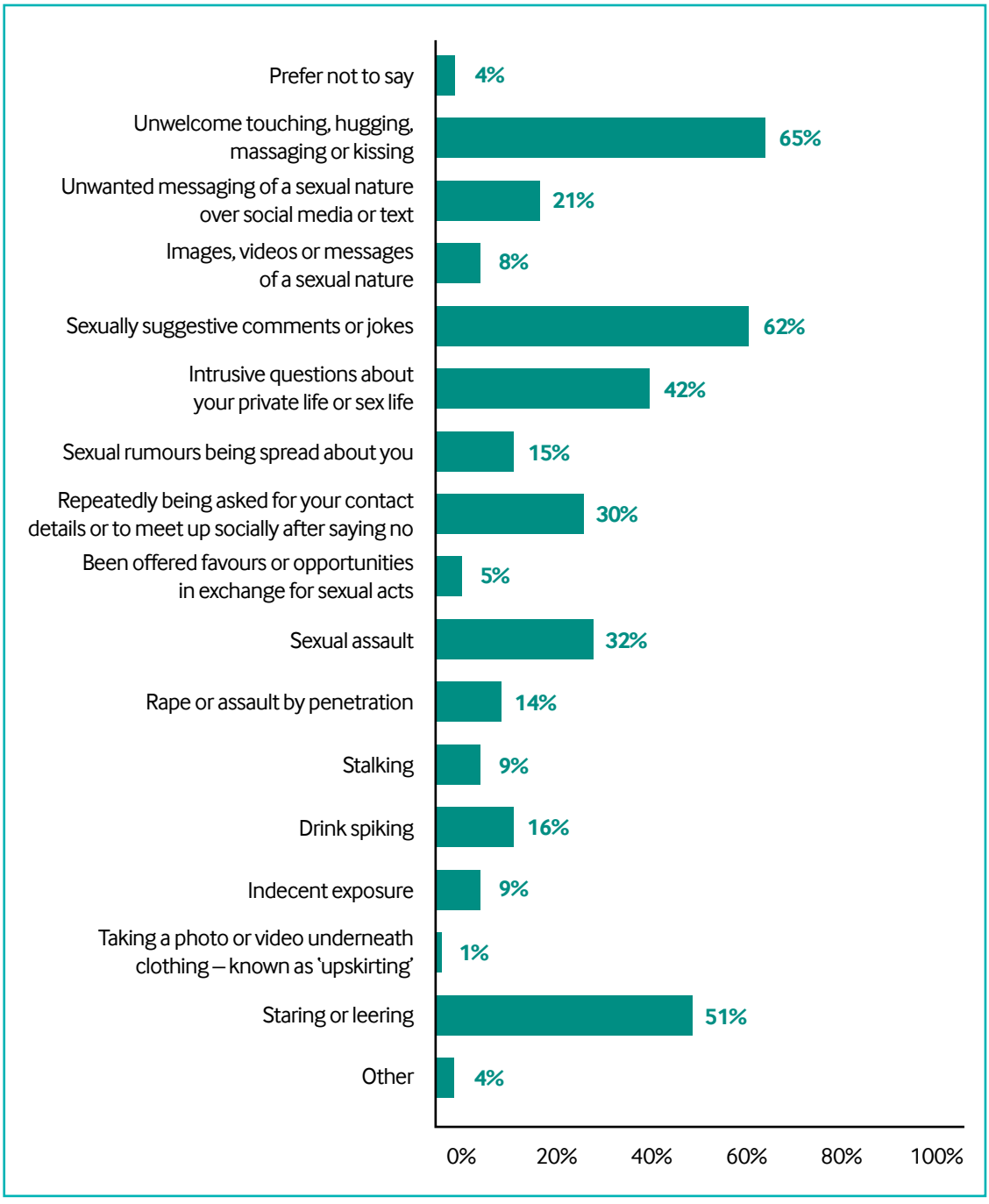
44% witnessed these incidents take place. Female respondents were significantly more likely to have witnessed sexual harassment of sexual assault (47% compared to 32%). This could be an indication that these incidents are less likely to take place with men present or that men may be less aware of which actions are classified as a harassment and assault.

Have you personally been a target of sexual harassment or sexual assault at university, including university social or extracurricular events?



For the 37% respondents who said they were targets of sexual harassment or sexual assault we asked further details on what the incident(s) included.

Did the incident(s) you personally experienced include any of the following? Please select all that apply



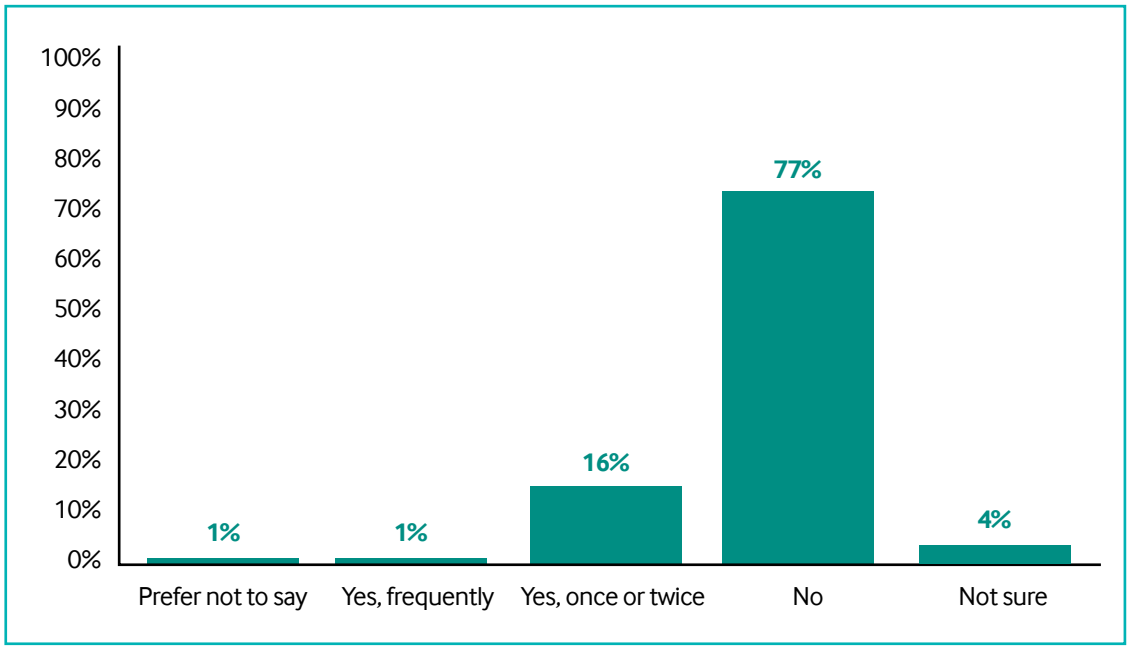
The most common incidents cited included unwanted touching, hugging, massaging or kissing (65%) and sexually suggestive comments or jokes (62%). When asked about incidents at university the most common perpetrators were other students.

There was a concerningly high number of incidents that are criminal sexual offences. This included, but was not limited to, 37 incidents of rape or assault by penetration, 85 cases of sexual assault, and 43 cases of drink spiking.

Sexual harassment and assault on clinical placement

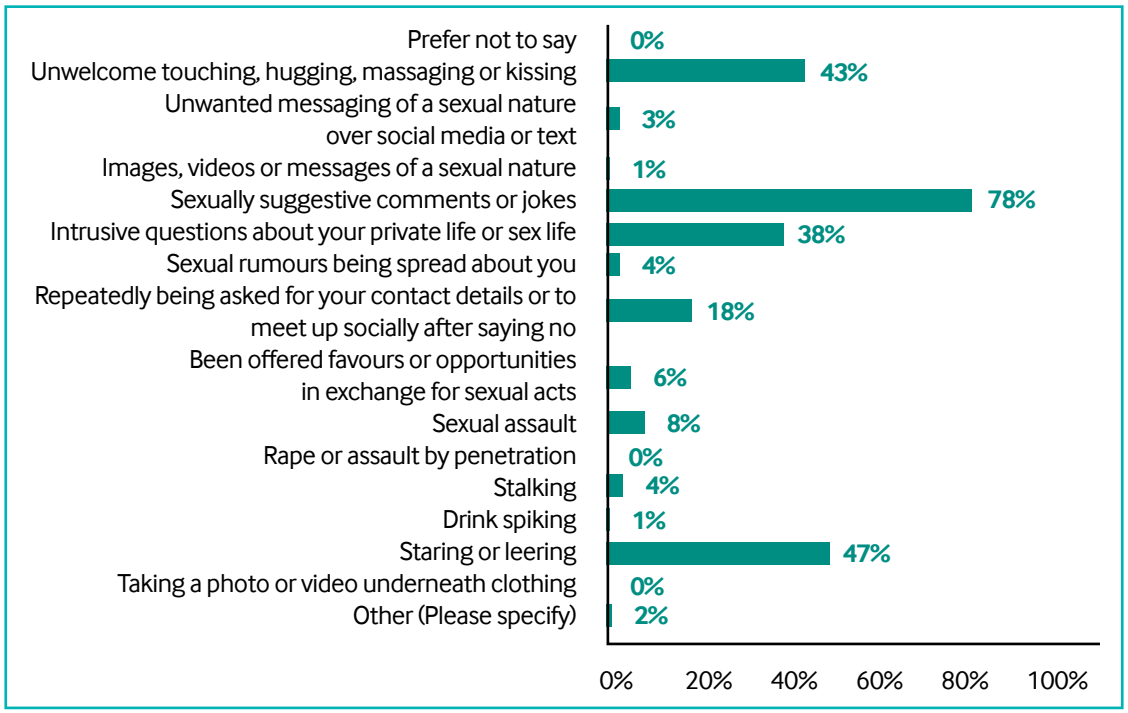
The respondents were asked specifically about their experiences on clinical placement.

Have you personally been a target of sexual harassment or sexual assault on clinical placement?



