

## Sexual Harassment in Academic Medicine: Persistence, Non-Reporting, and Institutional Response

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**Abstract** - Sexual harassment occurs with regularity during medical training, and it remains largely unreported. This study is one institution's attempt to understand how third and fourth-year medical students perceive and experience sexual harassment, what they believe about reporting sexual harassment, and how they believe it might be eradicated from the educational environment. We used a qualitative research method for our investigation, which would generate more specific language to use in a larger empirical study involving larger numbers of our students. We conducted five focus groups with 24 students, which yielded five categories of response obtained through a close, line-by-line reading of transcribed audiotapes. In addition, we offer four recommendations to medical education researchers, deans of medical schools, and medical school accrediting bodies that may reduce the incidence of sexual harassment of medical students. While we do not make the case that the observations, explanations, and recommendations of these 24 students reflect the opinions of all medical students here or elsewhere, we do propose that they are a snapshot of one medical school's gender climate and offer a valuable foundation for further inquiry.

*"The problem is not . . . that people mistakenly believe the world is just; actually, only the privileged think that. It's that they believe they are powerless."*<sup>1</sup>

*"It's just something you suck up."* – Female M-4 student

The literature tells us with great consistency that sexual harassment occurs with regularity during medical training, that it occurs most often in clinical settings, primarily surgical specialties, and that it remains largely unreported. This literature, which began to emerge with great frequency in domains outside medicine almost a quarter century ago,<sup>2-4</sup> did not appear with any regularity in the academic medicine literature until the late 1980s and early 1990s.<sup>5-8</sup> Since that time, it has been a consistent publication thread in academic medicine<sup>9-13</sup> and can also be found embedded in the literature on medical student abuse.<sup>14, 15</sup>

For example, Nora and colleagues found that 69% of women surveyed at 14 U.S. medical schools had experienced gender discrimination or sexual harassment.<sup>11</sup> Frank, Brogan, and Schiffman<sup>9</sup> conducted the largest survey to date on sexual and gender-based harassment among female physicians and found that 47% of physicians 30-70 years old reported having experienced gender harassment, while 37% had ex-

perienced sexual harassment. Hinze, a medical sociologist, found that 96% of female residents she surveyed had experienced "hostile environment" harassment that ranged from sexist jokes (83%) to unwanted sexual advances (22%).<sup>16</sup> However, in the both the workplace and academic settings, most people who are harassed do not report their experiences.<sup>17-24</sup> This reluctance to report or sometimes even label behaviors as sexual harassment has been called "the silent reaction to sexual harassment."<sup>17</sup>

In spite of its documented ubiquity in academic medicine, investigating one's own environment for evidence of sexual harassment is a difficult task because the perpetrators are one's colleagues. Still, we undertook this study because of a disturbing finding in the AAMC Graduation Questionnaire, i.e. that many female students at the Northeastern Ohio Universities College of Medicine (NEOUCOM) believe that women receive "less attention and respect" than their male peers. We report this local study of how third and fourth-year female medical students perceive and experience sexual harassment and gender discrimination, along with their beliefs about how it might be eradicated from the educational environment, because of its possible usefulness to other institutions who seek to understand and eliminate the same phenomenon in their unique settings.

We chose a qualitative research method for our investigation, which would generate more specific language to use in a larger empirical study involving larger numbers of our students. Below we describe our method, then discuss our findings in light of other sexual harassment research, and offer recommendations for further study of sexual harassment in academic medicine.

## Method

We conducted five focus groups with medical students during the months of May and June, 2004, regarding their experiences and perceptions of sexual harassment and other issues surrounding gender equity during their medical education. Focus groups encourage interaction among participants and provide a forum for addressing sensitive topics. In fact, focus groups explicitly use group interaction as part of the method whereby people are encouraged to talk to one another, ask each other questions, exchange anecdotes, and comment on each others' experiences and points of view.<sup>25</sup> Moreover, focus groups provide a particularly effective forum for addressing sensitive topics and do *not* inhibit response relative to fears of breaches in confidentiality. Kitzinger<sup>25</sup> argues that the opposite may be true, that focus groups can “actively facilitate the discussion of taboo topics because the less inhibited members of the group break the ice for shyer participants. Participants can also provide mutual support in expressing feelings that are common to their group. . . . This is particularly important when researching stigmatized or taboo experiences” (np).

