



Prevention of Sexual Harassment in the Workplace and Educational Settings

Committee on Pediatric Workforce

Organizational Principles to Guide and Define the Child Health Care System and/or Improve the Health of All Children

ABSTRACT

The American Academy of Pediatrics is committed to working to ensure that workplaces and educational settings in which pediatricians spend time are free of sexual harassment. The purpose of this statement is to heighten awareness and sensitivity to this important issue, recognizing that institutions, clinics, and office-based practices may have existing policies.

STATEMENT OF THE PROBLEM

Although this policy statement focuses on medical schools and hospitals, the same principles apply to other professional settings including publicly and privately supported clinics and office-based practices regardless of the number of employees.

More than one third of female physicians perceive that they have been sexually harassed. Research supports the significance of the problem in the medical education setting. According to a study of female physicians, sexual harassment has been found to be more common among individuals in medical school (20%) or during internship, residency, or fellowship (19%) than in practice (11%).¹ Although conventional wisdom has held that sexual harassment is perpetrated only on women, 13.5% of sexual harassment charges brought to the Equal Employment Opportunity Commission in 2001 were from men. This represented an almost twofold increase in reports by men compared with the previous decade.² Despite increasing awareness about sexual harassment in the workplace, a survey of hospital human resources managers in 2002 indicated that among the sexual harassment allegations lodged over 4.5 years, physicians were the reported perpetrators 15% of the time, up from 10% 7 years earlier, and 10% of sexual harassment complaints were filed by men.³

Gender discrimination and/or sexual harassment were reported in all academic contexts by 69% of female and 33% of male graduating medical students in a 1997 survey of 14 US medical schools, with 63% of women and 30% of men describing these problem behaviors during their core clerkships.⁴ In another survey of 1001 graduating students from 8 US medical schools, 21% of the female students and 2% of the male students reported that they had experienced some form of sexual harassment in medical school.⁵ In a 1991 survey of second-year residents about their working and learning environment, 63% of female respondents reported having experienced at least 1 episode of sexual harassment or discrimination.⁶ A survey of full-time faculty at 24 US medical schools found that 52% of female and 5% of male faculty indicated that they had been sexually harassed by a superior or

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Key Words

sexual harassment, gender discrimination, sexual orientation, office or institutional policies and guidelines

Abbreviation

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colleague; the reported incidence of sexual harassment was almost twice as high in non–primary care compared with primary care specialties.⁷

Sexual harassment in the workplace and in educational settings creates an environment that demeans people and may have a negative impact on individual performance and effectiveness as well as organizational productivity and unit morale. Female medical residents who experienced disrespectful behavior, including sexual harassment, were shown to be 11 times more likely to score high for possible problem drinking compared with their female counterparts who experienced no harassment.⁸ Female medical school faculty members who were sexually harassed scored lower on career-satisfaction scales despite equivalent academic achievement.⁷ Two studies of university employees demonstrated that those who experienced sexual harassment experienced adverse alcohol-related outcomes and increased utilization of either mental health or health services.^{9,10} Although these examples highlight problems in hospital and educational settings as they apply to students, residents, and other employees, there is no reason to believe that other settings such as clinics or physician offices are immune to the effects of this unwelcome behavior. Sexual harassment is certain to affect employees at all levels.

Although sensitivity to this complex issue has been heightened recently, much confusion exists, even about exactly what constitutes sexual harassment, as well as about modalities appropriate for dealing with the problem. It is incumbent on employers, organizations, and institutions to represent all their constituents, male and female, and provide education and guidance to facilitate eradication of this destructive behavior. In particular, medical schools and training programs must be aware of the prevalence of the problem and have action plans available. It is also important to recognize that most medical schools and university hospitals will have separate sexual harassment policies with disparate policies and procedures in place, so grievances from medical students, residents, or staff members may need to be handled in very different ways. The first step is a proactive approach based on fair policy development. Due process is a particularly important component, because false accusations may be made. Policy development, therefore, will also need to address those who are falsely accused. Second, dissemination of grievance and complaint procedures, followed by a prompt response to all complaints, should be the standard in all health care settings, from a small office-based practice to more formal institutional or educational settings.