18% of respondents said that they had been a target of sexual harassment or sexual assault on clinical placement and 19% said they had witnessed an incident of sexual harassment or assault. Once again, female respondents were more likely to be targets of this behaviour, with 20% of female respondents saying they had been targets of sexual harassment or sexual assault compared to 6% of male respondents.

Did the incident(s) you personally experienced include any of the following?



For those who shared the nature of the incidents that had taken place, the most common incidents were sexually suggestive comments or jokes (78%) and staring or leering (47%). Patients and service users and doctors were the groups that most respondents cited when asked about perpetrators on clinical placement.

When sexual violence occurs on clinical placement, students and personal friends were left vulnerable and isolated. As a consequence, barriers to solutions like moving placements or requesting a different class to perpetrators of violence were not taken seriously. These have devastating impacts on the trust between students and placement providers as well as the medical education team.

Key themes from free-text responses on sexual harassment and assault

Respondents shared with us the many concerning accounts of sexual harassment and assault that they had been victims of during their time at medical school. The free-text responses were coded into themes.

Student relationships and consent

Respondents shared incidents where they had been sexually harassed or assaulted after rejecting romantic or sexual advances from fellow medical students. This included having sexual rumours spread about them, stalking, repeated sexual advances and pressure and coercion to participate in sexual acts.

The first incident involved a medical student in my year consistently trying to emotionally manipulate me into having a sexual relationship with him. Over the course of months, he tried to isolate me from my peers by telling me he was the only person who liked me and no one else did, told me stories about his other 'sexual conquests' (which I later found out were made up) and tried to break down my confidence both academically and socially and tried to break down my confidence both academically and socially.

A fellow medical student touched me in intimate areas on a night out without consent. I felt unable to say the words 'stop that' but I froze and cried and was clearly uncomfortable. When I went to report this to a senior member of staff at my university, I was told it might reflect poorly on my professionalism if I told the medical school I had been assaulted by another student but refused to reveal their identity. There was no way to anonymously report this, and I felt too scared to report it non-anonymously. I later ended up in classes with my assaulter because there was no anonymous reporting process.

Respondents who were in existing relationships also shared incidents of domestic abuse and coercion in relationships.

Sexual offences

There were several deeply concerning accounts of criminal behaviours that were shared in the survey. These included rape, sexual assault, upskirting, drink spiking, stalking and indecent exposure. The incidents that involved these types of offences were most likely to be perpetrated by other students.

> *Domestic violence situation with rape, continual sexual assault, physical assault, verbal and emotional abuse and stalking including breaking into my university accommodation (this was a graduate student whom at the time was at another college in my uni).*

There were examples shared of students being removed who had perpetrated this behaviour, but also investigations failing. There were highly concerning examples of students being deterred from reporting. Students shared the impact of continuing to have to work alongside perpetrators during and after investigations and the desire to have policies implemented that would minimise any future interactions.

> *Domestic violence and sexual assault by partner who was also a medical student. University were made aware, he was allowed to continue on the course without a proper investigation while I had to take time away due to PTSD (from the abuse and sexual assault). I filed a police report and had to have a letter sent from my lawyer telling him to leave me alone or I would take him to court for a protection order. The university took 8 months to put a no-contact order in place. When I was back on the course staff were not given the details of the no-contact order, so I was asked to check placements my ex-partner was on to make sure I wasn't at risk. This would trigger my PTSD and hyper-vigilance as I was struggling to feel safe while on placement. As soon as the no-contact order broke, he tried contacting me again. When I contacted the university to let them know I might struggle with attendance as I was not feeling safe and worried he was coming for me again, I was met with gaslighting ('maybe he's just being nice' and punitive measures).*

A note on sexual offences in the criminal justice system

A concerning number of experiences revealed in this survey would constitute criminal offences. Criminal sexual offences are covered by a range of legislation such as the Sexual Offences (England, Wales, Northern Ireland) Act 2003, Sexual Offences (Scotland) Act 2009, Abuse and Sexual Harm (Scotland) Act 2016. In spite of legislation, the criminal justice system is widely believed to be unfit to manage cases of rape and sexual assault with worryingly low convictions rates and long court backlogs.[17] Our legal system is so poor in this area that the End Violence Against Women Coalition argued that it had effectively become decriminalised.[18]

17 House of Lords Library, Rape: Levels of Prosecutions, 24 January 2025
18 End Violence Against Women coalition, Centre for Women's Justice, Imkaan, and Rape Crisis England and Wales, The decriminalisation of rape: Why the justice system is failing rape survivors and what needs to change, November 2020

Sexual comments

The most common type of incident shared in the free-text responses was receiving sexual comments, particularly from patients.

> *Myself, a fellow female student and a female doctor were at a male patient's bedside taking an ABG from him and he said something along the lines of 'lucky me, 3 attractive women down on their knees for me'. We all felt so uncomfortable, and I expected the doctor to say something, but she just laughed awkwardly, and we carried on. It was as if this was an accepted part of the job, and it would be rude or unprofessional to call out the inappropriate sexualisation.*

There appears to be a normalisation of sexual jokes and comments. While the incidents may not be as severe as the incidents that meet criminal standards, tolerance of these behaviours in the workplace and at medical school can create an uncomfortable and upsetting environment and enable more sinister incidents to take place.

Respondents also reflected on how these types of comments impacted them, including steering them away from pursuing careers in certain specialties. The experiences of medical students receiving or witnessing these types of comments and seeing no action from employees has the long-term implication of students believing this type of behaviour is an expected consequence of being a doctor.

A note on NHS England's sexual misconduct policy

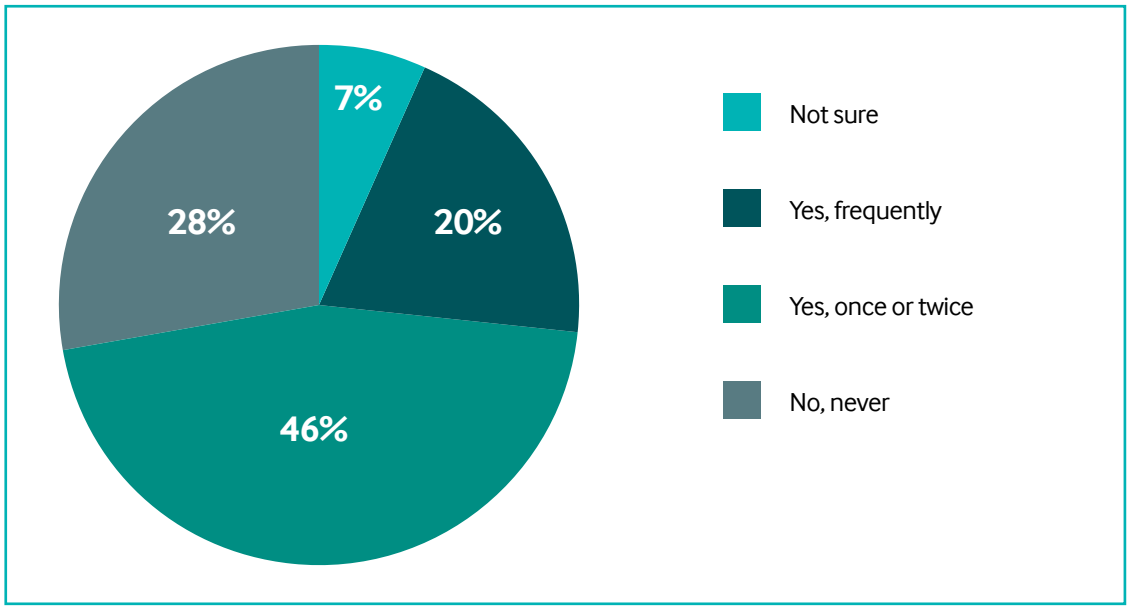
NHS England has been undertaking a programme of work to address sexual misconduct in the NHS. This has included launching a sexual-safety charter,[19] a sexual-misconduct policy framework,[20] and new training materials.[21] However, at the time this report was written, employer responsibilities to students had been absent.

19 NHS England, Sexual safety in healthcare – organisational charter, webpage updated 20 August 2025
20 NHS England, NHS England sexual misconduct policy, 16 October 2024
21 NHS England and E-learning for healthcare, Understanding sexual misconduct in the workplace, webpage accessed November 2025

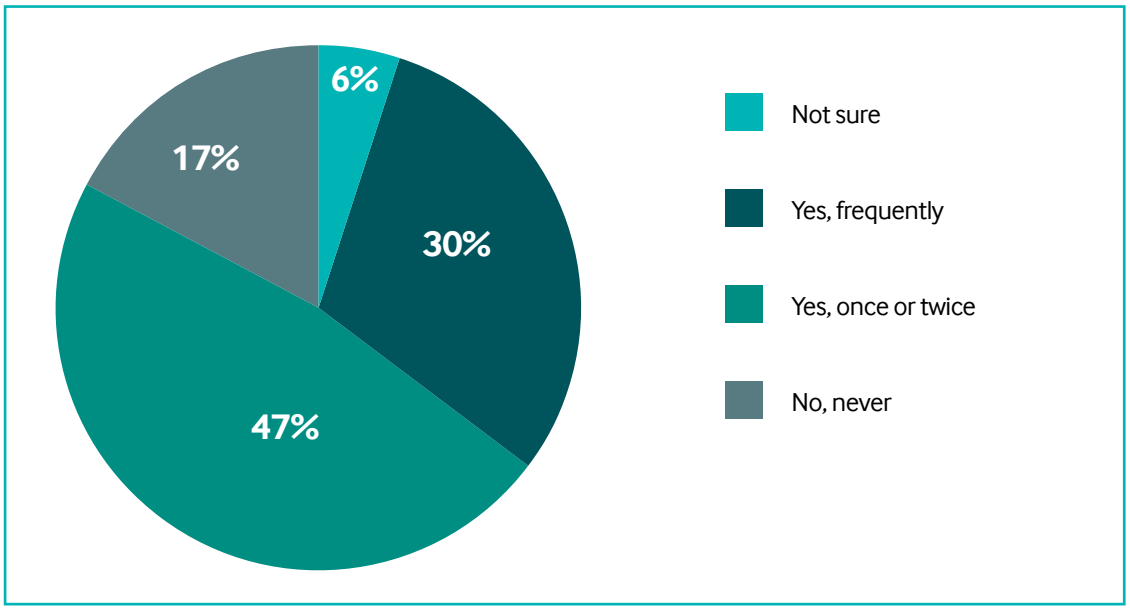
Sexism

The survey also explored the issue of sexism faced by medical students.