The process began after IRB approval when we recruited volunteers for focus groups from all four classes via e-mail and one paper mailing. We indicated that the graduation survey warranted investigation into gender issues throughout the curriculum, particularly surrounding matters of respect and equity. We assured students that anonymity and confidentiality would be maintained in any documents (internal and external) arising from the study, and that any identifiers linking a particular student to the study would be removed. As a result of these efforts, we scheduled five focus groups with 24 students: 2 M-1s, 4 M-2s, 4 M-3s, 14 M-4s; 6 were male. The fact that far more students from the third and fourth year responded reinforced what we already knew, that sexual harassment occurs most often in clinical settings.<sup>11,12,14</sup> That is, more students at this level had more to say based on experience. In addition, focus groups were organized by class standing (i.e., M-1s in one focus group, M-2s in another, and so on) because of student availability in terms of location

and class schedules. Both authors facilitated focus groups; each has extensive experience in doing so.

Before providing the list of questions used in each focus group, we first offer a brief background of the language we used to construct the questions. After an extensive review of the sexual harassment literature in medical education and other fields (psychology, sociology, organizational behavior, education, management, and women's studies, among others), we chose to use the overarching, inclusive term “sexual harassment” as defined by Louise Fitzgerald, arguably one of the most prolific and respected investigators of sexual harassment in academia, the workplace, and the military.<sup>26-32</sup> The structure of sexual harassment is often broken into three related sets of verbal and nonverbal behaviors: *gender harassment*, *unwanted sexual attention*, and *sexual coercion*.<sup>32</sup> *Gender harassment*—also referred to as gender discrimination by Nora et al.<sup>11</sup>—includes a range of behaviors “generally not aimed at sexual cooperation” that suggest “insulting, hostile, and degrading attitudes about women”;<sup>25</sup> such behaviors also include ignoring or excluding women<sup>33</sup> or other related behaviors indicating that female students are less worthy of their faculty's attention than male students. *Unwanted sexual attention* includes repetitive requests for dates, persistent messages or phone calls, and unwanted physical contact; it is different from sexual coercion because no job- or grade-related losses or advantages are attached. Such unwanted attention is an indicator of a “hostile environment,” a frequently used term in the literature that is a violation of Title VII of the Civil Rights Act of 1964, along with *sexual coercion*, which is the third type of sexual harassment. This third type, also referred to as *quid pro quo*, refers to threats that tie sexual cooperation to some job- or grade-related benefit. Research in the workplace “routinely provide[s] prevalence estimates in the 5-10% range [for sexual coercion], compared to 20-25% for unwanted sexual attention and 50% and higher for gender harassment.”<sup>32</sup>

We asked the following questions in each focus group, emphasizing that this was not a witch hunt but rather an attempt to assess how students experience the environment at NEOUCOM along gender lines:

1. Across all 4 years, do you believe that men and women students at NEOUCOM get the same respect and attention? This includes experiences in labs and lectures; clinical settings; formal and informal interactions with basic science, community health science, and clinical faculty (advising, tutorials, mentoring, and other forms of getting “taken under someone's wings,” etc.). This

also includes experiences with administration and staff at both Rootstown and clinical campuses, along with experiences among peers.

2. Have you personally experienced or observed gender discrimination or sexual harassment while a student at NEOUCOM? Where?
3. What was your response (or those you observed) to such incidents? What should a student's response be to such incidents?
4. What is your understanding of how such incidents are reported? What is your understanding of the consequences of such incidents?
5. What should the institutional response be to documented cases of gender discrimination and sexual harassment?

Focus groups, which averaged 60 minutes, were audiotaped and transcribed after distributing and reviewing the IRB-required Information Sheet (which had already been sent via attachment or enclosure to students) that delineated that confidentiality was expected among participants and that anonymity would be guaranteed in research reports. We each analyzed the transcripts using a close, line-by-line reading, and together found a number of recurring themes, which we discuss below. All words, phrases, and extended descriptions enclosed in quotation marks indicate the exact language students used. We do not make the case that the observations, explanations, and recommendations of these 24 students reflect the opinions of all NEOUCOM students, but we do propose that they are one snapshot of the school's gender climate and offer a valuable foundation for further inquiry.

