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

Carol K. Bates
Harvard Medical School

Reshma Jagsi
University of Michigan - Ann Arbor

Lynn K. Gordon
University of California, Los Angeles

See next page for additional authors

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Authors

Carol K. Bates, Reshma Jagsi, Lynn K. Gordon, Elizabeth Travis, Archana Chatterjee, Marin Gillis, Olivia Means, Linda Chaudron, Rebecca Ganetzky, Martha Gulati, Barbara Fivush, Poonam Sharma, Amelia Grover, Diana Lautenberger, and Terence R. Flotte

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Author: Bates Carol K. MD; Jagsi Reshma MD, DPhil; Gordon Lynn K. MD, PhD; Travis Elizabeth PhD; Chatterjee Archana MD, PhD; Gillis Marin PhD, LpH; Means Olivia; Chaudron Linda MD; Ganetzky Rebecca MD; Gulati Martha MD; Fivush Barbara MD; Sharma Poonam MBBS; Grover Amelia MD; Lautenberger Diana MA; Flotte Terence R. MD

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**IT IS TIME FOR ZERO TOLERANCE FOR SEXUAL HARASSMENT IN
ACADEMIC MEDICINE**

Carol K. Bates, MD, Reshma Jagsi, MD, DPhil, Lynn K. Gordon, MD, PhD, Elizabeth Travis, PhD, Archana Chatterjee, MD, PhD, Marin Gillis, PhD, LpH, Olivia Means, Linda Chaudron, MD, Rebecca Ganetzky, MD, Martha Gulati, MD, Barbara Fivush, MD, Poonam Sharma, MBBS, Amelia Grover, MD, Diana Lautenberger MA, and Terence R. Flotte, MD

Dr. Bates is associate dean for faculty affairs and associate professor of medicine, Harvard Medical School, Boston, Massachusetts.

Dr. Jagsi is professor and deputy chair, Department of Radiation Oncology, University of Michigan Medical School, Ann Arbor, Michigan.

Dr. Gordon is senior associate dean, Diversity Affairs, and professor of ophthalmology, David Geffen School of Medicine at UCLA, Los Angeles, California.

Dr. Travis is associate vice president, Women and Minority Faculty Inclusion, and professor, Department of Experimental Radiation Oncology, University of Texas MD Anderson Cancer Center, Houston, Texas.

Dr. Chatterjee is professor and chair, Department of Pediatrics, and senior associate dean for faculty development, University of South Dakota Sanford School of Medicine, Sioux Falls, South Dakota.

Dr. Gillis is professor, chief of division, and director of faculty advancement, Department of Humanities, Health, and Society, Herbert Wertheim

College of Medicine, Florida International University, Miami, Florida.

Olivia Means is a medical student at the University of South Alabama College of Medicine, Mobile, Alabama

Dr. Chaudron is professor of psychiatry, pediatrics, and obstetrics and gynecology and associate vice president and senior associate dean for inclusion and culture development at the University of Rochester School of Medicine and Dentistry, Rochester, New York.

Dr. Ganetzky is an attending physician in the Mitochondrial Disease Clinical Center at Children's Hospital of Philadelphia, Philadelphia, Pennsylvania.

Dr. Gulati is professor of medicine and chief of cardiology, University of Arizona, Phoenix, Arizona.

Dr. Fivush is associate dean for women in science and medicine and professor of pediatrics, Johns Hopkins University School of Medicine, Baltimore, Maryland.

Dr. Sharma is professor and chair, Department of Pathology, Creighton University School of Medicine and CHI Health, Omaha, Nebraska.

Dr. Grover is associate professor of surgery, Surgical Oncology, VCU Health, Richmond, Virginia.

Diana Lautenberger is director, Women in Medicine and Science, Association of American Medical Colleges, Washington, DC.

Dr. Flotte is Dean of the School of Medicine, Provost and Executive Deputy Chancellor, and The Celia and Isaac Haidak Professor of Medical Education, University of Massachusetts, Worcester, Massachusetts.

Corresponding author: Carol K. Bates, MD, Associate Dean for Faculty Affairs., 25 Shattuck Street, Gordon Hall, Suite 206, Boston, MA 02115, 617-432-1165 , Fax 617-734-4382, Carol_Bates@hms.harvard.edu

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Previous presentations: Our GWIMS group sponsored a related session on Sexual Harassment in Academic Medicine at the 2016 Learn Serve Lead Meeting of the AAMC in November 2016 in Seattle, Washington.