Have you personally experienced sexism at university, including university social or extracurricular events?



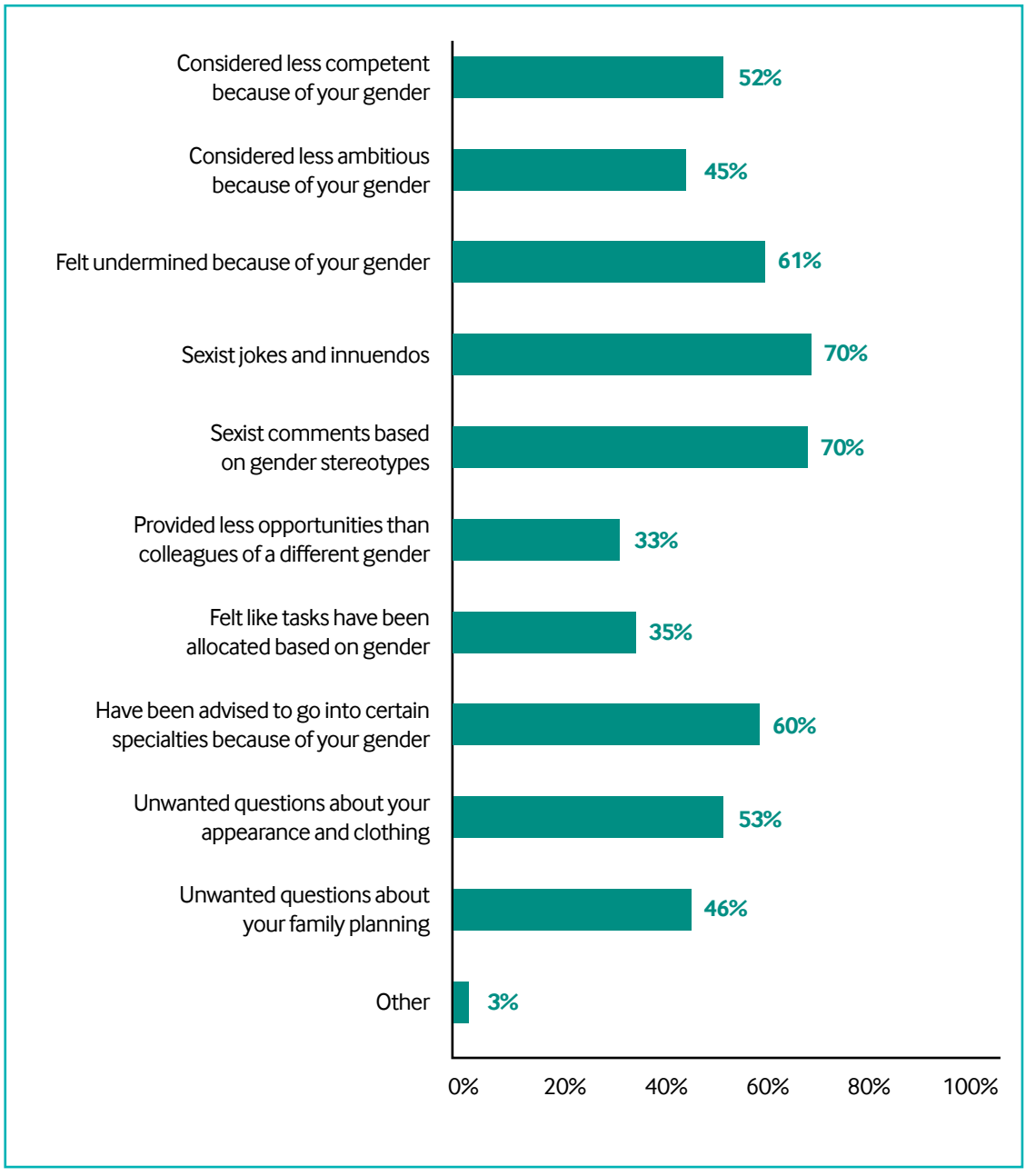
Have you personally witnessed sexism at university, including social or extracurricular activities?



66% of respondents had personally experienced sexism at university, including at university social or extracurricular activities. The most common were sexist jokes and innuendos (70%) and sexist comments based on gender stereotypes (70%). Female respondents were significantly more likely than male respondents to say that they had experienced sexism (73% vs 29%).

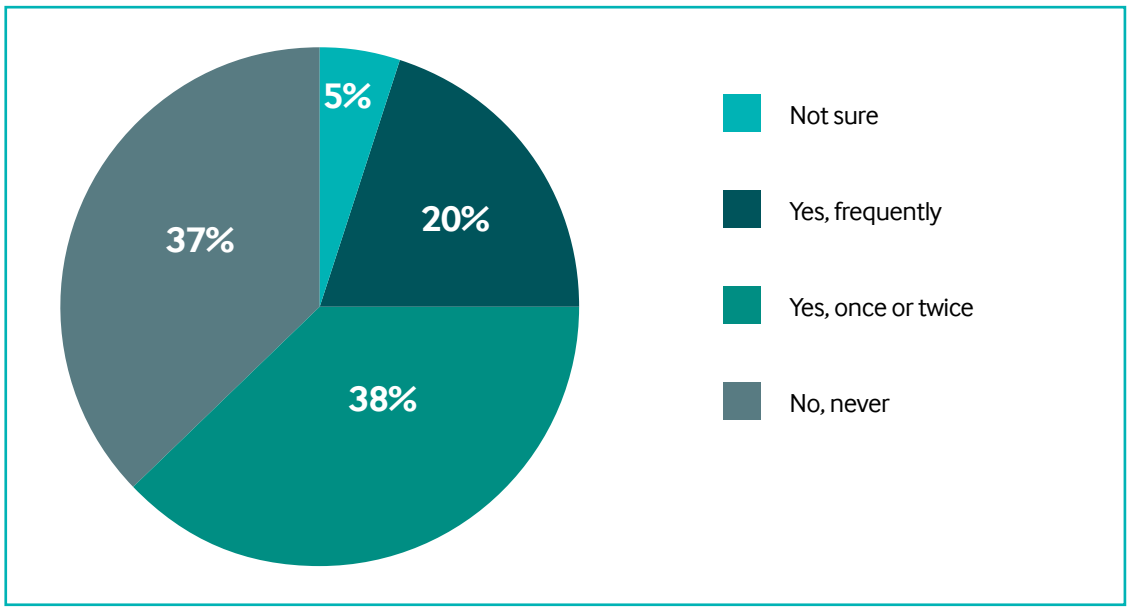
77% of respondents had personally witnessed sexism at university, including at social or extracurricular activities.

Did your experience(s) of sexism at university include any of the following?



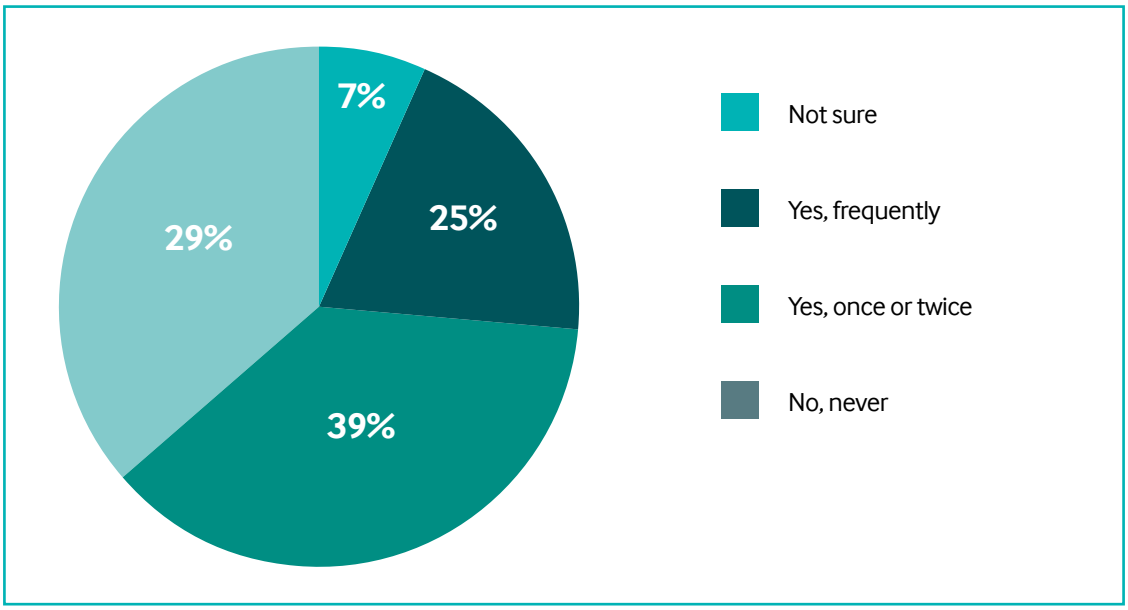
Sexism on clinical placement

Have you personally experienced sexism on clinical placement?



When asked specifically about clinical placements, 58% of respondents said they had personally experienced sexism, with 20% saying they experienced sexism frequently. There was a difference between the male and female respondents, with female respondents being significantly more likely to experience sexism (69% vs 16%).

Have you witnessed sexism on clinical placement?



64% of respondents had personally witnessed sexism on clinical placement, with 25% of respondents saying this is something they witnessed frequently. Male respondents were more likely to say that they had never witnessed sexism (41% vs 27%).

