It Is Time for Zero Tolerance for Sexual Harassment in Academic Medicine

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Abstract

While more women are in leadership positions in academic medicine now than ever before in U.S. history, evidence from recent surveys of women and graduating medical students demonstrates that sexual harassment continues in academic health centers. Academic medicine's ability to change its culture is hampered by victims' fear of reporting episodes of harassment, which is largely due to fear of retaliation. In this Perspective, the authors describe efforts in scientific societies to address the issue of sexual harassment and to begin to establish safe environments at national meetings. The authors contend that each institution must work to make it safe for individuals to come forward, to provide training for victims and for bystanders, and to abolish "locker room" talk that is demeaning to women.

While women in leadership positions in academic medicine are still in the minority and women still have a long way to go to reach full parity, more women hold roles as professors, department chairs, and chief executive officers than ever before in U.S. history. Despite these successes, sexual assault and sexual harassment of women continue to occur at all levels in academic medicine. It must stop.

Here, we provide information on the incidence of harassment, reporting, vulnerable populations, and the efforts of some societies to curb sexual harassment and assault. We also provide recommendations for leaders to implement at the institutional level.

The Incidence and Reporting of Sexual Harassment and Assault

Of 953 female faculty members surveyed in 1995, 52% reported that they had personally experienced sexual harassment; in contrast, only 5% of 1,010 men reported harassment.[1] Forty-eight percent of the women reported sexist remarks or behavior, and 27% reported unwanted sexual advances.[1] More recently, a survey of National Institutes of Health K award recipients showed that 30% of women described experiencing sexual harassment—defined as "unwanted sexual comments, attention, or advances by a superior or colleague"—in their professional careers.[2] Of the 150 women who reported harassment, 92% reported sexist remarks or behavior, 41% unwanted sexual advances, 9% coercive advances, 6% subtle bribery to engage in sexual behavior, and 1% threats to engage in sexual behavior.[2] Medical students and residents are also affected by these behaviors. The authors of a 2014 meta-analysis of 35 studies found that a mean prevalence of 33.1% of students and residents reported experiencing sexual harassment.[3] Also, according to the 2016 Association of American Medical College (AAMC) Graduation Questionnaire (GQ), 3.8% of 13,897 students reported experiencing unwanted sexual advances, 12.9% had been subjected to offensive sexist remarks or names, and 0.2% experienced requests for sexual favors in exchange for grades or other awards.[4] While 0.2% may seem like a small number, the number should be zero. Also concerning is that these numbers have changed very little since 2012 when the AAMC first added questions about sexual harassment to the GQ.

The GQ also asks respondents whether they report unwanted sexual advances, sexist remarks, requests for sexual favors in exchange for grades or privileges, public humiliation, physical harm, gender-based treatment, and other behaviors, to medical school administrators. Only 20% of those experiencing such conduct reported the behavior, and of these only 42.1% were "satisfied" or "very satisfied" with the outcome of having reported the behavior.[4] These sobering numbers underscore a significant gap: If less than 43% of individuals are satisfied with the outcome of reporting sexual harassment, and only 20% are even reported, then less than 10% of harassment events are addressed in a way that is helpful to the victim.

Sexual Harassment, Vulnerable Populations, and Fear of Reprisal

Sexual harassment is often perpetrated upon vulnerable populations. That is obvious when the victims are children or patients. Vulnerable targets may be less obvious in the workplace, but harassment in academic health centers (AHCs) does occur and is deeply problematic. Medical students, residents, fellows and other postdocs, and junior faculty are all in vulnerable positions. They are dependent on recommendation letters and evaluations to advance to the next stage of training, and to access new opportunities in their careers, including mentors for career development awards. Also, those in more junior positions often depend on those of higher ranks

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to include them in projects, introduce them to colleagues in professional networks, share authorship on relevant scholarship, and provide information on other beneficial, career-advancing opportunities. The power differential leads to a real and justified fear of retaliation that might undermine many years of work and might threaten careers. As a consequence, many women stay silent. According to the 2016 AAMC GQ, 27% of all students who had not reported serious behaviors, including but not limited to sexual harassment, named fear of reprisal as a reason they remained silent.[4]

We have heard of other examples of professional women who have experienced sexual harassment and have actually been encouraged to stay silent. A particularly egregious case occurred in 2015 in Australia. A female surgeon named Gabrielle McMillan—ironically, on a book tour to promote her book *Pathways to Gender Equality: The Role of Merit and Quotas*—commented:

> What I tell my trainees is that, if you are approached for sex, probably the safest thing to do in terms of your career is to comply with the request. The worst thing you could possibly do is to complain to the supervising body, because then, as in Caroline's position, you can be sure that you will never be appointed to a major public hospital.[5]

This case exploded in the Australian media and prompted a major effort of the Royal Australasian College of Surgeons (RACS) to address the issues of sexual harassment and work to change the climate for women. Their 2015 action plan, "Building Respect, Improving Patient Safety," outlines policies and procedures to address discrimination, bullying, and sexual harassment.[6] The plan focuses on cultural change and leadership; emphasizes trainee education; and introduces a complaints management system that is transparent, robust, and fair.

