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Permalink

https://escholarship.org/uc/item/21s0s4p4

Journal

Academic medicine : journal of the Association of American Medical Colleges, 93(12)

ISSN

1040-2446

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Publication Date

2018-12-01

DOI

10.1097/acm.0000000000002302

Peer reviewed

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Sexual Harassment in Medical Schools: The Challenge of Covert Retaliation as a Barrier to Reporting

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Abstract

Although Title IX, the federal law prohibiting sexual harassment in educational institutions, was enacted in 1972, sexual harassment continues to be distressingly common in medical training. In addition, many women who experience sexual harassment do not report their experiences to authorities within the medical school.

In this article, the authors review the literature on the prevalence of sexual harassment in medical schools since Title IX was enacted and on the cultural and legal changes that have occurred during that period that have affected behaviors. These changes include decreased tolerance for harassing behavior; increased legal responsibility assigned to institutions; and a significant increase in the number of female medical students, residents, and faculty. The authors then discuss persisting barriers to reporting sexual harassment, including fears of reprisals and retaliation, especially covert retaliation. They define covert retaliation as vindictive comments made by a person accused of sexual harassment about his or her accuser in a confidential setting, such as a grant review, award selection, or search committee.

The authors conclude by highlighting institutional and organizational approaches to decreasing sexual harassment and overt retaliation, and they propose other approaches to decreasing covert retaliation. These initiatives include encouraging senior faculty members to intervene and file bystander complaints when they witness inappropriate comments or behaviors as well as group reporting when multiple women are harassed by the same person.

Recent news stories have highlighted the widespread prevalence of sexual harassment in employment sectors such as the entertainment industry, journalism, politics, and higher education. Many women and men have reported experiencing harassment, including episodes that occurred decades ago. In this Perspective, we focus on sexual harassment in the context of medical schools and medical training. Medical schools operate within organizational hierarchies where harassment may be disproportionally directed toward vulnerable individuals. These individuals, from an organizational perspective, do not have power, and the reporting of harassment could have long-term, negative effects on their careers. We also describe one significant barrier to reporting harassment, which we call covert retaliation, defined as vindictive comments made by a person accused of sexual harassment about his or her accuser in a confidential setting, such as a grant review, award selection, or search committee.

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Acad Med. 2018;93:1770–1773.
First published online May 22, 2018
doi: 10.1097/ACM.0000000000002302
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Prevalence of Sexual Harassment in Medicine

Sexual harassment is defined as "unwelcome sexual advances, requests for sexual favors, and other verbal or physical conduct of a sexual nature … when this conduct explicitly or implicitly affects an individual's employment, unreasonably interferes with an individual's work performance, or creates an intimidating, hostile, or offensive work environment."[1] Although men can experience sexual harassment, we focus on the sexual harassment of women in heterosexual situations because it is the most commonly reported scenario.

Although Title IX, the federal law prohibiting sexual harassment in educational institutions, was enacted 46 years ago (in 1972),[2] sexual harassment continues to be distressingly common in medical training. In a recent meta-analysis of 51 studies published over a 24-year period (1987–2011), the authors found that more than half (59.4%) of trainees had experienced at least one form of harassment or discrimination during their training, most commonly perpetrated by individuals more senior to them rather than by their peers.[3] Verbal harassment was the most common type, and female trainees were significantly more likely than male trainees to report harassment (mainly sexual).[3] In a more recent study of clinician–researchers who had received K awards between 2006 and 2009, women were more likely than men to report having personally experienced sexual harassment (30% vs. 4%, respectively).[4] While these studies analyzed distinct subgroups of medical professionals, the results suggest that sexual harassment remains prevalent in academic medicine and that gender differences persist. Unfortunately, neither study gave data about how many trainees reported their harassment to their institution.

Changes Since the Implementation of Title IX

Over the last four decades, we have seen anecdotal and statistical evidence of a decrease in sexual harassment in medicine. For example, a 1971 anatomy textbook that included photographs of naked women that were similar to images seen in Playboy centerfolds to illustrate female surface anatomy was quickly

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withdrawn from the market.[5] Next, in response to a 1992 survey of internal medicine residents, 73% of the women reported that they had experienced sexual harassment at least once during their training and that other physicians were usually the perpetrators. One resident described an experience in medical school when, during a performance evaluation, an attending physician asked if she had seen the movie *Deep Throat* while he ran his tongue around his lips.[6] In comparison, in response to a 2001–2002 survey of graduating medical students, a smaller percentage of the female respondents (60%) reported firsthand experience of sexual harassment during medical school. They described incidents such as stereotypical comments; sexual overtures; offensive, embarrassing, or sexually explicit remarks; and inappropriate touching. One female medical student wrote about a male urologist who commented on the genitalia of his male patient: "Doesn't this penis look great? How many penises have you seen? No one is allowed to have a penis bigger than mine."[7]

