Medicolegal Sidebar: Avoiding Gender-based Inequities During Orthopaedic Training

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Introduction

High-quality investigative journalism [5, 11, 19] helped usher in the #MeToo era, resulting in a heightened sensitivity toward sexual abuse and harassment in the workplace. While the lay media's initial focus centered around the pervasiveness of sexual harassment in Hollywood [5, 11], we've since seen similar reports purporting widespread sexual harassment in finance [15], athletics [3], and academic science, engineering, and medicine [16]. A 2018 Consensus Study Report on Sexual Harassment of Women, issued by the National Academies of Sciences,

Engineering and Medicine, reported that it is "clear that sexual harassment is a serious issue for women at all levels in academic science, engineering and medicine" [16]. About 30% of women medical faculty members in the United States have reported sexual harassment, and many of whom have faced retaliation from their institutions or from those whom they accused [9, 10].

Sexual harassment and gender discrimination likewise are widespread in medical training, and even many more of these incidents go unreported owing to victims' fears of the consequences of speaking out [13]. A 2014 meta-analysis of 51 studies related to harassment and gender discrimination

found "a surprisingly high prevalence of harassment and discrimination among medical trainees that has not declined over time" with 59.4% of medical trainees having experienced at least one form of harassment or discrimination during their training [6].

The data regarding orthopaedics are just as disconcerting. In her inaugural address, Kristy L. Weber MD, the first woman president of the American Academy of Orthopaedic Surgeons, cited a 2018 survey that showed that more than 50% of women orthopaedic surgeons had experienced sexual harassment [22]. Orthopaedic surgery is the least diverse of all medical specialties. While the gender distribution

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in U.S. medical schools is nearly equal between men and women, orthopaedic residency programs are about 90% men [18]. Change is slow; women trainees accounted for 11.6% of US orthopaedic surgery residency programs during 2004-2009. That number increased to only 12.6% during 2009-2014 [24].

While the reasons for the underrepresentation are multifactorial, they are in part a function of the perpetuation of a work culture dominated by men, and a dearth of women mentors [2]. We must also acknowledge an avoidance strategy that seems to have recently taken hold among men working in the #MeToo era, as Seth S. Leopold MD noted in his recent Editorial in this Journal: “Apparently, many businessmen are declining to mentor women because they fear unsubstantiated accusations of sexual harassment being perceived as credible in the era of #MeToo. Inexcusably, the same phenomenon appears to have taken root in medicine” [14].

Anxiety related to minimizing exposure to allegations of gender discrimination and harassment is not limited to individuals—academic departments, their faculties, and residency programs are deeply involved in the training, hiring, and career advancement of women physicians. All these parties may face lawsuits from those who perceive that they have been treated unfairly at work because of gender.

Legal Liability

Lawsuits alleging sexual harassment and gender bias, however, can be hard to prove. In the 2014 legal ruling, *Shervin v Partners Healthcare Systems Inc.*, a woman resident in the Harvard orthopaedic training program challenged her academic probation, alleging gender discrimination and retaliation

that diminished her job prospects [20]. The allegations referenced an executive committee member who had told a fellow colleague that [Shervin] “needs to get her head screwed on and realize that she is a woman in a man’s specialty” and “suck it up.” The jury ruled in favor of the residency program, and in upholding this verdict, the First Circuit US Court of Appeals remarked that while there is “a certain rough-and-tumble quality to the high-stakes world of academic medicine ... the defendants’ conduct—though perhaps insensitive in some respects—did not cross the border into the forbidden realms of discrimination and retaliation” [21].

Shervin shows the difficulty in establishing causation between actions of the alleged harasser and the loss sustained by the plaintiff, and also in distinguishing between what is merely insensitive and what represents actionable discrimination in the eyes of the law. Despite institutional policies to address unprofessional conduct, it may still be difficult to draw the line between subtle sexism and illegal gender discrimination that can contribute to unequal opportunities. Well-intentioned physicians who are men may be concerned that casual jokes or comments could be misconstrued as harassment. And much has been made of Vice President Mike Pence famously commenting that he never dines with a woman alone, other than his wife—dubbed the Pence Rule [23].

Avoidance and Discrimination

While the Pence Rule discourages men from interacting with women colleagues in order to avoid any hypothetical appearance of impropriety, the very-real fallout of this rule will accrue to women physicians, who will find it harder to develop professional

relationships that can help advance their careers. Women residents may miss out on professional networks, informal teaching, and critical mentoring. To our knowledge, there is no current case law alleging differential training arising from gender discrimination in residency training, but the door is open to such claims. Specifically, the 2017 decision of the Third Circuit U.S. Court of Appeals, *Doe v Mercy Catholic Medical Center*, is timely and instructive on the subject of gender discrimination in residency programs [4].