## Results and Discussion

Regarding the gender climate during students' pre-clinical education, the overwhelming response of all students was positive. They used descriptors such as "treated equally," "equal opportunities," "very, very good experiences," and "really good responses . . . from professors." However, many were able to point out problems areas in both pre-clinical and clinical locations, particularly the latter. NEOUCOM, a community-based state medical school, has partnerships with 17 hospitals with volunteer faculty. Pre-clinical experiences all relate to students' experiences at the basic science campus; clinical experiences take place in those 17 hospitals. The categories of response we uncovered are listed below:

1. **Some female students perceive that they receive less attention or negative attention in selected settings/areas than their male peers.**

**Attitudes toward women/motherhood in medicine:** "I'm terrified about having a baby right now." One female student felt strongly that the medical school environment ignores the concerns of women with families or women who decide to start a family while in medical school, an issue addressed elsewhere in the academic medicine literature.<sup>34, 35</sup> She reported that she had received some "negative comments" from clinical faculty about being married in medical school and especially about having children in medical school.

*. . . they look at you like you're nuts. I've had physicians go as far as saying, "well, why are you going into medicine if you want a family?" I don't think they'd say that to a male student. There's not the support here at NEOUCOM—they don't tell you anything about what [curricular] options you have in terms of, I'm going to have a baby, what are my options? . . . I'm terrified about having a baby right now. It shouldn't be that way. You hear all these comments and you begin to think, maybe they're right, maybe I shouldn't have a family, maybe I can't handle the family and everything else. It's disheartening.*

Several female students noted similar attitudes expressed by clinical faculty, offhand comments made particularly in surgical rotations by clinicians who excuse themselves by disclaimers ("oh you know I am really old fashioned") then go on to proffer disrespectful, sexist commentaries on the careers the very female students before them were planning ("the woman's job is in the home," "my wife takes care of my kids and you know I just don't understand how you can have two doctors in the family").

One M-3 female student pointed out another condescending attitude toward women involving their clinical skills that was sometimes cloaked in humor. For example, when women answer particularly difficult pimping questions or exhibit exemplary knowledge or skills in, say, suturing or tying, "there are some clinical faculty who routinely look at the guys [in the group] and be like 'she's whooping your butt' or 'wow, you better watch out for this girl'." But because such comments are viewed with humor they "get blown off as just a friendly joke but it's just kind of a feeling like there is an underlying sense of you

know, they didn't expect the girls to answer the questions."

**Relationships with nurses: "It's kinda sad but you just compensate."** Consistent with the literature on female nurse-female physician relationships,<sup>36,37</sup> an area of concern expressed by seven M-4 female students was their relationship with nurses. One student stated that "some nurses take charts from you, they don't give you the chart if you're a female. I've seen it and I do watch for it cause, I don't know, maybe it's from going to an all-girls high school, I watch for this. I see it ALL the time." Another spoke of how she'd learned to "compensate" for getting treated differently by nurses because she was a woman:

*"When I need information from a nurse I'll approach her as if I don't know anything so maybe she'll feel bad for me. . . . It's kinda sad but you just compensate. You just want to get your work done. It's not just the [male] attendings that discriminate, it's anyone you can deal with in a hospital."*

Only one M-4 male student (in another focus group) described the same phenomenon, noting that he believed that some nurses "don't treat male and female students equally," with male students having a decided edge in many settings.