Guidance on clinical placements

The GMC (General Medical Council) and MSC (Medical Schools Council) have issued guidance outlining the role of the medical school and the placement provider in ensuring a valuable educational experience for students.[22] The experiences on clinical placement that respondents shared raise serious doubts that this guidance is being followed.

Key themes from free-text responses on sexism

Respondents were asked to share further details of incidents of sexism they had faced. Below are some of the key themes from the free-text responses.

Gender-based careers advice

One of the key themes that came from the free-text responses was careers advice based on gender stereotypes. The free-text responses suggest this tends to be unsolicited and comes from doctors on placements. The experiences shared suggest that in many cases doctors providing this advice to medical students are well-intentioned, demonstrating a form of benevolent sexism.

The most frequent was female respondents being advised to select their career choices around future childcare responsibilities. Many female respondents shared that they had been steered away from careers in specialties like surgery and moved towards general practice as it is perceived to be more compatible with having children. This stereotype around children was also extended to assumptions that women would be better at paediatrics.

> *It just makes me feel unworthy and guilty, like somehow my ambitions of wanting a career in a specialty that is known for its poor work-life balance somehow makes me feel inadequate, like I should feel bad for not wanting to prioritise having kids or spending time with them.*

Other issues raised included receiving advice containing assumptions that men would not be interested in specialties focused on obstetrics and gynaecology and that women did not have the physical strength to work in surgery.

22 General Medical Council, Guidance on undergraduate clinical placements, August 2022

Unequal training opportunities

Another key theme that came from the responses was a feeling that the treatment from educators on placement and at university could vary based on gender, with some vocalising to their students that they preferred working with men. Respondents mentioned examples of feeling ignored and undermined during teaching.

> *Many of the male professionals (at the university and on placement) prefer male students. Favouritism is a hard thing to quantify and therefore hard to report, but I and many of the other women at my university have noticed that male teachers spend a lot more time and effort getting to know and forming friendly/ professional relationships with male students.*

Surgeons were disproportionately mentioned by respondents when describing incidents of unequal training opportunities and preferential treatment based on gender. This is likely to be one of the factors that causes the continued overrepresentation of men in the surgical specialty.

> *One key moment that stands out me is when I was on my first day of my surgery block and in the introduction session too, the consultant leading the group said that some surgeons in this hospital have a tendency to let the male students scrub in and give them more opportunities in surgery but don't let the female students.*

A note on surgery's problem with sexism and sexual violence

Surgery is seen as having a particular issue with gender equality and a culture of silence on sexual violence. This has been highlighted by the research from the Working Party of Sexual Misconduct in Surgery. Their survey found that 63% of surgeons had been a target of sexual harassment from a colleague.[23]

Misogynistic views on women as doctors and in higher education

Respondents shared examples of seeing negative reactions to women entering the medical profession and participating in higher education. Respondents shared hearing comments from doctors, students and patients where they had stated that the lowering of standards of healthcare and the NHS was down to the increase in women doctors. There were also comments shared where respondents had been told that women go to medical school as they want to marry a doctor.

23 Begeny C, Arshad H, Cuming T et al, British Journal of Surgery, Sexual harassment, sexual assault and rape by colleagues in the surgical workforce and how women and men are living different realities: an observational study using NHS population-derived weights, 12 September 2023

One particular man in my cohort is known for being sexist. He frequently talks about how my cohort is predominantly female and 'the reason why the NHS is failing'. He's made judgemental comments at my female friends for not knowing the answer to questions and then spent the rest of the session laughing about how 'let me guess, I'm mansplaining am I?' I was told by another medical student that he doesn't believe women should be doctors.

Many respondents shared comments they had heard stating that women were less intelligent and competent than their male counterparts.

I had a top male surgeon tell me to stay at home, marry rich and become a housewife.

Women's health

Some respondents shared concerns that there are some doctors who do not take women's health as seriously as men's health or displayed a disrespect for female patients. There were also numerous examples of students making sexualised or disparaging remarks around female bodies.

Our supervisor, who was meant to be teaching us anatomy refused to teach about the female anatomy but spent an extraordinary about of time on male anatomy and made very inappropriate jokes.

Perpetrators

We asked questions around who had perpetrated this behaviour, and there were patterns of different types of behaviour stemming from different groups. It is necessary to understand this as it enables actions to stop this behaviour to be tailored and targeted.

Patients

The free-text responses provided numerous examples of sexual harassment and sexist comments from patients when respondents were on clinical placement. One of the key issues raised by respondents was the lack of intervention from doctors and other staff members when this behaviour took place.

Patient was making sexual comments to us – for example when I asked him if he could lay down he said, 'only if you get on top'. He continued to make sexual comments and comments about our appearance, and staff members seemed to be aware of/enable this – an HCA said 'I bet you're loving having four young girls in this'. He then touched one of my colleagues.

Doctors

Sexual harassment is rooted in power imbalances. This was reflected in the responses where we found incidents of doctors abusing the influence they have over medical students. The structure of medical education can make it challenging for students to report inappropriate behaviour with senior doctors who may have power over their educational opportunities and future career prospects. By a significant margin, the free-text responses mentioned these incidents taking place on surgical placement.

> *In my second year at university, I was on an extracurricular committee with a consultant (who ran the group). We ran monthly lectures, and he would find any excuse to touch me inappropriately, including holding my waist for prolonged periods, and touching up my thigh while no one else was around. This escalated to one day putting his hand up my top. He continued to find excuses to privately message me, and kept offering me opportunities to conferences or research if I was to do things like 'go for a run with him'.*

Respondents also shared examples of senior doctors acting unprofessionally. This included asking personal questions, providing unsolicited advice on family planning, making sexist comments and jokes and undermining female medical students.

There were also examples of doctors in educational roles using their positions of power to coerce medical students into activities.

> *One clinical teaching fellow in my fourth-year placement threatened not to sign me off for my rotation unless I had dinner with him after placement. I had to report this to the educational wellbeing officer.*

There is either a lack of understanding or deliberate breach of professional boundaries being shown by some doctors.

Other students

Both medical students and other students were mentioned as perpetrators. This demonstrates that action will need to be taken at a university level, not just at medical schools. The most severe incidents that took place, such as sexual assault and rape, were most likely to be perpetrated by students. The testimonies identified concerns that some students do not respect consent or are not able to cope with rejection.

> *Amongst male medical students I have heard story after story about how they speak about women. Some stories and rumours being serious and worrying about they have treated girls they have been in relationships or friends with.*

There were also examples from respondents of male students projecting dated and sexist attitudes, countering a common view that younger people always have more progressive values.

> *I've had both fellow students (male) make numerous comments and insults, saying things 'like you should go back to the kitchen'. I also hear conversations about other girls being talked about in a negative way and slut shamed but never any of the guy, who often brag about sleeping with multiple people.*

A note on male violence and misogyny

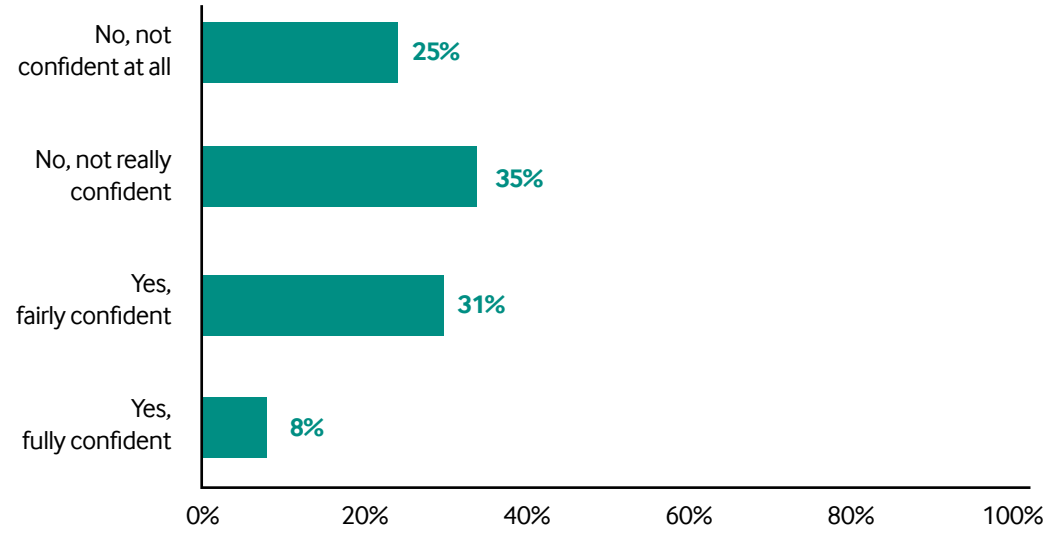
We asked respondents about the gender of perpetrators. However, in the testimonies it was overwhelmingly men that were mentioned. This matches wider sexual violence statistics: 91% of people persecuted for sexual offences are men.[24] Reducing sexism and sexual violence towards medical students will need to address what is driving male violence and misogyny.

Reporting

The survey included a section on reporting of sexual harassment and assault. In this section we found a deep-rooted distrust in reporting processes and disappointment in reporting outcomes. Confidence in the reporting process is one of the most important steps to successfully stop sexism and sexual violence towards medical students.

I feel repercussions for those who exhibit such behaviours are not faced with adequate repercussions. Many have been allowed to continue their medical education despite showing that their attitudes and behaviours that do not align with the GMC Good Medical Practise and that they are a risk to future colleagues and patients.

Do you have confidence that your medical school would adequately manage a future sexual harassment or sexual assault complaint?



