Gender-based Harassment of Emergency Medicine Trainees: What Faculty Educators Need to Know

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ABSTRACT

There is increased interest in workplace harassment as reports of improper workplace conduct have surfaced among multiple industries and governments. Accounts of sexual misconduct in academic medical centers also highlight the need for further education and training for faculty educators. The purpose of this paper is to provide faculty educators with the tools to recognize and respond to gender-based harassment of medical trainees. More specifically, we will review existing literature, the definition of gender-based harassment, federal laws, institutional reporting protocols, and retaliation toward reporters of harassing behavior.

Accounts of sexual harassment in the workplace have surfaced in multiple sectors, including government and academia.^{1,2} Academic medical centers are not immune to the increasing number of reports of sexual harassment, highlighting the need for further education and training.^{3,4} The unpredictable environment of the emergency department can lead to an increased risk of trainees experiencing gender-based harassment. Trainees in the emergency department are particularly vulnerable due to the high volume of patients they may be meeting for the first time, who can possess varying pathologies and decision-making capacities. Gender-based harassment of trainees leads to emotional health problems, cynicism, thoughts of wanting to leave the specialty, and normalization of the experience.⁵⁻⁷ These negative effects of harassment on trainees can impair performance and ultimately affect patient care.⁵ Barriers that can prevent trainees from reporting harassing behaviors include shame, lack of confidence that they will be helped, and fear of negative consequences.^{8,9}

This paper attempts to provide faculty educators in the field of emergency medicine tools to recognize and intervene on instances of gender-based trainee

harassment. The term gender-based harassment was chosen to include behaviors that are not overtly sexual, but still target a particular gender. Faculty educators are responsible for not only demonstrating workplace behavior free from harassment but also recognizing and responding to aberrant behavior toward trainees. Faculty can also have a role in helping trainees formulate response strategies to sexual harassment, which can be useful throughout a physician's career.

EXISTING LITERATURE

In 1995, a landmark study by McNamara et al.¹⁰ drew into focus the high prevalence of gender-based harassment experienced by emergency medicine residents. For example, of 1,774 surveyed emergency medicine residents, 63% of women and 32% of men reported unwanted sexual advances, and 66% of women and 27% of men reported discomfort from sexual humor. This study further elucidated that the most common source of gender-based harassment for emergency medicine trainees were patients and family, followed by residents, nursing, and faculty. Since the publication of this study nearly 25 years ago, very few

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additional studies have examined the incidence and source of gender-based harassment of emergency medicine trainees. Additionally, more recent studies lack the degree of detail necessary to discern what surveyors and responders consider to be sexual harassment.¹¹ Survey questions that ask about sexual harassment in general, without discerning the frequency of specific types of behaviors, do not accurately estimate the prevalence of gender-based harassment.¹² Even fewer publications address the steps faculty can take to help mitigate instances, or the negative effects of, sexual harassment of trainees. For example, in a recent landmark publication by the National Academies of Engineering, Science, and Medicine on sexual harassment of women, the closest recommendation specifically for faculty educators was general bystander training.¹³

DEFINITIONS

Gender-based harassment, gender discrimination, and sexual violence have distinct and overlapping characteristics. For medical professionals working with trainees who may be targets of harassing behavior, it is important to recognize the distinguishing characteristic of each type of behavior. *Gender-based harassment* is any offensive and unwelcome conduct that targets a particular gender. Instances of gender-based harassment can include offensive comments that are sexual or gender-based, unwanted attention, offensive body language, and touching. Gender-based harassment is unlawful if severe and pervasive enough to create a hostile work environment or if the situation is considered quid pro quo harassment. A hostile work environment is created when harassing behavior is severe and pervasive enough to affect any reasonable person's ability to do their job, limits opportunities for job advancement or receiving of benefits.¹⁴ Requesting any sexual or gender-based favors as a condition of employment or career advancement is a type of gender-based harassment, termed quid pro quo harassment. An example of quid pro quo harassment can be the following scenario: A resident invites a student out and the student declines. The resident facetiously responds that it might help the student's grade.¹⁵ This scenario illustrates an instance of an offer of a favorable evaluation in exchange for the acceptance of an invitation.

In comparison, *gender-based discrimination* in medical education is any difference in the training environment between men and women. For example, discouraging male trainees from participating fully in

obstetrics and gynecology cases creates a difference in the training environment for men and women and could be considered gender-based discrimination in medical education.⁷ In addition, the reluctance of patients to recognize female trainees as physicians could lead to a difference in training environment for male and female trainees and contribute to gender-based discrimination in the medical education setting.¹⁰ *Sexual violence* is any unwanted sexual experience and can be contact or noncontact.¹⁶ For example, being exposed to unwanted sexual attention, sexual comments, and exposure to explicit images can be examples of noncontact sexual violence. Of note, the previous examples are also instances of sexual harassment in addition to sexual violence.

