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Sexual misconduct as an institutional inconvenience: Silence, invisibility and complicity in health sciences in South Africa

Ethical practice in the health sciences – in both clinical environments and academic institutions – is founded on the principles of beneficence, justice and respect for persons, with the goal of first doing no harm. However, for many women and gender-diverse people working and training within clinical and academic medicine, these principles are undermined by experiences of sexual harassment, discrimination, assault and other forms of sexual misconduct. Despite professional codes of conduct and institutional policies, sexual misconduct remains a persistent and largely hidden feature of clinical and academic medicine. Too often, allegations of sexual misconduct are 'managed' as reputational risks and institutional inconveniences, rather than as warning signs of systemic failure. The problem is not simply the behaviour of individual perpetrators; it is the institutional culture that renders misconduct invisible, discourages reporting, and protects institutional reputations rather than the people it is meant to protect who are harmed by such abuse.[1]

Sexual misconduct exists along a continuum of acts, ranging from misogynistic language, undermining the professional authority of women, sexism and sexist discrimination, escalating to unwanted sexual advances, sexual coercion, sexual assault and rape. We use the term sexual misconduct as an umbrella concept encompassing sexual harassment, sexual coercion, sexual assault and related abuses of power, while recognising that sexism and gender discrimination create enabling environments for such misconduct. Women and gender-diverse people working in clinical and academic medicine are particularly vulnerable because of entrenched hierarchies and unequal power relationships.[2] For example, students in all disciplines depend on supervisors for assessment and career progression; junior clinicians rely on senior colleagues for training and references; and early career academics depend on established researchers for mentorship, funding and promotion. These asymmetries create opportunities for exploitation and make disclosure of sexual misconduct exceptionally difficult. Beyond its devastating impact on individuals, sexual misconduct erodes trust within clinical and academic medicine, drives talented clinicians and researchers away from their professions, undermines mentorship and weakens the ethical foundations on which health sciences education and patient care depend.

In South Africa, where gender-based violence has been recognised as a national crisis, health sciences institutions have both ethical and constitutional obligations to provide safe environments for learning and work. To be fair, most universities and healthcare institutions have policies that address sexual harassment. However, these have not necessarily translated into significant protection for the most affected groups, given the reported cases of sexual misconduct that make their way to public media outlets, even before universities report on them. Furthermore, women and gender-diverse people continue to report profound distrust of institutional processes, particularly where organisational climates are perceived as tolerant of harassment or unsupportive of complainants.[3] Fear of retaliation, and concerns about confidentiality, reputational damage and the potential loss of career opportunities remain important barriers to reporting sexual harassment. More importantly, women observe how institutions respond to complaints. Disciplinary processes are frequently perceived as opaque, are slow, and do not offer relief or protection to complainants, while outcomes remain confidential and sanctions may appear inconsistent or disproportionately lenient. When influential perpetrators are protected while complainants bear the professional and emotional consequences of reporting, silence becomes an understandable strategy rather than a personal failing.

Institutional culture is reinforced not only through formal processes but also through daily interactions. Women in leadership positions may, often unintentionally, perpetuate sexual misconduct, embedded within historically male-dominated organisations. Some may distance themselves from junior women, minimise reports of misconduct, or hold female colleagues to higher standards than their male peers – a pattern historically described as the 'Queen Bee' phenomenon.[4] Contemporary evidence suggests that these behaviours are not inherent characteristics of women leaders, but adaptive responses to organisational cultures in which success has traditionally depended on conforming to masculine norms. Increasing the representation of women in leadership is therefore necessary but insufficient, unless accompanied by deliberate efforts to transform the institutional culture.

Perhaps the most troubling manifestation of institutional complicity is the treatment of sexual misconduct as an isolated disciplinary issue, rather than as an ongoing risk to others.[3] Institutions may negotiate settlements, issue minimal sanctions, or allow perpetrators to resume positions of authority after a so-called 'first offence'. Such responses fail to recognise that sexual misconduct is not merely a breach of institutional policy; it represents a breach of professional ethics, a violation of human dignity and a failure to uphold the constitutional right to a safe working and learning environment. Every inadequate institutional response increases the likelihood that future students, trainees and colleagues will be exposed to similar harm.

These risks extend beyond hospitals and university campuses. Conferences, research collaborations and academic travel often occur in environments with reduced institutional oversight, altered professional boundaries and increased dependence of junior researchers on senior colleagues for mentorship, networking opportunities and financial support. Therefore, institutions have a duty of care that extends to all settings in which academic work is undertaken.

Addressing sexual misconduct requires transparent and independent reporting mechanisms, survivor-centred support services, timely investigations and sanctions that prioritise the safety of current and future staff and students.[5] Professional boundaries, trauma-informed responses, bystander intervention and ethical leadership should be integral components of medical and health sciences education, rather than optional training modules. Institutional transparency is equally important. While confidentiality for complainants is essential, institutions must demonstrate that allegations are investigated fairly, consistently and without regard for the status or influence of the accused.

Medicine cannot credibly advocate for the health, dignity and safety of society while failing to protect its own members. Sexual misconduct in clinical and academic medicine is sustained by institutional silence, unequal power and cultures that continue to privilege reputation over accountability. The true measure of an academic institution is not whether it has a sexual harassment policy, but whether all the people who work and train within it believe that they will be protected when they use it.

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1. Christl ME, Pham KT, Rosenthal A, DePrince AP. When institutions harm those who depend on them: A scoping review of institutional betrayal. Trauma Violence Abuse 2024;25(4):2797-2813. https://doi.org/10.1177/15248380241226627
2. Kiguwa P, Nduna M, Mthombeni A, Chauke P, Selebano N, Dlamini N. Half of the picture: Interrogating common sense gendered beliefs surrounding sexual harassment practices in higher education. Agenda 2015;29(3):106-117. http://doi.org/10.1080/10130950.2015.1052678
3. National Academies of Sciences, Engineering, and Medicine. Preventing and addressing retaliation resulting from sexual harassment in academia. Washington, DC: The National Academies Press, 2023. https://doi.org/10.17226/27362
4. Faniko K, Ellemers N, Derks B. The Queen Bee phenomenon in academia 15 years after: Does it still exist, and if so, why? Brit J Soc Psychol 2021;60(2):383-399. https://doi.org/10.1111/bjso.12408
5. Ani JI, Katende-Kyenda LN. Gender-based violence in clinical training: insights into and call for interventions in South African higher education institutions. Soc Health Sci 2026;24(1):19997. https://doi.org/10.25159/2957-3645/19997

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