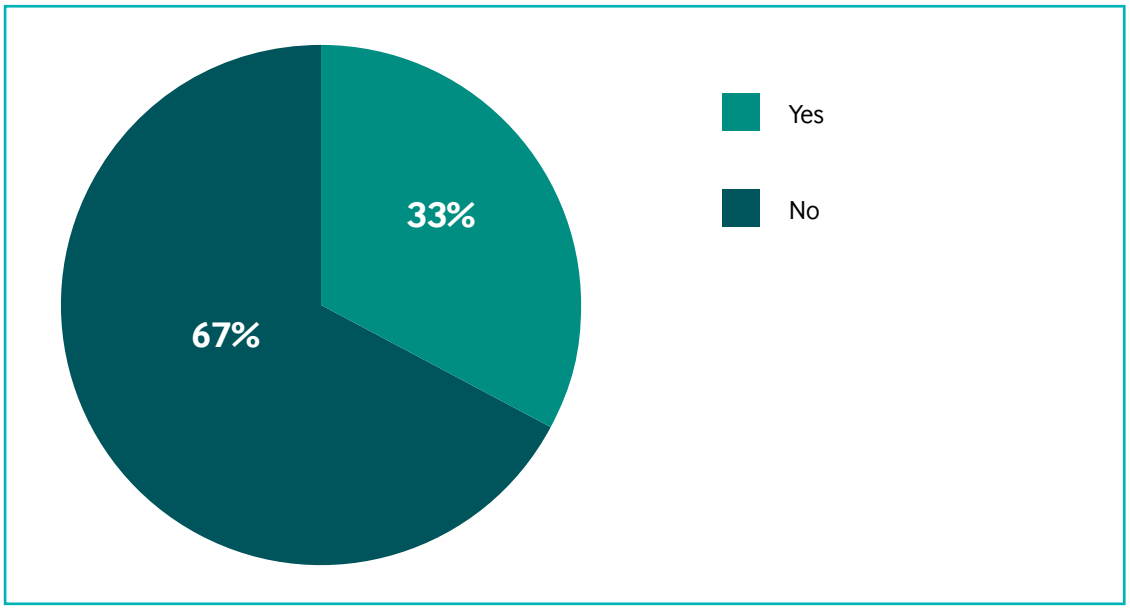
The majority of respondents (60%) did not have confidence that their medical school would adequately manage a future sexual harassment or sexual assault complaint, with only 8% saying they were fully confident.

24 Rape Crisis England and Wales, Rape and sexual assault statistics, webpage accessed November 2025

Personal experiences of reporting

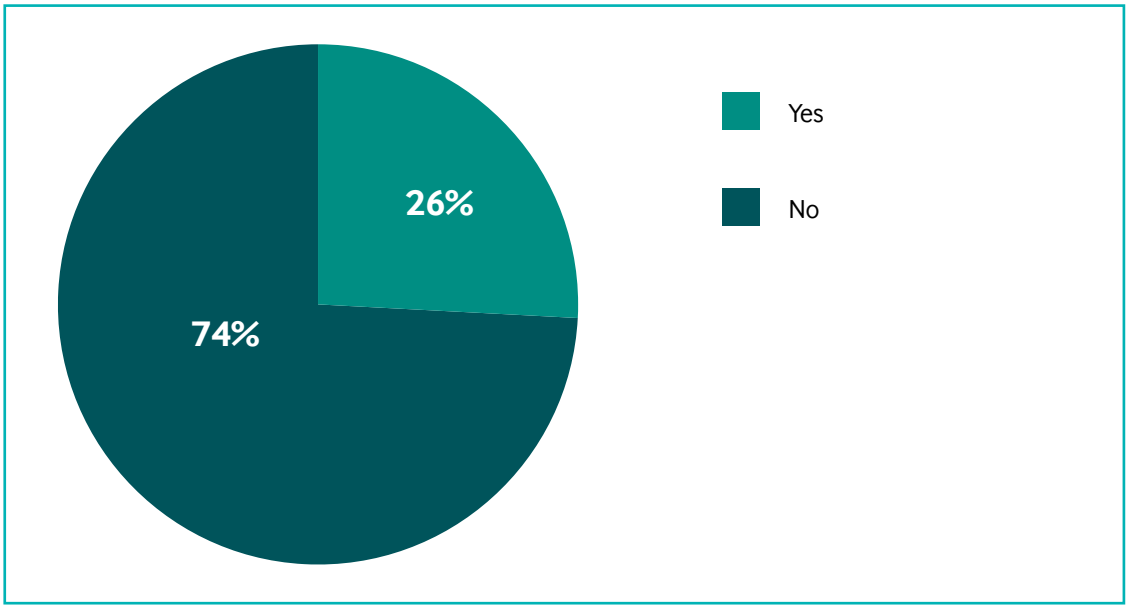
Respondents who had experienced sexual harassment or assault at university, including in social or extracurricular activities, were asked follow-up questions on their experiences of reporting incidents.

Did you report the incident(s) of sexual harassment or sexual assault at university?



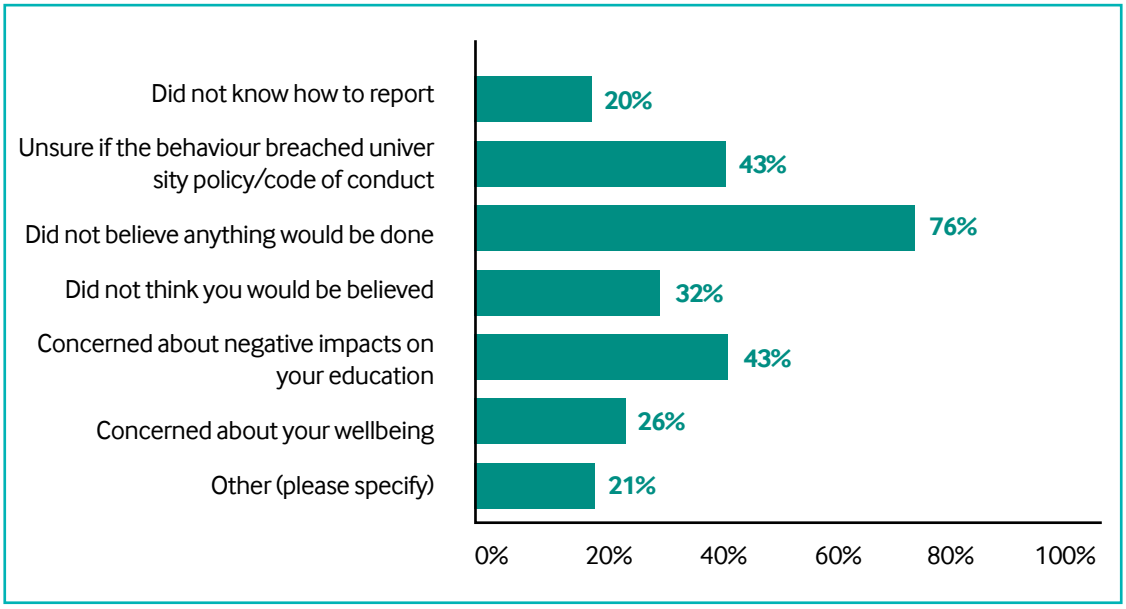
The majority of respondents (67%) said they did not report the incident(s) they experienced to anyone.

Respondents were even less likely to report incidents perpetrated on clinical placements, with 74% choosing not to report.

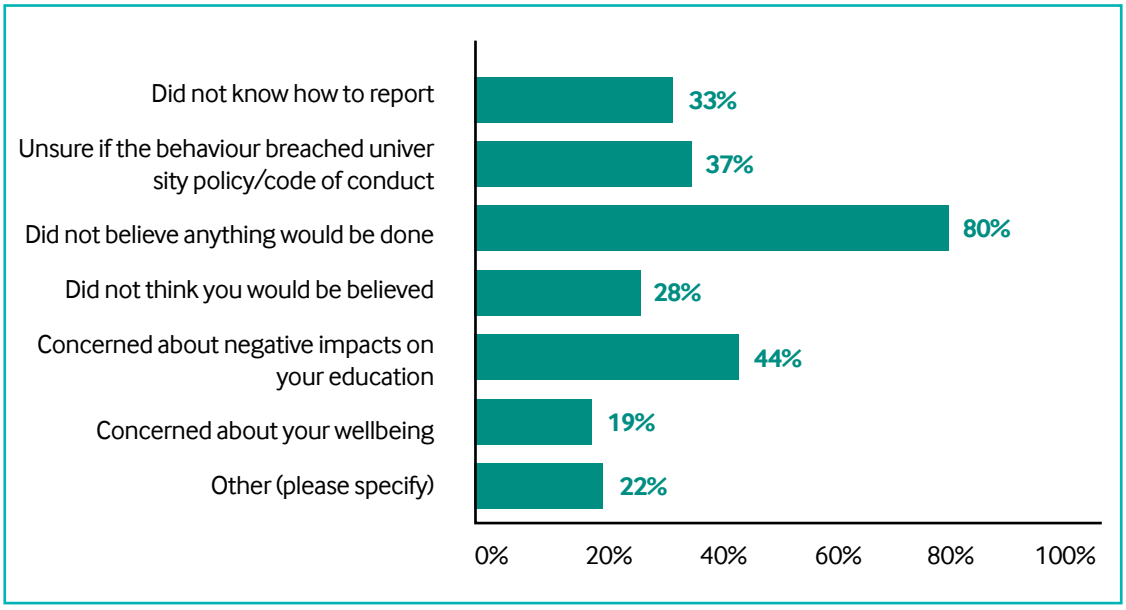


Respondents were asked why they did not report, with the option to select all applicable choices. The following reasons were selected.

Why did you not report the incident(s)? (at university)



Why did you not report the incident(s)? (only clinical placement)



The most frequently given reasons for not reporting incidents on clinical placement aligned with the reasons given when asked about incidents at university. However, when asked about clinical placement a greater percentage of respondents cited not knowing how to report as a factor that deterred them (33%).

> *Clearer guidance on what to do when the perpetrator is a patient would be helpful. The idea of reporting a patient has been a bit tricky for me, as I feel I am in a position where I must serve patients and simply accept that their views can be 'outdated'.*

The most common response was a belief that nothing would be done. This response is understandable when assessing the testimonies that respondents left and the low levels of satisfaction in reporting outcomes. Although not asked directly, multiple respondents shared they had reported an incident(s) but it had not led to action being taken by the university.