BACKGROUND

Title VII of the Civil Rights Act of 1964 states that it is unlawful for an employer to discriminate against an individual because of gender¹¹; sexual harassment is one form of gender discrimination. Sexual harassment is de-

finied by the Equal Employment Opportunity Commission as follows:

Unwelcome advances, requests for sexual favors, and other verbal and physical conduct of a sexual nature constitute sexual harassment when: 1) submission to such conduct is made explicitly or implicitly a term or condition of an individual's employment; 2) submission to or rejection of such conduct by an individual is used as a basis for employment decisions affecting such individuals; or 3) such conduct has the purpose or effect of substantially interfering with an individual's work performance or creating an intimidating, hostile or offensive work environment.¹²

Thus, there are 2 general aspects of sexual harassment.¹³ The first aspect involves the "quid-pro-quo" or "this-for-that" situation, when submission to unwelcome sexual conduct becomes a condition of employment or personnel action (items 1 and 2 in the aforementioned definition). The second aspect involves the creation of a "hostile work environment" (item 3 in the definition).

Sexual harassment is not gender specific, nor is it always clear-cut. Its presence, however, is noted throughout the entire workforce, which includes all health care personnel. To determine if certain conduct constitutes harassment, various factors may be taken into consideration:

- whether the conduct was unwelcome, unsolicited, or offensive;
- whether the conduct was repeated, particularly if it was repeated despite a warning that it was unwelcome or offensive;
- whether the behavior involved a supervisor-subordinate relationship in which one individual had "power" over another;
- the substance and severity of the conduct: verbal, physical, hostile, disruptive, continuous, pervasive, or provoking;
- whether preferential treatment of individuals in the workplace, on the basis of their sexual behavior, had a negative impact on others in the working environment¹⁴; and
- whether a "reasonable person" would be substantially negatively affected by similar circumstances.¹⁵

Notwithstanding all the law, literature, and discussion on this issue, even very well-meaning people remain confused and concerned about what really constitutes sexual harassment. Until very recently, sexual harassment of men by other men was not explicitly defined by Title VII; discrimination based on sexual orientation was generally not considered sexual harassment. However, a number of court cases and surveys of undergraduate students, medical students, and physicians make us reconsider these long-held beliefs. In a landmark case

brought to the US Supreme Court in 1997, a man filed a complaint against his employer after being subjected to egregious “hazing” behaviors involving groping and physical contact by co-workers. The court held that same-sex harassment is actionable under Title VII and that men, as well as women, are entitled to protection.¹⁶

Although not much research has been published on sexual harassment of gays and lesbians in medicine, in a survey conducted by the US-based Gay and Lesbian Medical Association, 59% of gay and lesbian medical students and physicians reported job-related discrimination.¹⁷ A survey of gay and lesbian Yale students and community members indicated that 65% were targets of verbal insults, 25% received threats of physical violence, and 42% were physically abused because of their sexual orientation. Of both male and female respondents, 12% indicated that they were sexually harassed or assaulted because of their sexual orientation.¹⁸ A survey of gay and lesbian third- and fourth-year medical students applying for residency was conducted in parallel with a survey of family practice program directors to assess attitudes and biases about sexual orientation. More than 70% of the medical students indicated that their specialty choice was influenced by their own perceptions of how other physicians in a given field would accept them. Furthermore, 8% of family medicine program directors regarded disclosure about an applicant’s homosexuality in a negative light, 25% demonstrated a neutral perspective, and 67% demonstrated an accepting attitude.¹⁹

Certain egregious behaviors clearly represent sexual harassment. Rape or indecent assault, as well as using one’s position of authority by offering rewards or threatening to influence another person’s career on the basis of sexual favors, are agreed on as clearly constituting sexual harassment. At the other end of the spectrum, most people agree that it is acceptable behavior for a person to respectfully compliment someone’s appearance. However, repetitive unwelcome requests or leering, gesturing, or making insulting, sexually oriented comments also constitute sexual harassment. Although consensual sexual relationships with no duress generally do not fall within the rubric of sexual harassment, they nonetheless may still be ethically inappropriate (if not sexual harassment) in the workplace if, for example, a supervisor-subordinate relationship exists. The American Medical Association has taken a firm stand on this issue in their policy titled “Sexual Harassment and Exploitation Between Medical Supervisors and Trainees” and suggests that even consensual sexual relationships between supervisors and trainees are not acceptable.²⁰ Thus, it may be important for an institution, organization, or employer (including medical school administration, faculty members, and program directors) to address, as well, standards of conduct that are broader in scope than just those that are considered sexual harassment.

What constitutes a “hostile environment” is often unclear but may certainly include sexually oriented posters, pictures, or calendars as well as sexually explicit jokes or comments. Touching is considered to be sexual in some cases but not in others. Common sense should prevail. The best solution to the problem of sexual harassment is prevention. Individuals working in all medical education and health care delivery settings should take steps to ensure open communication, dissemination of institutional policies, and creation of an environment in which individuals can safely communicate their discomfort to those harassing them.