**Surgical rotations: "Harder" or "nicer" to female students?** In one focus group, the M-4 women were evenly split on their assessment of how they were treated in surgical rotations. Nora and colleagues<sup>11</sup> found a significantly higher prevalence of sexual harassment in general surgery and OB/GYN than in other specialties. Several female students here thought that they were treated "nicer," one noting that "the majority of the surgeons are males and they . . . don't ask us as hard of questions, they don't expect you to do as much, they don't expect you to protract as long." This interpretation was challenged by others in the group who pointed out that perhaps women aren't pimped as hard or often because they weren't considered "worthy" of the surgeons' attention. Moreover, several women thought that it is more difficult being a woman on surgical rotations because "you just have to work harder and prove yourself more." One recalled disparaging remarks her chief resident made about women in surgery, particularly one of his female surgical colleagues ("nobody respects her, all she does are wimpy breast cases"); he also did "everything he could" to discourage women from going into surgery.

One M-4 male student reported that he received inferior training during his OB/GYN rotation because he was male, particularly surrounding the number of exams he was permitted to do.

## **2. Many women experience unwanted sexual attention in clinical settings.**

Five M-4 and four M-3 female students—nine of the 14 female students with clinical experience—described explicit sexual comments directed at them in clinical settings. All but one said such comments made them very uncomfortable. The language directed at them was coarse, involving their own or patients' bodies, invitations to give or receive oral sex, or jokes about their handling of patients' genitalia. These reports are not unique to this setting; similar descriptions of crude behaviors have been consistent in the literature on sexual harassment in medical education.<sup>5,6,16</sup>

In general, one student remarked, there are "sexual innuendos all the time in surgery." However, one M-3 female student reported a strategy used by a faculty member that she thought was "nice"—when he "asked" female students about their comfort level with sexual talk in the operating room, such as "We tend to have some crazy conversations in here, so what's appropriate for you?" She thought such an approach was very good because "if you don't take the initiative to say 'okay, I don't appreciate that kind of conversation,' it could be directed at you because that is just the kind of way a conversation goes in that setting."

Four M-4 and one M-3 female students—five of the 14 female students with clinical experience—reported being "hit on" in disturbing ways by residents or attendings. One described an intern who "would just not give up" on her, "hanging on" her all the time. Another spoke of an attending who often takes female students to dinner alone; she indicated that "everyone at [hospital] knows about him [and] no one bats an eye." In fact, this student reported being "touched inappropriately [by this physician] in front of at least four other physicians and no one even gave a sideways glance. No one asked if I was bothered, no one said anything."

Another female student was taken to dinner by a preceptor who "then proceeded to proposition [her] for an hour and a half." One woman's experience was more subtle, this time an attending "under the guise of 'Oh we have to review your tape'" asked her

to dinner and acted “kind of flirty,” making her uncomfortable and unsure of what was going on.

### 3. Victims of sexual harassment rarely report it but develop other strategies for dealing with it.

Research on sexual harassment may actually underreport the extent of the problem because many women label only the most serious behaviors as sexual harassment,<sup>38</sup> the other “less serious” behaviors accepted as normative or routine.<sup>16,39</sup> One female M-4 female student at NEOUCOM described her orientation to harassing behaviors that mirrors this perspective, proud of the way she didn’t let inappropriate language affect her:

*“The surgeon I was working with is known to be a pervert because of the comments he makes. During surgery he’s very strict, I was scared that I was going to do something wrong, but like afterwards, he’s like talking to me, brings up comments about porn, about women. . . . I’m okay with discussions like that, I can roll with it. . . . For me, they’re like immature boys “*

Hinze calls this “not sweating the small stuff” orientation a “tactic of resistance” that female residents employ. In her study, residents said that enduring such behaviors was just part of medical training, having moved from being embarrassed by the behaviors to viewing them as “mildly humorous”.<sup>16</sup> Thus, acceptance of mistreatment is passed on from one generation to the next.

Several women downplayed issues related to gender. One M-4 female student spoke energetically about how she was treated like she was “one of the guys,” which made her feel good because she then felt like she was “part of the team. . . . The girls on the team who couldn’t handle that type of talk—it’s like [the team] is more delicate with them and then they’re treated differently.” Another M-4 female student put it this way regarding offensive language: “In terms of guys talking a certain way to girls—they’re talking the same way to guys, so in reality they’re not treating us any differently by saying these things because the surgeons will say the same things to both.” Hinze suggests that by refusing to name sexual harassment women then resist being labeled a victim, or that “acknowledging ‘discomfort’ with hostile environment sexual harassment would make one seem . . . not tough enough to occupy the (formerly male) role of physician”.<sup>16,pp.107</sup> Other research proposes that many women refuse to name

harassment because to admit that one has been harassed is to admit that one is not respected by some colleagues.<sup>40</sup> Yet Vaux suggests a more unfortunate interpretation, that “obnoxious conduct may be accepted because of false consciousness—a failure to recognize one’s victimization because one accepts the world view that justifies it,”<sup>41, pp 125</sup> such as a “boys will be boys” orientation.