Following investigation into several incidents of sexual harassment and violence by a medical student towards other medical students, our medical school has allowed him to return. They have put him on placement in the same hospital as his victims. Another student physically harassed me during my GP placement. Following a brief argument about pharmacology, he got angry and grabbed my arm despite me telling him to stop several times. I do not feel comfortable reporting this to the medical school as I feel it would not be taken as seriously as it should.

The second most selected reason was concern around negative impacts on career progression (43%). The free-text responses provided further insight into what these concerns may include. As previously mentioned, there is a power imbalance that exists between doctors and medical students in terms of the career opportunities they have access to and how they progress. Another issue that came through the free-text responses was respondents who had been victims of sexism, sexual harassment or assault being told that their own professionalism could be brought into question if they reported an incident.

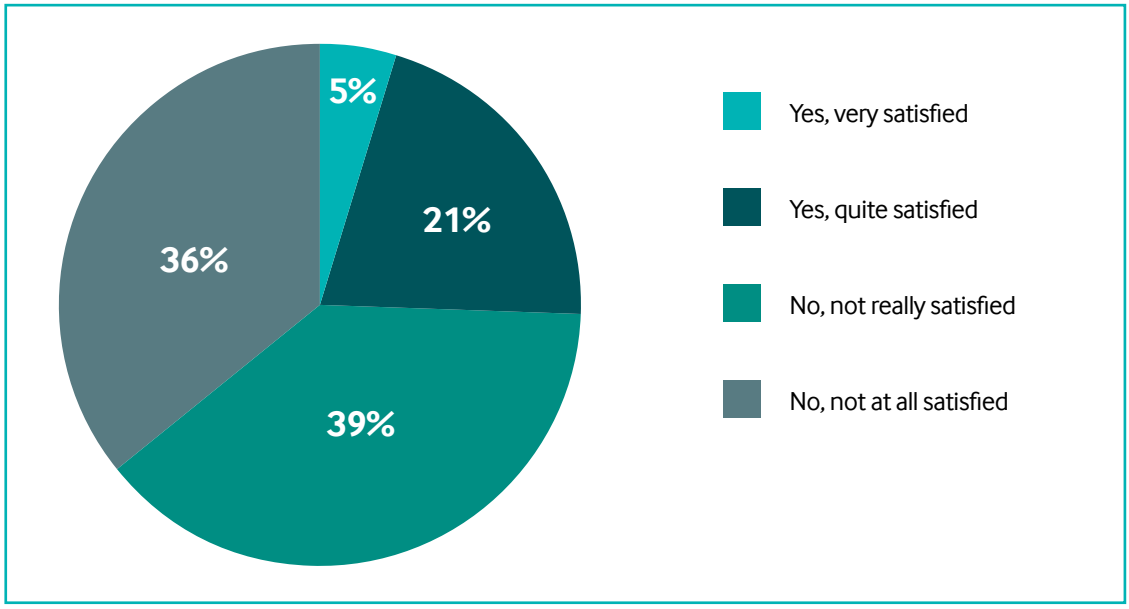
Another issue shared by respondents was that they had been discouraged from reporting and told to ignore incidents.

Respondents who reported incidents of sexual harassment or assault

A staff member constantly makes in appropriate comments to female students. An example of this is when learning how to perform a cardiovascular exam he kept making comments such as preforming the task 'like you would your lover. Starting at the hands and working your way up to the face.' This male staff member made these comments while making eye contact with female students. When we talked to the other staff member in the room about the comments we were told to ignore him.

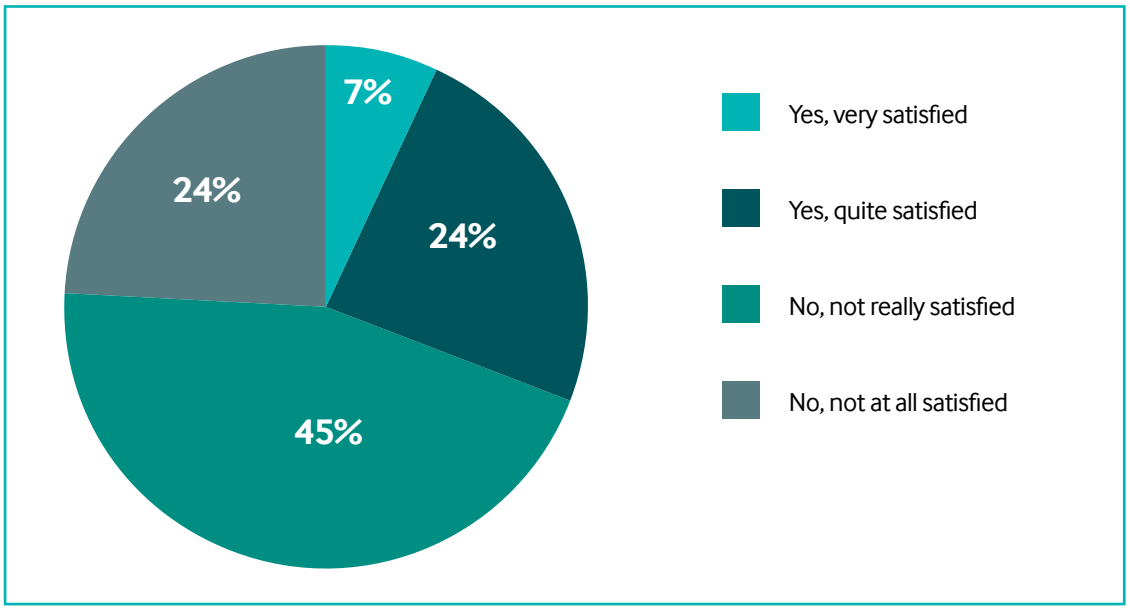
As a man I think we are told to ignore the events that happen to us, to keep them in and not share them. Coming to the realisation that I had been sexually assaulted was incredibly difficult to accept and felt that it diminished my self-esteem and value.

Were you satisfied with the outcome of having reported? (University)



Those who did report were asked if they were satisfied with the outcome. 75% of respondents said they were not really or not at all satisfied with the outcome.

Were you satisfied with the outcome of having reported? (clinical placement)



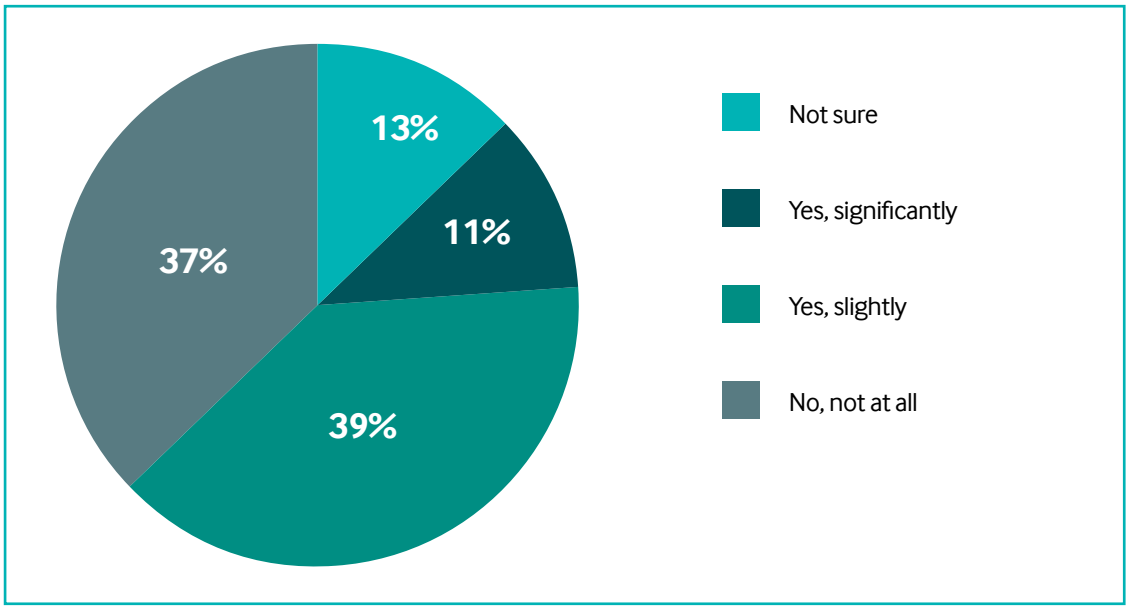
When looking at the question specific to clinical placement, the numbers are also concerning with 69% of respondents saying they were not really or not at all satisfied with the outcome.

While we did not specifically ask free-text questions on reporting, some respondents incorporated details of the reporting process in their testimonies, which provided insight into why satisfaction rates are low. For example, people reporting incidents and not seeing outcomes for perpetrators.

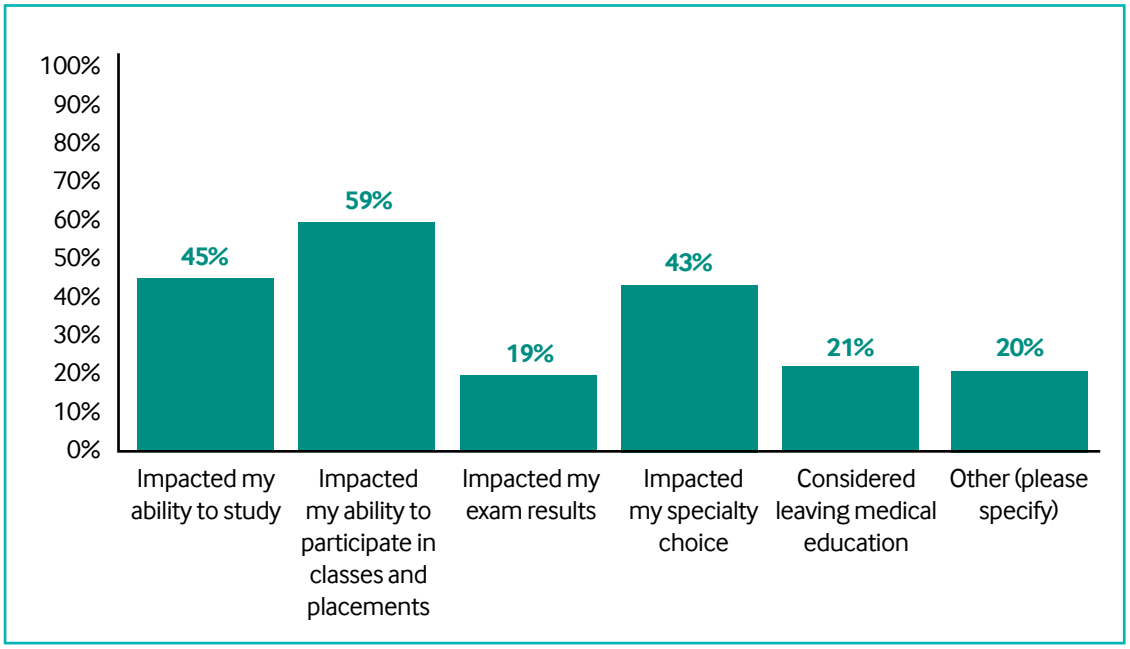
> *Our university allowed a repeated predator who sexual assaulted other students back onto the course. The university also encouraged students who were victimised not to go to the police as it would impact their reputation.*

Impact on education

Has sexism, sexual assault or sexual harassment negatively impacted your education?



