Brave individuals in the #MeToo movement have exposed widespread sexual harassment across many industries. Medicine is no exception.

In an episode of the “AMA Moving Medicine” podcast, Reshma Jagsi, MD, PhD, director of the Center for Bioethics and Social Sciences in Medicine at the University of Michigan, provides an overview of sexual harassment and discrimination in the medical field.

Below is a lightly edited full transcript of the presentation. You can tune in on Apple Podcasts, Google Play or Spotify.

Dr. Jagsi: I wanted to begin by defining our terms. Sexual harassment is probably best understood as behavior that derogates, demeans or humiliates an individual based on that individual’s sex. Some scholars actually now prefer the term sex-based harassment, because the behavioral science definition actually encompasses three major categories of behavior.

There’s gender harassment, which includes sexist remarks and behaviors, typically known colloquially as a put-down, generated out of animosity rather than sexual interest. But then there’s also unwanted sexual attention and sexual coercion, which are colloquially known as come-ons.

Now if you think about the law—and of course, our counselor over here is going to actually inform you about the law, but I will just briefly say, as by way of introduction—that in the law, these are grouped slightly differently from the way they’d be grouped by colloquial terms … the first two categories constituting a hostile work environment, and the third being termed quid pro quo.

Title VII of the Civil Rights Act of 1964 outlawed discrimination on the basis of sex. It did not apply to institutions of higher education. Title IX, the Higher Education Act amendments in 1972, then extended this protection to institutions of higher education, and, in 1980, a federal appeals court established that sexual harassment constitutes discrimination under Title IX.
So, that's just a very brief overview of definitions, just to get us all on the same page before we move on.

There have actually been decades of research on this phenomenon in the field of occupational psychology. That research has shown that harassment is more common in historically male-dominated fields, like medicine, where big power differentials exist, like medicine, where women are in the minority, still like medicine, and especially in certain specialties and when institutions tolerate the behavior.

While we can intervene in a number of different ways, I think that it is this last area, where institutions and organizations are tolerating the behavior, where we can most immediately intervene.

Here we see that women have only become 50% of the medical school class in the past year, the first year that women broke 50% of the incoming medical student class. But we've seen a dramatic increase in women's participation since Title IX in 1972, and we do see an increase over time in the workforce of practicing physicians.

We do know that the strong hierarchies in academic medicine are necessary as part of our training, but unfortunately, we do still see that low proportions of senior academic positions are being held by women, such that even though nearly 40% of academic faculty are women, only 16% of medical school deans and 16% of medical school department chairs are.

And we are well aware of publicized cases of egregious trespasses that have occurred at the most prominent institutions in the country and elsewhere, where physicians have been found to have committed sexual harassment. But these egregious cases might seem like they're isolated. And so the question remains, how prevalent is this in academic medicine?

I used to have a slide … from a study that was published in 2000. The survey was actually done back in 1995, and I used to say, "a relatively recent survey." 1995 doesn't seem all that recent anymore. In that survey, 55% of the female faculty, but only 5% of the men, had experienced a form of sexual harassment.

And the question began to nag at me—because this was a cross-sectional faculty survey and it included a number of women who attended medical school in the 1970s, the early 1980s, which you saw from that graph, was a time when women were only in the small minority—whether things might have gotten better because, as I told you, the occupational psychologists say that this is worse when women are in the small minority.

Maybe as we've seen women becoming more present in the medical profession, we would see better news if we actually looked at prevalence in a more recently trained cohort of physicians. In fact, when we did that study, which was published in JAMA back in 2016, the survey was conducted in 2014, we
actually found that 30% of the women in a Generation X cohort of physician researchers had actually personally experienced harassment.

So that was lower than the 50% in the 1995 cross-sectional survey, just not as much lower as we had hoped to find. Thirty percent of the women, 4% of the men. When you ask more generally about gender bias in the academic environment, 70% perceived that and 66% reported that they had personally experienced gender bias in their professional advancement.

Before I move on from this slide, I just want to point out that the way we asked this question was worded identically to the 1995 survey, intentionally to allow for comparison with that 1995 study. That survey actually asked, "In your professional career, have you encountered unwanted sexual comments, attention or advances by a superior or colleague?"

If it had been worded differently, if it had allowed to include such unwanted attention from patients or had been specifically worded more generally, the way that women's study scholars would recommend doing, it probably would have picked up even higher rates of harassment.

You can see here that 41% of those who reported harassment had experienced unwanted sexual advances, and 9% had experienced coercive advances in our study. Of those who experienced harassment, 59% perceived a negative impact on confidence in themselves as professionals, and 47% reported that these experiences negatively affected their career advancement.

So, after we published that study, I got a lot of emails, really heartwarming and simultaneously dismayng emails, from individual women who told me about their personal experiences. Here's one example, which is reproduced with permission and deidentified.

These women talked about the environment that allowed the trespasses to occur. A department where the chair invites male and not female residents and attendings over every week for poker. They talked about feeling like they had done something wrong, like there was something pathologically wrong with me, that I invited that kind of behavior. Was it because I wasn't smart enough? Was it because I was soft spoken? Was it because there was something so wrong with me that I couldn't even recognize it?

And the way that seeing these data about the prevalence of this issue actually helped them to recognize that this wasn't their own fault and asking me to call attention to this. And, of course, I emailed her back and said, "You know, JAMA has a great section called 'A Piece of My Mind.' You're such an eloquent writer. You should publish this." And she said, "I can't publish this. I don't want anyone to know."

And what these women told me, time and time again, was stories about the fears of retaliation, about marginalization, about stigmatization. And when you're a woman and you're a physician and you've devoted most of your life to becoming a professional, the last thing you want to do is jeopardize your
standing in the field.

In fact, it’s a reasonable fear. This is actually a comment from an Australian surgeon who said, "The worst thing you can possibly do is to complain to the supervising body, because then, as in one person's position, you can be sure you'll never be appointed to a major public hospital.”

I, with the permission of many of these women who wrote to me, used their stories to illustrate a more vivid and nuanced description of the nature and reasons that we have underreporting and persistence of harassment in medicine, more recently in *The New England Journal of Medicine*, in the wake of the #MeToo movement. And what I will say is that I closed that piece talking about the importance of allies. ...

We all in this room can be allies. We are, even when we are bystanders, in a position to help others. And there is tremendous information from occupational psychology about the impact of bystander intervention and the importance of bystander empowerment and training. Because when we see something like this going on, we can speak up. We can distract, we can remove the victim and, if we're in positions of power, as many of the people in this room are, we can also report or make sure that that situation is addressed more formally.

In conclusion, the growing attention regarding sexual harassment in the workplace is creating an opportunity to address this challenge that so many women continue to face. Many women, even those who've been trained since relative gender equality in the medical student body, have experienced harassment.

The experiences are not rare. They can have lasting impact. Those who have these experiences may be reluctant to disclose. And institutions in our profession have to not only gather data, but also ensure that there's proactive interventions to transform the workplace.

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