In *Doe*, a woman radiology resident enrolled in a private hospital program that accepted Medicare payments alleged that the program director (a man) made unwanted sexual advances, ultimately dismissing her from the program when she did not return his overtures, and filed a complaint instead. The lawsuit was brought under Title IX of the Education Amendments of 1972, 20 USC § 1681, a federal law that protects individuals from discrimination based on gender in education programs or activities that receive federal funds. Title IX protections extend, for example, to recruitment, admissions, gender-based harassment, discipline, and retaliation for filing of complaints.

The district court ruled that Title IX did not apply to Mercy Catholic Medical Center because it was not an “education program or activity;” instead, *Doe* would have to rely on Title VII, a different federal statute that governs employment discrimination, and that would have made it more difficult for *Doe* to prove. On appeal, a unanimous Third Circuit held that a resident could bring a private claim for gender discrimination under Title IX, even against a private institution without academic affiliation [4].

The significance of the *Doe* ruling is that it opens up a clear pathway to file

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claims under Title IX for gender discrimination and sexual harassment during residency training. University of Illinois law professor Robin Wilson has commented that the *Doe* ruling is important enough that it is “going to be felt throughout the industry” [1]. Another law professor addressed the Pence Rule head-on [7], opining that if applied to workplace dinners, the Rule could be illegal labor discrimination under Title VII of the Civil Rights Act of 1964, a federal law that prohibits employment discrimination based, among other things, on gender.

Proposed Solutions

In our view, unintentional gender discrimination, even if it is the result of deliberate avoidance strategies such as the Pence Rule, can lead to legal liability. To avoid such liability, residency programs should implement systemic measures to improve its work culture, including providing required training that addresses: (1) Unconscious bias; (2) the importance of team diversity, and (3) healthcare disparities.

Additionally, programs could take additional measures to mitigate the risk of allegations of harassment by (1) performing confidential surveys of their team members to understand the perception; (2) having leadership publicly state a commitment to diversity and inclusion; (3) stating the goals of the program and (based on survey results) addressing identified issues; (4) pledging zero tolerance for harassment; and (5) holding both leadership and team members accountable should harassment claims be proven true.

The above programs should also target long-term behavior. Saturated training, such as an intense 2-day seminar addressing sexual harassment

may lead to initial increases in desired behaviors, but the learning quickly fades, generally speaking, with no enduring impact. Instead, a distributive approach, such as shorter programs spread over time that continually address the issue of gender discrimination may be more likely to have lasting effects. Training programs should include not only the knowledge of the legal implications of sexual harassment, but should foster development of a set of attitudes that promote harmony between the social values inherent in the antidiscrimination laws and a belief that sexual harassment is inconsistent with one's personal social values. Program effectiveness should be critically measured with pre and posttesting endpoints. For example, what are the attitudes and the strength of the attitudes of the targeted audience prior to the program and following the program? What is the knowledge of the audience concerning legal exposure prior to the programs and after the programs? Such pre- and post-testing will allow institutions to measure whether attitudes are truly changing for the better.

Much like workplace bullying, a key factor in addressing negative conduct such as sexual harassment is that organizational authority acknowledges that it exists, takes the problem seriously, and shows a willingness to challenge it [8]. The Consensus Study Report from the National Academy of Sciences has also clarified that “the most potent predictor of sexual harassment is organizational climate—the degree to which those in the organization perceive that sexual harassment is or is not tolerated” [16]. As such, steps should be taken on an institutional level to have a rigorous, fair, and transparent review process for complaints that communicates to employees that every issue will be taken seriously, and that the

complainant will be protected [17]. But departments must earn the right to make that promise. To that end, departmental leadership must build trust and positive relationships among their staff, including resident physicians. Even with the fostering and maintaining of such relationships, in these matters, oversight of department leadership by high level officials at the medical center should be seriously considered.

Formal mentorship programs can be created with the goal of promoting and channeling women into leadership positions, such as the Pipeline Protégé Program created by the American Society for Radiation Oncology's Committee on Health Equity, Diversity and Inclusion [12]. Inter-institutional cooperation may also help; TIME'S UP Healthcare (<https://www.timesuphealthcare.org/>) is a network of healthcare professionals who are committed to creating a safe and healthy working environment that is free from harassment or gender discrimination. Another crucial measure to ensure gender equality in the medical field is to take active steps towards ensuring that women progress to leadership positions. With better representation at the highest levels, decisions that are geared towards gender equality are more likely to be made.

References

1. Advisory Board. Residency programs can be sued for gender discrimination under Title IX, court says. Available at: <https://www.advisory.com/daily-briefing/2017/03/13/title-ix>. Accessed March 20, 2019
2. Bernstein J. Male practice: Gender inequality in orthopaedic surgery. *Clin Orthop Relat Res*. 2013;471:1754-1757.
3. Correa C. The #MeToo moment: For U.S. gymnasts, why did justice take so long? Available at: <https://www.nytimes.com/2018/01/25/us/the-metoo-moment-for-us-gymnasts-olympics-nassar-justice.html>. Accessed March 26, 2019.