In what ways has it impacted you?



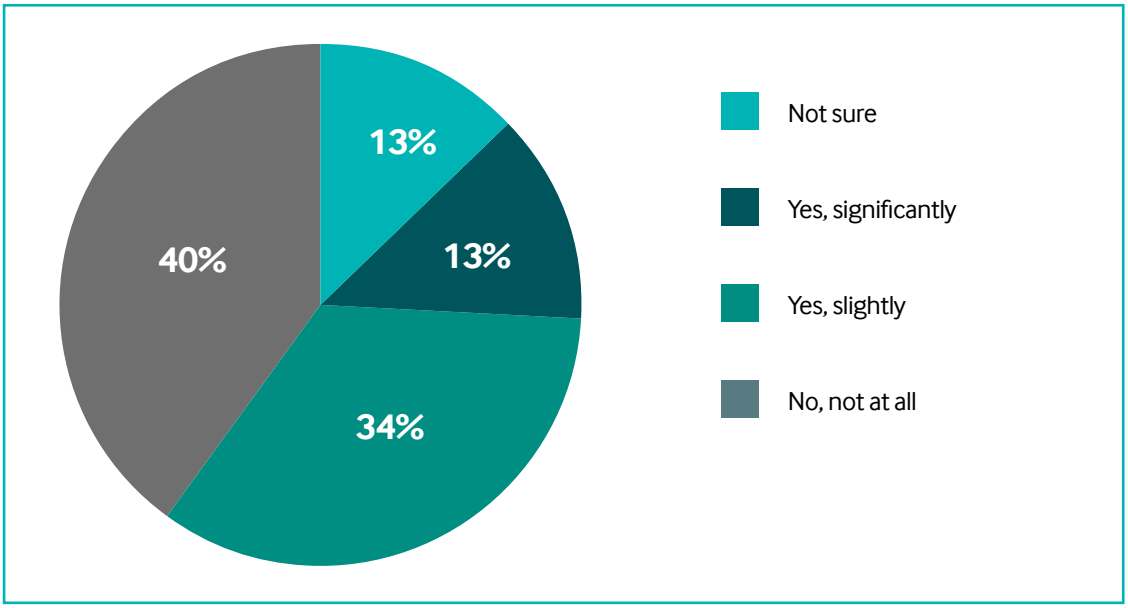
Half of respondents said that sexism, sexual harassment or sexual assault had negatively impacted their education, with 59% of that group saying it had impacted their ability to participate in classes and placements, 45% saying it had impacted their ability to study, and 43% saying that their specialty choice had been impacted.

> *I was scared of going to lectures and team based learning activities or even doing classes in small groups online because the perpetrator was often allocated to my group. It caused a lot of distress and anger because I kept asking to change group and this never happened.*

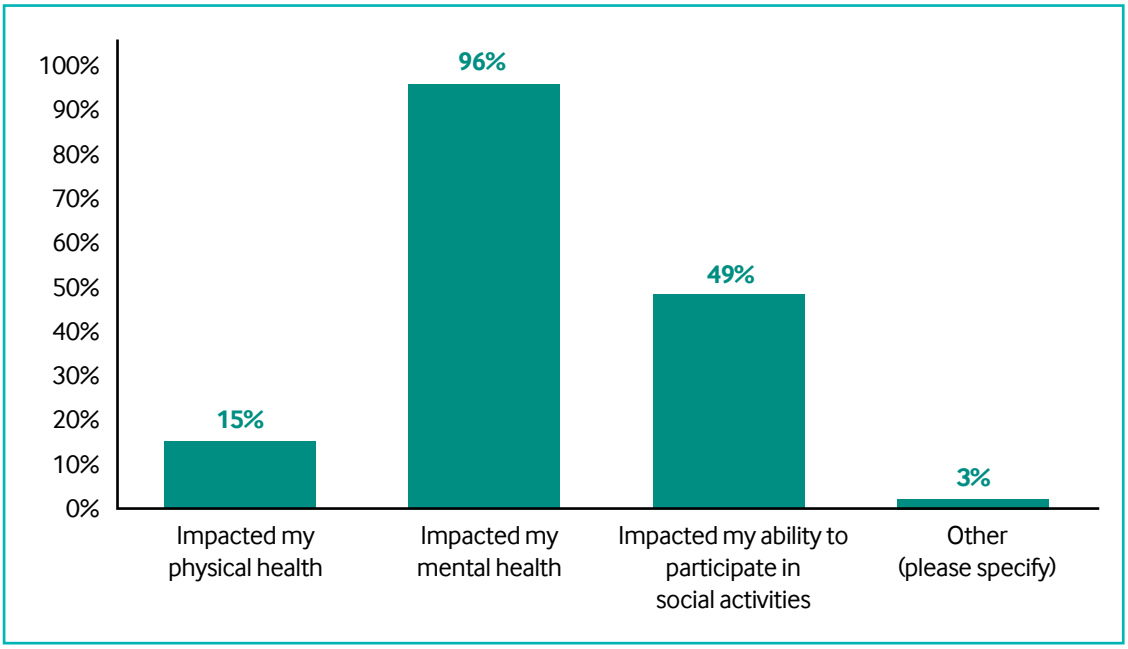
Impact on health and wellbeing

The respondents were asked about the impact that sexism, sexual assault or sexual harassment had on their health and wellbeing.

Has sexism, sexual assault or sexual harassment negatively impacted your health and wellbeing?



In what ways has it impacted you?



Nearly half of respondents said that sexism, sexual assault or sexual harassment had negatively impacted their health and wellbeing. Of this group, 96% said that it had impacted their mental health and nearly half said that it had impacted their ability to participate in social activities.

I was scared to leave the house or go anywhere alone, I was scared to be around him or any of his friends, I was paranoid of everyone and felt sick is anyone touched me, a became very down and socially isolated.

Some respondents shared further detail on the impact that this had on them. This included panic attacks, PTSD and needing therapy. Respondents shared how it impacted their view of the profession and damaged their idea of what pursuing a career path in medicine would look like. Some also shared a feeling of isolation and being excluded from social activities.

I considered leaving medicine altogether. That thought scared me because all I ever wanted to do is become a doctor.

EmilyTest

It is vitally important not to underplay the impact that sexual violence can have and the crucial need to have the right support services available. This was demonstrated in the tragic case of Emily Drouet, an 18-year-old who took her own life after a campaign of abuse from her boyfriend while living in her halls of residence at Aberdeen University. Even after seeking support from the university, she continued to live in the same hall as her abuser.

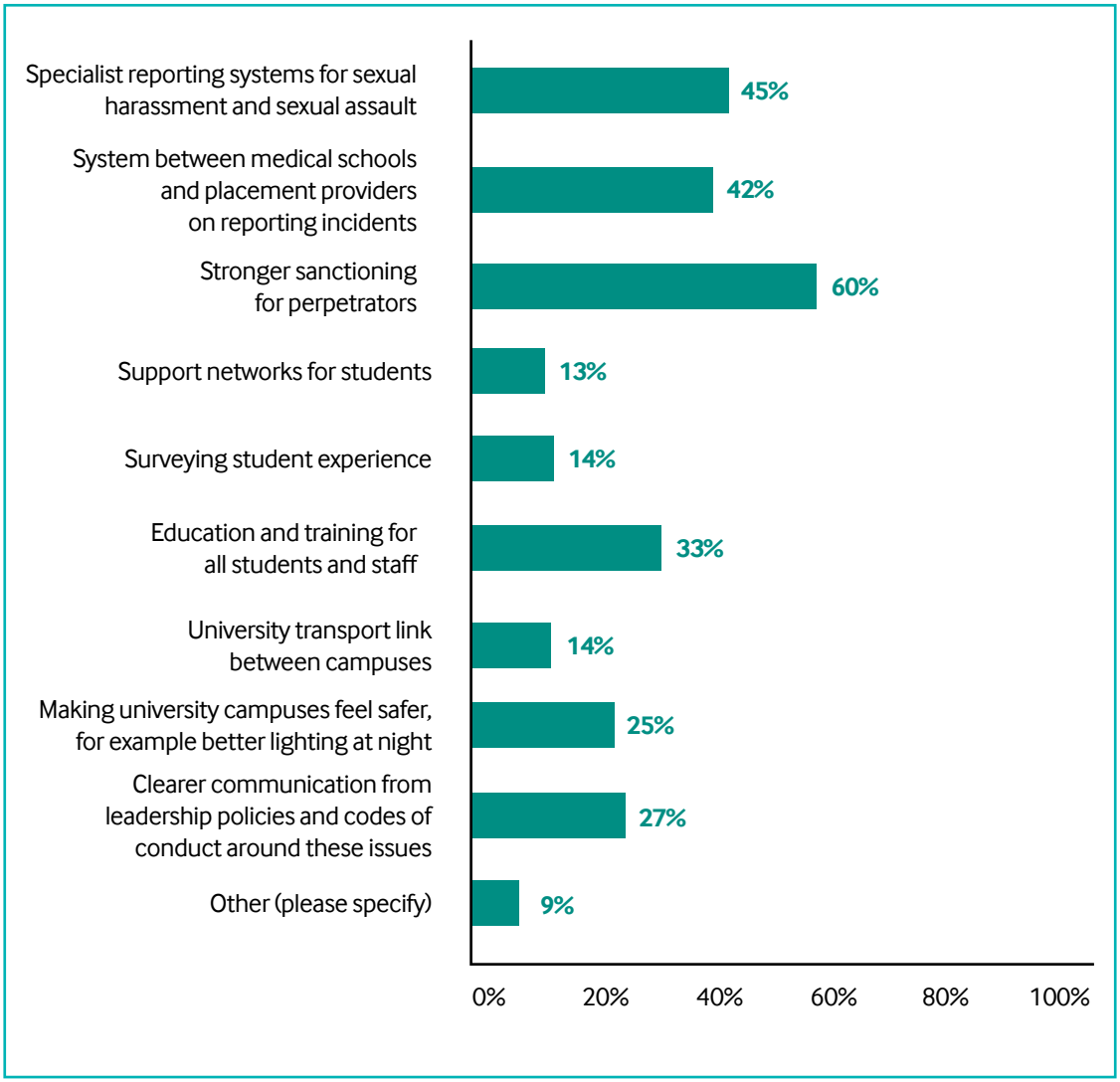
Emily's mother established EmilyTest, a charity that works with universities and colleges to improve gender-based violence prevention, intervention and support services. This has included the launch of the Gender-Based Violence Charter.[25]