### 4. Most students, both male and female, believe that nothing will be done to perpetrators of harassment.

A strong sentiment emerged during all focus groups that reporting harassment is futile and indeed may have repercussions to the student. Some of the comments illustrating this belief include:

- *“What are you going to do? Tell the clerkship director? Then that person is going to be called into his office and that person is going to get slapped on the wrist and then your grade is going to suffer.”*
- *“The belief is that nothing ever gets done if you complain. And the thing is once you complain to the medical school, what is NEOUCOM going to do for something that’s happening at [one of the teaching hospitals]? Nothing. The doctors are still much more important than you are.”*
- *“You think you’ll be penalized for saying anything. Why don’t you ask students if they think the school CARES if people do this? I don’t think the school cares that women—and some men—are not treated fairly.”*
- *“Your grade is on the line and you’re not about to do anything about it. Plus, I was applying to \_\_\_\_\_ at the time and I wasn’t going to open my mouth when I wanted to go to that place. It’s just something you suck up.”*
- *“My whole perspective is that it’s dealt with seriously at first and then like everything else it gets dumped into a bureaucratic system and then gets lost and then nothing ever really changes.”*
- *“I think that the overall consensus is just to keep your mouth shut and don’t rock the boat.”*
- *“Don’t bring it up because it’s going to hurt you in the end, it’s better to stay quiet, not say anything, let it happen, take your grade at the end, be thankful that you passed. . . . Basically it’s just lie down and take it.”*

These comments can be directly linked to literature on non-reporting, which most often includes worries about retaliation, hostility from peers, increased stress, and possible humiliation and ostracism from peers.<sup>42</sup> This literature is consistent with what our students expressed, which includes negative perceptions of reporting policies and no confidence that complaints will be taken seriously and harassers confronted. Adams-Roy and Barling<sup>38</sup> refer to formal and informal organizational justice as relevant concepts to understand if and how harassment targets respond. *Formal* organizational justice is the degree to which an organization “is perceived to have fair and just policies. . . . [how it] would treat a report of sexual harassment.”<sup>38, pp. 330</sup> *Informal* organizational justice “reflects the perceived fairness of the manner in which the sexual harassment policies and procedures are actually enacted or followed.”<sup>38, p. 330</sup> Thus, while most M-3 and M-4 students in our study conceded that there must be formal policies against sexual harassment and that at the start of clerkships there were “blurbs” about what to do (“report it”), their overall belief was that if reports were made, either nothing would happen or there would be negative consequences for the person who reports. In fact, the one person in all the focus groups we conducted who actually did report gender harassment—a male during his third year—said that he was told by the clerkship director just to “look for the good in people.”

Unfortunately, the students we interviewed may have been assessing the consequences of reporting harassment accurately, that is, there is some literature suggesting that reporting may indeed have negative consequences for the person who reports. At best, individuals who report harassment generally have no better results than those who choose not to report,<sup>43</sup> and for some, reporting can actually make the situation worse.<sup>44,45</sup>

##### **5. Some female students blame themselves or make excuses for perpetrators of harassment.**

After observing one of her peers being harassed by a clinician, one M-3 female student blamed herself for not knowing that she too had been a harassment target in a similar situation. She blamed herself for not knowing where to draw the line between “playful talk” and sexual harassment, and for not reporting clinicians who make sexual comments and/or overtures that many, if not most, female students would view as inappropriate. Another M-3 female student explained how one clinician told her in the presence of other students that he didn’t get along with female students, a comment she learned that he had made to other female students previously. Although another

student (a male M-3) notified the clerkship director about this comment, the clerkship director said that he would act (i.e. confront or reprimand the perpetrator) only if a formal sexual harassment report was filed by the female student. She did not file a report because she “did not want to be in the spotlight and . . . didn’t want to be the reason for him to lose a position or whatever. . . . I just think that is the way he is. I don’t think he meant anything really bad by it. He’s just an old-school type of guy. I really didn’t do much but maybe I should have.”