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4. *Doe v Mercy Catholic Med. Ctr.*, 850 F.3d 545 (3d Cir. 2017).
5. Farrow R. From aggressive overtures to sexual assault: Harvey Weinstein's accusers tell their stories. Available at: <https://www.newyorker.com/news/news-desk/from-aggressive-overtures-to-sexual-assault-harvey-weinsteins-accusers-tell-their-stories>. Accessed March 26, 2019.
6. Fnais N, Soobiah C, Chen MH, Lillie E, Perrier L, Tashkhandi M, Straus SE, Mamdani M, Al-Omran M, Tricco AC. Harassment and discrimination in medical training: a systematic review and meta-analysis. *Acad Med*. 2014;89:817-827.
7. Grossman JL. Vice President Pence's "never dine alone with a woman" rule isn't honorable. It's probably illegal. Available at: <https://www.vox.com/the-big-idea/2017/3/31/15132730/pence-women-alone-rule-graham-discrimination>. Accessed April 4, 2019.
8. Illing JC, Carter M, Thompson NJ, Crampton PES, Morrow GM, Howse JH, Cooke A, Burford BC. *Evidence synthesis on the occurrence, causes, consequences, prevention and management of bullying and harassing behaviours to inform decision making in the NHS*. Durham University, 2012. Available at: http://www.netscc.ac.uk/hsdr/files/project/SDO_FR_10-1012-01_V06.pdf. Accessed April 4, 2019.
9. Isaacs D: Sexual harassment. *J Paediatr Child Health*. 2018;54:341-342.
10. Jaggi R, Griffith KA, Jones R, Perumalswami CR, Ubel P, Stewart A. Sexual harassment and discrimination experiences of academic medical faculty. *JAMA*. 2016;315:2120-2121.
11. Kantor J, Twohey M. Harvey Weinstein paid off sexual harassment accusers for decades. Available at: <https://www.nytimes.com/2017/10/05/us/harvey-weinstein-harassment-allegations.html>. Accessed March 26, 2019.
12. Knoll MA, Glucksman E, Tarbell N, Jaggi R. Putting women on the escalator: How to address the ongoing leadership disparity in radiation oncology. *Int J Radiat Oncol Biol Phys*. 2019;103:5-7.
13. Launer J. Sexual harassment of women in medicine: A problem for men to address. *Postgraduate Med J*. 2018;94:129-130.
14. Leopold SS. Editorial: Fears about #MeToo are no excuse to deny mentorship to women in orthopaedic surgery. *Clin Orthop Relat Res*. 2019;477:473-476.
15. McLean B. "We all wear black every day": Inside Wall Street's complex, shameful, and often confidential battle with #MeToo. Available at: <https://www.vanityfair.com/news/2018/02/inside-wall-street-complex-shameful-and-often-confidential-battle-with-metoo>. Accessed March 26, 2019.
16. National Academies of Sciences, Engineering, and Medicine. 2018. *Sexual Harassment of Women: Climate, Culture, and Consequences in Academic Sciences, Engineering, and Medicine*. Washington, DC: The National Academies Press.
17. Newman C, Ng C, Pacqué-Margolis S, Frymus D. Integration of gender-transformative interventions into health professional education reform for the 21st century: implications of an expert review. *Hum Resour Health*. 2016;14:14.
18. Nguyen L, Amin N, Vail T, Pietrobon R, Shah A. Editorial: A paucity of women among residents, faculty, and chairpersons in orthopaedic surgery. *Clin Orthop Relat Res*. 2010;468:1746-1748.
19. PBS News Hour. Pervasive sexual harassment takes a toll on women in the sciences. Available at: <https://www.pbs.org/newshour/show/pervasive-sexual-harassment-takes-a-toll-on-women-in-the-sciences>. Accessed March 26, 2018.
20. *Shervin v Partners Healthcare System Inc.*, 2 F. Supp. 3d 50 (2014)
21. *Shervin v Partners Healthcare System Inc.*, United States Court of Appeals, First Circuit. No. 14-1651, Decided October 09, 2015
22. Stanton T. Kristy L. Weber, MD begins her term as president. https://www.aaos.org/AAOSNow/2018/Apr/Special_Coverage/special_coverage02/?ssopc. Accessed March 17, 2019.
23. Tolentino J. Mike Pence's marriage and the beliefs that keep women from power. *The New Yorker*. Available at: <https://www.newyorker.com/culture/jia-tolentino/mike-pences-marriage-and-the-beliefs-that-keep-women-from-power>. Accessed April 4, 2019.
24. Van Heest AE, Fishman F, Agel J. A 5-year update on the uneven distribution of women in orthopaedic surgery residency training programs in the United States. *J Bone Joint Surg Am*. 2016;98:e64.