Even though such egregious examples of sexual harassment in medical training are less likely to occur today than even a decade ago, there is still evidence of ongoing harassment. In response to the Association of American Medical Colleges' 2017 Medical School Graduation Questionnaire, which surveyed graduating medical students at 140 medical schools, 14.8% of students reported that they had been subjected to offensive sexist remarks or names at least once, and 4.3% reported unwanted sexual advances.[8] In considering especially egregious behavior, 0.3% said that they were asked to exchange sexual favors for grades or other awards.

Since Title IX was enacted in 1972, there has been a gradual culture change in medical training as well as in society in general. Offensive behavior and comments are not as readily tolerated. In the field of higher education, administrators and faculty are very concerned about the welfare of students and faculty, and programs are being developed to promote well-being and prevent burnout. The laws also have changed and have clarified the consequences to institutions if sexual harassment occurs. For example, in 1986, the U.S. Supreme Court ruled that employers were responsible for the acts of their employees, even if they did not know about the harassment.[9] In addition, there are many more female medical students, residents, and faculty members, and they make up an increasing percentage of physicians at all levels. In 1980, 23.3% of medical students were women. In 2017, that percentage rose to 50.7%.[10,11] Today, medical schools offer continuing education about unconscious bias and microaggressions with the intent of increasing awareness and decreasing comments and behavior that make individuals feel devalued. Schools also emphasize sexual harassment prevention training and increased reporting of incidents that do occur.

Barriers to Reporting Sexual Harassment

Barriers to reporting sexual harassment include a fear of not being believed, embarrassment if peers learn of the harassment, a lack of trust in those who are in positions of authority, and a belief that these behaviors are a necessary part of becoming a physician.[3] A recent report described female physicians who had been harassed and remained silent because they questioned their self-worth after their experiences and wondered whether they brought it on themselves. They also feared being labeled as troublemakers.[12]

According to the Association of American Medical Colleges' 2017 Medical School Graduation Questionnaire, only 21% of the students who had experienced harassment or other offensive behaviors reported these incidents to faculty members or medical school administrators. Among the subgroup who said that they experienced offensive behaviors, 28% said they did not report the incident because of a fear of reprisal.[8]

Equal employment opportunity laws specify that retaliation for filing a complaint is prohibited. When women report sexual harassment, they are told that retaliation is against the law.[1] Alleged perpetrators are also warned against retaliation and told that they will be disciplined if they retaliate against their accuser(s). In an attempt to address retaliation concerns, many institutions have engaged in focused efforts to increase awareness of sexual harassment and sexual violence prevention resources, including requiring sexual harassment prevention training and having reporting mechanisms that include anonymous whistleblower complaints.

At our medical school, the University of California, San Francisco, School of Medicine, the Sexual Violence and Sexual Harassment policy prohibits harassment and identifies resources for reporting.[13] The policy also states:

> Any person may make a report, including anonymously, of Prohibited Conduct to the Title IX Officer, or to any Responsible Employee, or to another appropriate office such as the Academic Personnel Office, Student Affairs, Office of the Provost, or to the Human Resources Office. The report shall be sent forward to the Title IX Officer. (V.A.1)
>
> Individuals making reports shall be informed about: confidentiality of reports, including when reports cannot be kept confidential. (V.A.3.a)[13]

Medical schools have a responsibility to proactively prevent sexual harassment. They do this by requiring all supervising faculty to participate in educational modules and by investigating allegations of sexual harassment. During and after the investigation, it is critical to protect the complainant from continued harassment.[14] When complaints of sexual harassment are made at our institution, the person who makes the report is referred to the Title IX office. There, specially trained investigators have knowledge of the law as well as of the investigation process. These investigators may try to resolve the complaint using mediation, separating the parties, and/or conducting educational programs. The Title IX office also may determine that a formal investigation is warranted. If a person is found to have engaged in inappropriate behavior, discipline is imposed by the institution.