Another M-3 student, the only female in a group of male students and clinicians, was told by her attending in front of the entire group not to wear tight shirts or skirts for her oral exam. This comment was made during a time when “we were all sitting in scrubs so I thought that was a little inappropriate and I just kind of shoved it under the rug and thought okay whatever, maybe he’s just had bad experiences in the past with girls.” Uncomfortable with the comment and for being singled out, she ignored the situation and made an excuse for the clinician, who continued to make sexist comments to her throughout her clerkship. She described how angry and frustrated she was when she thought back on this situation, but also indicated that at the time she did not want to confront this clinician because she didn’t think “it was . . . a big deal, he was just telling me his opinion.” Similarly, another female M-3 decided not to confront a clinical perpetrator because she was “babied” at other times during the clerkship by this same person. “I think it kind of balances out,” she explained.

A strong sentiment existed among many of the female students we interviewed that reporting discrimination or harassment would get the perpetrator in “trouble,” which was problematic for the students. Ambivalence ruled in one focus group comprised of all women who went back and forth describing how on one hand they felt dismissed by a particular professor, but on the other viewed him as a “great professor . . . None of us dislike him, none of us want anything to happen to him.” It may be that gender socialization encourages women to adopt this stance, wherein one is “more likely to emphasize empathy . . . for offenders over confrontation and punishment.”<sup>46, p. 521</sup> In addition, other sociocultural issues determine how women respond to sexual harassment, such as women who hold traditional values surrounding gender roles choosing not to report because of fear of blame and damage to themselves, their families, and their professional reputations.<sup>47</sup> Similarly, other investigators of reporting behaviors suggest that women who label or report sexual harassment violate

cultural norms and expectations for gender roles along with norms for what a trustworthy colleague looks like.<sup>48</sup> Indeed, the culture of medicine socializes early and consistently (for both women and men) that whistle blowing on one's peers is not a professional behavior. Such attitudes, unfortunately, leave offenders unpunished and undeterred.

In addition, not wanting to get offenders "in trouble" may also lead victims to question themselves and their interpretations of harassing behaviors. Hinze found that even in cases when behaviors clearly indicate legal definitions of sexual or gender-based harassment, some women thought they possibly were being too sensitive.<sup>16</sup> One of her study participants identified an offender's comments clearly as "inappropriate" and "sexist" but then "second-guessed herself after [he] claimed to be complimenting her."<sup>16, p. 110</sup> This comment echoes those made by several students we interviewed who also used the language of self doubt (e.g. "not knowing where to draw the line," or "I really didn't do much but maybe I should have").

## Conclusions and Recommendations

The perspectives found in this report represent the comments of a small number of students at one medical school. Nonetheless, they are remarkably similar to comments found in other studies in other locations<sup>5,16,24,46,49</sup> and thus are worthy of further study here and elsewhere. Recommendations for future investigation arising from our study are that studies of sexual harassment move beyond confirmation of its existence to include the following:

### 1. The focus of sexual harassment inquiry should be on the institutional environment, not on women's failure to report.

The students we interviewed were very clear that whether or not harassment policies and procedures exist is irrelevant. Their issue is the *perception* that nothing will be done to perpetrators, which is the institution's fault. Recalling the distinction between formal and informal organizational justice,<sup>38</sup> we need better understanding of how students perceive justice to be enacted when someone is harassed in *all* environments where their education takes place. That is, we need to identify students' perceptions of the fairness of the actual policies surrounding sexual harassment (formal organizational justice) and the way the institution really responds to such reports (informal organizational justice). There are reasons—past actions, conjecture, local legend, or hearsay, among others—that students do not believe their medical

school administration will support them if they report sexual harassment, and a critical first step is identification of how such beliefs evolve in institutional settings. Such inquiry acknowledges the institution's "responsibility to create a climate in which victims have no reason to fear reporting mechanisms or their aftermath. The burden should be on the organization, not the victim."<sup>43, pp. 241</sup>