Groundbreaking Policies, Risks, and Next Steps

The American Astronomical Society (AAS) reacted similarly to news that Geoff Marcy, a renowned Berkeley faculty member, resigned because of allegations of sexually harassing women, including graduate students.[7] Their new policies attempt to address the problem of retaliation at national meetings, stating that "harassment, sexual or otherwise, is a form of misconduct that undermines the integrity of Society meetings."[8] They advise that any person who experiences such harassment should report it to a society officer, and they explicitly ban retaliation. The AAS also provides a list of informal emergency allies who can be texted to meet a woman at an AAS conference who finds herself in a vulnerable situation. To prevent any risk of retaliation, the ally escorts the vulnerable person away to what the ally describes as a preexisting obligation, without calling attention to the situation. In October 2015, the American Association for the Advancement of Science (AAAS), like the AAS, approved a new code of conduct with specific language about harassment.[9] The code specifically notes that the association reserves the rights both to remove individuals from the annual meeting and to prohibit future attendance.

These efforts in professional societies are laudable. The RACS is working to change the culture in the entire surgical field. The efforts of the AAS and the AAAS recognize that bad behavior has occurred at national meetings in the past, but should be prohibited in the future. That said, offenders are employed by institutions, and the employing school or hospital must also take action. While the outcomes of harassment cases should not affect finances, many of those accused of harassment are senior faculty who contribute substantially to the bottom lines of their institutions through patient care revenues and/or grant support. Importantly, we believe that institutions should not sacrifice a safe culture for money.

Perhaps the greatest fear is that in the eagerness to end harassment, academic medicine may create a system in which the innocent can be accused, and their reputations sullied by an unsubstantiated, false claim. The problem of false accusations filed against innocent individuals is real and difficult; thus, there is a critical need for a fair process for all. Those in the academic medicine community must be careful to address all claims of harassment with gravity and through due process. We must fully investigate reports, document patterns of behavior, and censure sexual harassment and related offenses while simultaneously changing the culture to prevent such offenses in the future.

We recommend the following as first steps:

1. Institutions must develop mechanisms that encourage victims to come forward without fear of retaliation from their harasser. All educational institutions are mandated under Title IX to investigate formal complaints of harassment, but institutions can also work to develop mechanisms to mitigate the harassment even for those who are afraid to file formal complaints. This can include interim measures (e.g., separating the parties within the institution) to reduce the impact on victims. Institutions can also provide a mechanism to detect recurrent patterns of behavior by specific individuals over time, even when victims are unwilling to file a formal complaint that would trigger a formal investigation. As it becomes clear that victims can report harassment without having their report shared with the harasser, we hope that fear of reporting will diminish.
2. Training for all must be mandatory at all institutions. The inclusion of information on reporting or intervention by bystanders will hopefully help to change the culture. Best practice approaches to reach those resistant to training should be developed and disseminated.
3. Sexual harassment cannot be tolerated. Those who are found to have committed sexual harassment must be monitored and sanctioned. Sanctions for the most egregious behaviors may include dismissal. While standard human resource practices may prevent full disclosure of reasons for dismissing an employee, we urge those charged with hiring new faculty to engage in due diligence, especially if a candidate seems to have been inexplicitly dismissed from a previous institution. Exploring, to the extent possible, the reason for departure may preclude the hiring of faculty who may sexually harass colleagues or trainees, especially those who engage in such behavior serially. We also encourage hiring committees to check state board websites to ensure that no sanctions

have occurred. The Federation of State Medical Boards should consider a warning mechanism.

4. The academic medicine community must get to a place where no one engages in "locker room talk" (i.e., sexually charged conversations in male-only settings). No form of sexual harassment should ever be accepted in any setting.
5. Professional societies should follow the lead of the AAS, the AAAS, and the RACS by both breaking the silence and addressing harassment during leadership councils and at annual meetings. Policies banning retaliation should be promulgated and enforced.
6. Given the paucity of data on the prevalence and severity of sexual harassment in academic medicine, additional research to characterize the nature of the behavior, the outcomes of investigations, and the success of interventions with harassers would inform practice moving forward.

We hope that the culture at AHCs will continue to evolve so that the "locker room" will never again be invoked as an excuse for sexual misconduct. We must make it safe for all women in academic medicine—from student to professor—to pursue their dreams.

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