FEDERAL AND INSTITUTIONAL POLICIES

For faculty educators to effectively support trainees, it is helpful to understand federal laws regarding gender-based harassment. Title IX of the Education Amendments of 1972 requires educational institutions to investigate and respond to any reports of gender discrimination, sexual harassment, and sexual violence.¹⁷ A recent ruling by the U.S. Court of Appeals in 2017 recognized residency programs as a type of educational program; thus, these programs are required to follow Title IX mandates.¹⁸ Since this recent ruling, it is unclear to whom the role of mandatory reporting of gender-based harassment will be assigned in the hospital setting. Federal laws recognize responsible employees as "any employee that has the authority to take action to redress sexual violence" or "whom (a trainee) could reasonably believe has this authority or duty."¹⁹ Gender-based harassment also violates Title VII of the Civil Rights Act of 1964.²⁰ Title VII of the Civil Rights Act of 1964 prohibits employment discrimination based on race, color, religion, sex, and national origin. Hence, a residency program could be held accountable to both Title IX and Title VII during the handling of a case of trainee harassment.²¹

INTERVENTION

Each academic medical center is unique in the means by which they respond to complaints of gender-based harassment. Two commonly recognized frameworks for institutions to address complaints of gender-based harassment is the grievance approach and the ombudsperson approach.²² The *grievance approach* is a

common reporting protocol that mimics the approach of most human resources departments. Through the grievance approach, the person(s) affected file a grievance with the supervisor of their respective education program or hospital department and the complaint goes through a chain of command. Another type of approach is the *ombudsperson approach*, where an appointed faculty at the institution is tasked with responding and resolving a variety of problems, including reports of gender-based harassment.²² Each approach has inherent weaknesses and strengths, the discussion of which is beyond the scope of this paper. When intervening or mentoring on behalf of trainees affected by harassment, faculty may consider if the reporting protocol at the institution more resembles more a grievance approach or an ombudsperson approach. Additionally, becoming familiar with the protocol for resolution of a complaint and the methods by which involved parties will be counseled or reprimanded will help create effective counseling for trainees.

Faculty may check in and consult with the trainee that was the target of harassment, but respect the trainee's confidentiality and autonomy as much as possible. Effective mentoring of a trainee includes assuring the faculty's commitment to the trainee's confidentiality and the limits of that confidentiality. Faculty educators, although controversial and institution dependent, may be considered mandatory reporters of gender-based harassment. Due to the potential sensitive nature of conversations regarding instances of workplace harassment, a phone call or in-person meeting is the best first mode of communication rather than detailed electronic exchanges. In addition, any electronic exchange between a trainee and faculty could be examined during the course of an investigation.

Of special mention are situations where patients and family are the source of trainee harassment. For physician educators, duty to treat patients can come into conflict with duty to educate and minimize threats to the learning environment. Faculty can navigate this difficult predicament by first assessing clinical acuity.²³ After assuring the patient's clinical stability, faculty educators can next take into account patient's decision-making capacity. If a patient is medically stable and demonstrates decision-making capacity, consider counseling the patient regarding the effects of their behavior on the targeted trainee and healthcare environment. In addition, it is important for the physician educator to debrief and empower the trainee to determine the next

steps. Finally, a decision can be made with the trainee on whether to accommodate, negotiate, or consider releasing a stable patient from care.

RETALIATION

Effective mentoring of trainees affected by harassment may include discussing potential retaliation scenarios. Retaliation for reporting workplace harassment is against the law.²⁴ Examples of retaliatory behaviors can include ostracism, negative evaluations, negative recommendations, and hindering advancement. However, trainees can also be vulnerable to covert retaliation, which is difficult to prove and prevent. Binder et al. uses the term covert retaliation to describe vindictive comments made by a person accused of sexual harassment about his or her accuser in a confidential setting, such as grant review, award selection, or search committee.²⁵

Depending on the egregiousness and pervasiveness of harassing behavior, one option to discuss with the trainee is delaying making a report until the trainee is no longer under the perpetrator's supervision and performance evaluations are complete (e.g., end of specialty or site rotation). Throughout the mentoring process, faculty can play an important role in ensuring that trainees maintain a sense of autonomy and control in decision making.

CONCLUSION

If faculty educators do not actively take steps to address harassing behavior, harassment will continue to persist. Trainees in emergency medicine are at increased risk of gender-based harassment due to the unpredictable and acute encounters with patients, cotrainees, staff, and faculty. Recognizing and effectively responding to harassing behavior takes practice, and faculty educators working with emergency department trainees should give themselves credit each time this is practiced.

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