The practice of encouraging anonymous reports has been recommended as a strategy to prevent retaliation.[15] However, in cases requiring a formal investigation, it is important to ensure due process for the accused. There may be false allegations, and faculty need to be able to defend themselves against allegations that could end their careers. The rights of all parties need to be preserved.[14,15]

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Fear of Covert Retaliation

Despite legal and organizational reassurances, a fear of retaliation, especially covert retaliation, remains an ongoing barrier to reporting sexual harassment. The phenomenon of covert retaliation is exemplified by a junior female faculty member who consulted us, in our roles in the Office of Academic Affairs, about a senior physician who had groped her under the table during educational sessions. She wanted to know her rights for being transferred to another work location, but she refused to name the perpetrator and did not want to make a report to the Title IX office out of concern that reporting the incident would have negative consequences for her career.

She intended to pursue an academic career and was afraid of offending the perpetrator. She was less concerned about overt retaliation, such as receiving a bad peer evaluation, because she believed the medical school would be able to protect her and she would know that the evaluation had come from the perpetrator. However, she was more concerned about future problems that might impact her career advancement. For example, the perpetrator might be on a study section and could say something negative about her grant application. Even a minor comment about the value of her research could result in her grant application not being approved. She asked: "What if 10 years from now I am a candidate for a competitive award and this prominent professor is on the committee? The deliberations are confidential, but he could make a subtle comment, such as, 'I heard there were some issues with her in the past.'" She was concerned that even subtle comments or questions could prompt the committee to give the competitive award to another candidate.

In addition, if she ever applied for a competitive academic position, she feared that he would be consulted confidentially by the search committee and that he would make a negative comment about her that would doom her application. Even if none of these events occurred, the female faculty member said that she would always be worried that some form of covert retaliation could happen and that she would never find out about it.

Strategies to Decrease Harassment and Retaliation

Culture change at the medical school level often begins with public declarations of zero tolerance for harassment. These types of statements likely will contribute to continued reductions in instances of harassment. In addition, mandatory sexual harassment training programs, which explain the definitions of harassment, legal prohibitions, reporting obligations, and consequences to the victim and perpetrator, probably will result in further decreases.

In addition, several professional organizations have developed strategies for decreasing sexual harassment. The Royal Australasian College of Surgeons developed a code of conduct prohibiting the sexual harassment of other health care professionals and trainees and imposed sanctions for breaching that code.[16] The American Astronomical Society introduced an Astronomy Allies program consisting of astronomers who can be contacted in person or via text or tweet if someone finds themself in a vulnerable situation at a professional meeting. The Allies wear prominent buttons so they can be identified easily.[17] In addition, the American Association for the Advancement of Science approved a code of conduct that states that individuals who engage in inappropriate conduct can be removed from a meeting and barred from future meetings.[18] The National Science Foundation announced that it may terminate funding to grantees who engage in sexual harassment.[19] Further research is needed to determine which approaches are most successful in deterring sexual harassment.

Despite widespread attention and a range of institutional and organizational approaches to prevention and intervention, our personal experience is that students, residents, and junior faculty still fear covert retaliation if they report instances of harassment. So, we propose two initiatives that may make a difference toward decreasing the threat of covert retaliation.

First, we should encourage senior faculty to intervene when they are aware of harassing comments or behavior. It is critical to enlist senior faculty because the impact of their observations and interventions is amplified by their stature in the academic hierarchy. When a senior faculty member points out offensive behavior and/or comments, she or he serves as a role model for other faculty, staff, and trainees. When a senior faculty member witnesses inappropriate behavior, she or he may file a third-party or bystander complaint based on those firsthand observations, which may protect the more vulnerable trainee. As has been suggested by others, institutions should provide training on this type of bystander reporting.[14]

Second, in cases that involve multiple victims and observers of sexually inappropriate behavior, we recommend that all individuals lodge a complaint. The perception of safety in numbers may encourage reporting when complainants are worried about retaliation. If there are multiple complainants reporting as a group, it is less likely that one person will be targeted as the individual responsible for any negative consequences to the perpetrator.

In conclusion, while the fear of retaliation may continue to be a barrier to reporting sexual harassment, efforts by medical schools to increase awareness, offer mandatory trainings, specify clear mechanisms for reporting, and carry out consistent institutional responses may serve to further reduce future incidents of sexual harassment and sexual violence. The increased visibility in the media of sexual harassment cases may prompt public discussion of this issue in medical schools, providing an opportunity to clarify expectations regarding behavior and encouraging those affected by sexual harassment to come forward.

Funding/Support: None reported.

Other disclosures: None reported.

Ethical approval: Reported as not applicable.

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