25 EmilyTest, EmilyTest, webpage accessed November 2025

Preventative Action

Respondents were asked what they would like to see universities do to prevent sexism and sexual violence, providing a list of options available. They were asked to select three options.

What do you think universities can do to prevent sexism, sexual harassment and sexual assault?



60% said they would like to see stronger sanctioning for perpetrators, 45% said they would like to see a specialist reporting system for sexual harassment and assault, and 42% said they would like to see a system between medical schools and placement providers on reporting incidents.

A specialist reporting system for sexual harassment and sexual assault was a popular option for respondents. Throughout the responses there were requests for anonymous reporting processes on this issue.

My university does not have clear guidance at all in regards to what would happen if we were to face any of these situations, only signposting to leads... If you were to experience this there's no template on what you should do and if you are under increase pressure due to these dire circumstances, how would you know what to do?

A high number of respondents wanted to see a joined-up system between medical schools and placement providers on reporting incidents. Testimonies demonstrate how interlinked incidents are, with medical students ending up in groups on placement with students who they have previously reported for harassment or assault. There were also incidents that took place between students while on placement highlighting the need for the medical school and/or university to be involved in investigation process and resolutions. An interlinking system also has the potential to mitigate some of the power imbalances between doctors and medical students on placement.

Recommendations

Reporting, Investigations and Sanctions

1. Universities must have national robust sanctioning guidelines for sexual violence cases. Sanctions should be sufficiently severe to deter sexual violence from taking place in the future and enforce zero-tolerance for sexual offences.

2. Medical schools must work together to agree consistent and robust sanctioning guidelines for cases of sexual violence that are sufficient to deter this behaviour from taking place. This must include a review of medical school fitness to practise guidance, and ensuring panels are equipped to manage cases of sexual misconduct, preventing weaponisation of these processes to discourage reporting.

3. Medical schools, universities and placement providers should put in place measures to minimise interactions between the complainant and the accused. These measures must prioritise the wellbeing of the complainant, avoid intimidation against them, and prevent any further incidents. This should also include potential interactions on clinical placement.

4. Medical schools must offer students the opportunity to provide feedback after placements to identify areas of concern. This could be done via surveying students.

5. Medical schools, universities and placement providers must link their reporting processes, with agreements over information sharing, the protection of students during and after investigations and timings of processes.

6. Universities, medical schools and placement providers should provide multiple channels for reporting, including anonymous reporting routes, ensuring medical students can confidentially disclose incidents without fear of reprisal and specialist reporting paths for sexual harassment and assault.

7. Experts in sexual violence should be involved in all investigations, ensuring that the decisions are informed by specialist knowledge.

8. Medical students should be informed of their right to a representative in all investigations, including clinical placements. Trade unions, including the BMA, should always be recognised as suitable representatives.

9. Once an investigation begins, all parties should be provided with timelines for how and when the outcome of the investigation will be communicated. This is applicable whether the investigation is being undertaken by the university, medical school or an employer.

10. If outcomes of investigations result in both/all parties remaining enrolled on the same course, a plan should be developed in consultation with and prioritising the wellbeing of the complainant to minimise interactions. This could include separate accommodation, seminars and examinations.

Education and training – medical students and medical school staff

11. All medical students and medical school staff must receive active bystander training. This ensures everyone is equipped with the necessary skills and understands their responsibility to intervene, challenge and address inappropriate behaviours when they occur.

12. Medical school staff should be given guidance on how to respond appropriately when they witness or are informed about incidents of sexism or sexual violence in any settings.

13. Inductions at university and medical school and should include information on how to report sexism and sexual violence.

14. Medical schools must empower medical students to enter specialties that have notable gender disparities by proactively implementing strategies to dismantle entrenched gender stereotypes and imbalances.

15. All students should be educated on sexism, misogyny, relationships, consent and sexual violence so that they are fully equipped to recognise, challenge and address these behaviours within academic settings, their own social interactions and in their career in the medical profession.

Education and training – clinical placement

16. All medical students should be informed of their rights as both students and future doctors regarding protections from discrimination and harassment from patients in the workplace.

17. Placement providers must give all staff involved in educational supervision guidance on how to respond when they witness or are informed about incidents of sexism or sexual violence. This would include how to respond compassionately, and progress concerns raised by medical students.

18. Inductions on placement should include information on how to report sexism and sexual violence.

19. Clinical placement providers must monitor teaching standards to ensure sexism in teaching does not take place and medical students can access equal opportunities, irrespective of their gender.

Health, wellbeing and sexual safety

20. Universities and medical schools must conduct sexual violence-based risk assessments to ensure their campuses are safe for students and staff. This should include reviewing the safety and security of accommodation.

21. Medical school academic performance policies should adopt a compassionate approach, recognising the profound long-term impact sexual violence has on a student's academic outcomes. Measures may include providing accommodations to attendance requirements, deadline extensions, and opportunities for exam retakes.

22. Specialist health and wellbeing services should be provided during sexual violence investigations, with regular check-ins after the investigation has concluded or a decision has been made by the victim to withdraw from the investigation process.

23. Universities should clearly define and communicate what the expected professional boundaries are in relationships between staff and students.

24. Clinical placement providers must provide a safe and inclusive working environment for all students. This should include enforcing professional boundaries and providing the same protections from sexual harassment and sexual violence to medical students that their staff receive.

Organisational policies and regulations

25. The Government must bring forward legislation that introduces a statutory duty of care on higher education institutions for their students.

26. Higher education institutions must publicly share plans and progress on how they are meeting the Office for Students' requirements for protecting students from sexual misconduct.

27. All medical schools should declare responsibility for ensuring clinical placements are safe and inclusive for their students, incorporating this responsibility into their duty of care.

28. Employers' responsibility for ensuring the safety of students on clinical placements must be clarified.

Conclusion

The survey findings show that medical students are facing gender-based discrimination during their time at university. It can be present in their medical education, their time working in the NHS and in their day-to-day lives.

The number of criminal sexual offences shared by respondents, many of which went unreported, is deeply concerning. There are repeated testimonies tabout incidents where medical schools have chosen not remove students found to have perpetrated these types of behaviours, which led to significant distrust in the system.

The level of sexism in the NHS, previously identified in the BMA's Sexism in Medicine report, is something that medical students are also exposed to while on clinical placements. The tolerance of sexism, particularly when coming from senior doctors and educators, is dangerously normalised and risks future doctors believing this is something that is acceptable in the workplace or is behaviour they are allowed to replicate without repercussions.

A key takeaway from these findings is a lack of responsibility and accountability by some medical schools and universities to provide a safe and fair learning environment for students. Medical schools should provide an education where students are able to participate fully and enjoy their time. Students invest significant resources into their medical education and in return, medical schools and universities should take all steps they can to stop sexism and sexual violence from taking place.

Appendix – Demographic breakdown of responses

Gender identity

Female	714
Male	165
Non-binary	13
Prefer to self-describe	5

Gender – is your gender the same as the sex you were assigned at birth

Yes	2216
No	132
Prefer not to say	98

Sexual orientation

Straight/Heterosexual	583
Gay or Lesbian	59
Bisexual	173
Queer	33
Other	13

Ethnicity

Asian or Asian British – Indian	65
Asian or Asian British – Pakistani	32
Asian or Asian British – Bangladeshi	11
Asian or Asian British – Chinese	16
Any other Asian or Asian British Background	21
Black or Black British – Caribbean	3
Black or Black British – African	36
Any other, Black or Black British group	2
White and Black Caribbean	8
White and Black African	4
White and Asian	24
Any other mixed ethnic group	20
White British	340
White English	101
White Welsh	37
White Northern Irish	16
White Irish	23
Any other White group	93
Arab	8
Any other ethnic group	23

Disability/Long term condition

Disability or long-term health condition	188
No disability or long-term health condition	663
Prefer not to say	49

Religion

No religion	535
Christian	201
Buddhist	5
Hindu	31
Jewish	9
Muslim	67
Sikh	8
Any other religion	6

Age

16-21	319
22-25	459
26-35	109
36-45	11
46-55	1

Medical school location

England	705
Northern Ireland	14
Wales	58
Scotland	120

Year currently completing

First year	153
Second year	115
Third year	165
Fourth year (not penultimate)	49
Penultimate year	222
Final Year	150
Intercalating year	30

BMA
British Medical Association, BMA House, Tavistock Square, London WC1H 9JP
bma.org.uk

BMA 20250745