Abstract:

While there are more women in leadership positions in academic medicine now than ever before in our history, evidence from recent surveys of women and from graduating medical students demonstrates that sexual harassment continues in our institutions. Our ability to change the culture is hampered by fear of reporting episodes of harassment, which is largely due to fear of retaliation. We describe some efforts in scientific societies that are addressing this and working to establish safe environments at national meetings. We must also work at the level of each institution 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 we have a long way to go to reach full parity, there are more female professors, department chairs, and CEOs than ever before in our history. Despite these successes, sexual assault and sexual harassment of women in medicine continues to occur at all levels in academic medicine. Of 953 female faculty surveyed in 1995, 52% reported that they had personally experienced sexual harassment; in the same survey only 5% of 1,010 men reported harassment¹. 48% of the women reported sexist remarks or behavior; 27% reported unwanted sexual advances. A meta-analysis of 35 studies found a mean prevalence of 33.1% of students and residents reported experiencing sexual harassment². More recently, a survey of national K awardees found that 30% of women described experiencing sexual harassment as defined as “unwanted sexual comments, attention, or advances by a superior or colleague” in their professional careers³. 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. Medical students are also impacted by these behaviors. Surveys of graduating medical students are conducted annually by the Association of American Medical Colleges (AAMC); in the 2016 survey, 3.8% of students reported experiencing unwanted sexual advances⁴. While only 0.2% experienced requests for sexual favors in exchange for grades or other awards, this number should be zero. 12.9% had been subjected to offensive sexist remarks or names. These numbers have changed very little since 2012. When asked if these experiences along with those of public humiliation, physical harm, gender based treatment and other behaviors had been reported to medical school administration, only 20% had reported the

behavior, and only 42.1% were satisfied or very satisfied with the outcome of having reported the behavior. These sobering numbers underscore a significant gap: if less than 43% of individuals are satisfied with the outcome of reporting sexual harassment, and yet 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 is perpetrated upon vulnerable populations. That is obvious when the victims are children or patients. It can be less obvious in the work place, but is nonetheless deeply problematic. Our students, trainees, post docs and junior faculty are all in vulnerable positions. They are dependent upon recommendation letters and evaluations to advance to the next stage or new opportunities in their careers, and on more senior faculty to serve as mentors for career development awards and often in writing publications. This 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. In the AAMC graduate questionnaire, 27% of all students who had not reported serious behaviors including but not limited to sexual harassment named fear of reprisal as a reason that they remained silent.

We hear of other examples where professional women who have experienced sexual harassment are encouraged to stay silent for fear of retaliation. A particularly egregious example of this occurred in 2015 in Australia, when female surgeon Gabrielle McMillan, on a book tour to promote her book “Pathways to gender equality: The role of merit and quotas” said “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 exploded in the Australian media and prompted a major effort of the Royal Australasian College of Surgeons (RACS) to address this issue and change the climate for women. Their 2015 Action Plan: Building Respect, Improving Patient Safety” outlines policies and procedures to address discrimination, bullying and sexual harassment⁶. The plan focuses on cultural change and leadership, trainee education, and a complaints management system that is transparent, robust and fair.

The American Astronomical Society (AAS) reacted similarly to news that Geoff Marcy, a renowned Berkeley faculty member had resigned because of sexual harassment. 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.”⁽⁷⁾ 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 meeting who finds herself in a vulnerable situation. To prevent any risk of retaliation, the ally then escorts the vulnerable person away to what the senior ally describes as a pre-existing obligation, without calling attention to the situation. In October 2015 the American Association for the Advancement of Science (AAAS) approved a new code of conduct with specific language about harassment⁸. They specifically note that they can both remove individuals from the annual meeting and prohibit future attendance.

These efforts in professional societies are laudable. In the case of the Australian association, the society is working to change the culture in the entire surgical field. The other society efforts recognize that bad behavior can occur at national meetings. That said, these offenders are employed by institutions and will require action by the employing school or hospital. While finances should not affect outcomes in these cases, many of those accused of harassment are senior faculty who contribute substantially to the bottom lines of their institutions through patient care revenues and through grant support. Institutions should not sacrifice a safe culture for money. Perhaps the greatest fear is that in our eagerness to end harassment, we may create a system in which the innocent can be accused—with their reputations sullied by an unsubstantiated and false claim. There is a very real and difficult problem of false accusations filed against innocent individuals, and thus a critical need for a fair process for all. We must be careful to address all claims of harassment with seriousness and through due process and to avoid dismissing claims because an occasional false accusation might occur. We must fully investigate reports and document patterns of behavior, 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 problem for those who are afraid to file formal complaints. This can include interim measures to reduce the impact upon 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 allow a formal investigation. As it becomes clear that one can report harassment without sharing that individual's report 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 disseminated.
3. Sexual harassment cannot be tolerated. Those who are found to have committed sexual harassment must be sanctioned and monitored; in the most severe behaviors this would include dismissal. While standard human resource practices may prevent full disclosure of reasons for dismissal, we urge those hiring faculty who seem to have been inexplicably dismissed to engage in due diligence to explore the reason for departure and thus avoid hiring faculty who may engage in

this serial behavior. We also encourage checks of state board web sites to ensure that no sanctions have occurred. The Federation of State Boards should consider a warning mechanism.

4. We must get to a place where no one would engage in “locker room talk” as the concept of any form of sexual harassment would never be accepted in any setting.
5. Our professional societies should follow the lead of the AAS, AAAS and the RACS and both break the silence and address this in leadership councils and in 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 our practice moving forward.

We hope that our culture 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 women in academic medicine, from student to professor, to pursue their dreams.

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