The American Academy of Pediatrics (AAP) concurs with the American Medical Association policy²¹ that dictates that all medical training programs develop and implement a policy that specifically addresses sexual harassment and exploitation. The Accreditation Council for Graduate Medical Education’s institutional requirements, which apply to all residency programs in all specialties, mandate that “[t]he Sponsoring Institution must have written policies covering sexual and other forms of harassment” and that “[t]he Sponsoring Institution retains responsibility for the quality of GME [graduate medical education] even when resident education occurs in other institutions.” This and other policies must be contained in, or referenced as part of, the resident’s agreement of appointment.²² These institutional requirements direct sponsoring institutions to maintain master affiliation agreements with major participating institutions and program letters of agreement or memoranda of understanding in compliance with program requirements. Resident education, therefore, is conducted at each site where residents rotate, with the expressed understanding that some harassment policy will apply. Some locations, such as major academic affiliations, may have their own harassment policies. According to Patricia M. Surdyk, PhD (Executive Director, Accreditation Council for Graduate Medical Education Institutional Review Committee, written communication, March 2006), the master affiliation agreement and/or program letters of agreement with individual sites such as physician offices would clarify which harassment policies apply in such cases. Residents must both be protected in all situations in which they find themselves as part of the education program, and likewise are expected to adhere to policies governing behavior at all locations.

Although the vast majority of hospitals have formal written policies on sexual harassment,³ many private medical groups and office-based practices may not have such policies in place. As medical professionals, interactions with patients, parents, and caregivers may also be subject to close scrutiny and potential accusations of impropriety. The AAP offers guidance on this through a number of resources including a policy statement, “Appropriate Boundaries in the Pediatrician-Family-Patient

Relationship.”²³ The rules that apply to conduct with co-workers should also apply to behavior at the bedside and during office visits. Although it is not required by law that private medical offices have in place official policies regarding sexual harassment, having such a policy may offset many potential claims from employees in this setting as well. Resources are now available to private practitioners to guide them in establishing such office policies. One author has suggested that employers develop a simple written policy on sexual harassment, which should include a step-by-step grievance procedure.²⁴ The sexual harassment policy should be made available in the employee handbook and posted in the office; employees may also benefit from 1 or more sexual harassment training sessions.²⁵ Several sample sexual harassment policies that can be adapted for medical offices and individual physicians are available online.^{26,27}

RECOMMENDATIONS

Sexual harassment has important implications for men and women and for all individuals involved in health care delivery. Reference literature provides guidance regarding the scope of protection, liabilities, and remedies for sexual harassment.²⁸ Irrespective of the specifics of the law, all individuals desire and deserve a workplace in which they are treated with appropriate respect in a comfortable environment conducive to effective teamwork and optimal productivity. As such, leaders and employers must set the pace in affirmatively combating sexual harassment in the workplace regardless of the number of employees.²⁹ Several recommendations for corporate, academic, and office-based practice settings include:

- Educate people to avoid sexually offensive behavior.
- Establish written procedures to address sexual harassment issues and achieve problem and grievance resolution.
- Ensure that the rights of both parties are considered and both are afforded due process.

The following are additional suggestions for decreasing the incidence of sexual harassment in the workplace and educational settings:

- Encourage supervisors, physicians, and administrators to set an example by serving as positive role models.
- Investigate all complaints promptly and confidentially.
- Follow-up on all complaints.
- Sensitize employees through an interactive training process.
- Consider using an outside mediator to evaluate any complaints of sexual harassment (especially for smaller health care organizations).³⁰

Risk management requires communication of clear

definitions of acceptable standards of behavior, treatment of all complaints as serious matters, discipline for offenders, and steps to prevent subsequent offenses. In addition, once a complaint has been adjudicated, efforts must be taken to ensure a smooth transition for the employees coming back into the workplace. Follow-up counseling and/or periodic meetings individually with the party or parties involved should be provided as warranted.

The AAP recognizes that its constituents work in a broad spectrum of settings, often moving from the office, to a hospital, and to an educational environment within a single day. The size and nature of each organization are important factors in determining the degree of formality required to accomplish the eradication of sexual harassment. It is our intent that this policy statement be used in concert with any existing procedures. The purpose of this statement is to heighten awareness and sensitivity to this important issue and encourage reassessment of existing policies in all medical practice and educational settings.

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