In addition, medical students here and elsewhere have a great deal to tell us about living in an environment that has hostile elements. Without impatience for students who choose not to report even when formal policies and procedures are in place, we need to "tend to *process*, which allows us to explore, uncover, examine and share the everyday lives of women and men in medical training. . . . Research grounded in the everyday makes visible the silent, symbolic world of gender and raises consciousness about the relations that shape and determine the everyday."<sup>16, p. 121</sup> Such inquiry may uncover the still highly gendered medical environment, where many female students learn to normalize their experiences of harassment as something they have to ignore or to endure if they want to succeed.

### 2. Institutional research efforts should focus on the implications for those who actually label and report.

Many students in our study truly believed that reporting would probably have negative outcomes for them in the location where the harassment took place. We must all address the literature on retaliation and other outcomes of reporting—that students who do report are more likely to be viewed as "troublemakers" and possibly even "less trustworthy,"<sup>51</sup> that reporters put themselves "at risk for negative judgments by others"<sup>52</sup>, and that reporters often suffer damage to their psychological and health status.<sup>43</sup> For students who must continue their undergraduate medical education or who wish to apply for a residency at the site where harassment took place, these are serious outcomes administrators must take into consideration as they evaluate existing or develop new sexual harassment policies.

### 3. Deans/chairs set the tone for the environment and have a responsibility for developing fair, non-intimidating reporting procedures for sexual harassment and enforcing sexual harassment policies.

The research is also clear on this point: "Climates that do not tolerate sexual harassment are associated with lower levels of sexual harassment."<sup>43, p.</sup>

238; see also.30,47,53 One study found that 93% of the respondents indicated that they would report sexual harassment if there were “*demonstrated* support from top management for enforcing sexual harassment policies.”<sup>42</sup>, p. 235

One wonders how institutional cultures might shift if deans and clinical department chairs personally addressed each new clerkship cohort with unambiguous statements about how sexual harassment—with specific behaviors designating harassing behavior clearly listed—would not be tolerated in that setting, that each report would be treated seriously, and that protection from retaliation would be ensured. Several of our students duly noted the existence of a “blurb” regarding sexual harassment at the start of some clerkships but clearly dismissed it. What would happen if institutional leaders showed up personally not only to recite the “blurb” but also to declare zero tolerance for sexual harassment, no matter what the stature or generated income of the perpetrator?

Other strategies for encouraging reporting include following:

1. Using an outside, independent investigator for reports of sexual harassment or an internal investigator victims can select from a diverse panel of persons within the organization;
  2. keeping harassment complaint records separate from personal files;
  3. requiring victims’ permission for access to their harassment complaint record;
  4. conducting focus groups to learn how students perceive existing policies and their suggestions for revising them.<sup>42</sup>
- 4. Sexual harassment and other forms of student mistreatment should be *directly* examined by each LCME accreditation team, not merely through self study reports.**

Because of its persistence here and throughout medical education in the face of a literature that denounces, it may be time to raise the negative consequences for institutions that allow it. Perhaps it is time for those who accredit medical education to look at the environment not through the lenses of self studies but through more unfiltered, uncensored methods such as focus groups or other assessment methods conducted independently before the accreditation team arrives. Accreditation should be tied to a climate that significantly, seriously, and consistently works toward a humane environment, a climate that

has no place for faculty members who do not share this goal.

The sexual harassment of medical trainees is a perverse contradiction in an environment whose goal is healing and wellness. We know it exists; in fact, documentation has been so thorough that there is little doubt that sexual harassment occurs throughout medical education.<sup>11</sup> Yet, as Stockdale notes, “despite over two decades of public awareness and research attention, sexual harassment continues to pose threats to individuals’ and organizations’ health and well-being.”<sup>45</sup>,p.521 Working locally and together across academic medicine, we have the power to change the medical environment so that two decades from now, such statements are impossible to make.

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