9.1.3 Sexual Harassment in the Practice of Medicine

Sexual harassment can be defined as unwelcome sexual advances, requests for sexual favors, and other verbal or physical conduct of a sexual nature.

Sexual harassment in the practice of medicine is unethical. Sexual harassment exploits inequalities in status and power, abuses the rights and trust of those who are subjected to such conduct; interferes with an individual's work performance, and may influence or be perceived as influencing professional advancement in a manner unrelated to clinical or academic performance harm professional working relationships, and create an intimidating or hostile work environment; and is likely to jeopardize patient care. Sexual relationships between medical supervisors and trainees are not acceptable, even if consensual. The supervisory role should be eliminated if the parties wish to pursue their relationship.

Physicians should promote and adhere to strict sexual harassment policies in medical workplaces. Physicians who participate in grievance committees should be broadly representative with respect to gender identity or sexual orientation, profession, and employment status, have the power to enforce harassment policies, and be accessible to the persons they are meant to serve.

AMA Principles of Medical Ethics: II, IV, VII

Background report(s):

CEJA Report 3-A-16 Modernized *Code of Medical Ethics*

CEJA Report G-A-93 Gender discrimination in the medical profession

CEJA Report B-A-89 Sexual harassment and exploitation between medical supervisors and trainees

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AMA Principles of Medical Ethics: II, IV, VII

1. Incentives should be administered through a federally funded donor registry offering future contracts to prospective donors. By entering into a future contract, an adult would agree while still competent to donate his or her organs after death. In return, the donor registry would agree to give some financial remuneration to the donor's family or estate after the organs have been harvested and judged medically suitable for transplantation.

2. No incentives should be allowed for organs procured from living donors.

3. It would be inappropriate to offer financial incentives for organ donation to anyone other than the person who would actually serve as the source of the organs. Only the potential donor, and not the potential donor's family or other third party, may be given the option of accepting financial incentives for the donation of his or her own organs. In addition, the potential donor must be a competent adult.

4. Any incentive should be of moderate value and should be the lowest amount that can reasonably be expected to encourage organ donation. By establishing a federally funded donor registry to administer the incentive, full control over the level of incentive can be maintained.

5. Payment of any incentive should occur only after the harvested organs have been judged medically suitable for transplantation. Suitability should continue to be determined in accordance with the procedures of the Organ Procurement and Transplantation Network.

6. Incentives should play no part in the allocation of donated organs among potential transplant recipients. The distribution of organs for transplantation should continue to be governed only by ethically appropriate criteria relating to medical need.

(References pertaining to Report F of the Council on Ethical and Judicial Affairs are available from the Office of the General Counsel.)

G. GENDER DISCRIMINATION IN THE MEDICAL PROFESSION

HOUSE ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS AND REMAINDER OF REPORT FILED;

INTRODUCTION

Although there has been progress in recent years, women in medicine are not generally advancing to the highest levels of the profession and are continuing to encounter subtle and overt forms of discrimination during their training and careers. In this report, the Council discusses some of the obstacles encountered by women in medicine, such as exclusion of women from the informal and formal power structures of medicine, inadequate accommodation of pregnancy and family, harmful sexual stereotypes or biases against women, sexual harassment, and a lack of mentorship available to women. All of these conditions may be contributing factors to the "glass ceiling"

phenomenon whereby women do not advance to the most senior positions in their fields. The medical workplace, including academia and all practice settings, must continue to improve the environment of women physicians and correct the disparities that remain between men and women in medicine.

TYPES OF GENDER DISPARITY

Disparities between female and male physicians exist in a number of areas including income and academic advancement. In this section, the report describes the disparities; possible explanations for the disparities follow in the next section of the report.

1. Income Levels of Practicing Physicians

Despite the growing presence of women in medicine, the incomes of female physicians still lag behind incomes of male physicians. In 1991, the average female physician earned 34 percent less than her male counterpart, with women earning a median income of $97,350 and men a median income of $146,980. Female physicians are more likely to earn a relatively low income and less likely to earn a relatively high one. For example, while 19 percent of female physicians earned less than $60,000 in 1991, only 7 percent of male physicians earned less than $60,000.

Some commentators have pointed to the relative youth of female physicians as an explanation for the income disparity, and it may, in fact, be a partial explanation. As a group, women are newer to medicine than their male counterparts. In the years between 1970 and 1980, the percentage of women graduates from medical school grew from about 9 percent to 25 percent, and the number of women entering medical school continued to increase through the 1980s. In 1990, the percentage of entering medical students who were women was 40.2 percent. These figures represent tremendous gains for women, who made up only 4-5 percent of all medical students until the 1970s. Though there have been women in the American medical profession since at least 1850, this relatively recent influx of women means that female physicians are younger than their male counterparts and therefore are less likely to have reached their peak earnings years.

Nevertheless, even when taking into account the number of years in practice, female physicians still earn less than male physicians. For 1-4 years in practice, women's average net income is 60 percent of men's average net income. For 5-9 years in practice, women's average net income is 65 percent of men's. For 10-19 years of practice, it is 58 percent.

Some of the income disparity also reflects differences in area of specialization as men are more likely to practice in lucrative specialties. However, even in specialties where there is a high concentration of women and older female establishment, there seems to be no greater likelihood of income parity between men and women. Women's median income was 27 percent less than men's in family practice, 29 percent less in internal medicine and 34 percent less in pediatrics in 1991. Moreover, it is questionable whether women's access to the higher paying specialties is unobstructed and encouraged. As discussed later in the report, discriminatory barriers may limit the choices of women in medicine more so than men.

Differences in workload may explain some of the income differential. Female physicians see fewer patients per week (100.5 vs. 120.9) and practice slightly fewer hours per week (54.3 vs. 59.8) than do male physicians.

However, income disparities persist even when controlling for workload and area of specialization. Female GP/FPs earn 83.5 percent of the average hourly wage of male GP/FPs. Among pediatricians, women earn 77.9 percent of the average hourly wage of men. Although there are too few women to control for both age and specialty at the same time, such controls would likely still leave hourly income disparities of 10-20 percent.

2. Academic Medicine: Faculty Members and Deanships

Although women have made substantial gains in access to medical school, their access to the positions in academic medicine continues to be seriously hindered. Little difference has been found in the academic performance

of men and women in medical school, and a greater proportion of women choose academic medicine over clinical practice than do men; nevertheless, academic medicine continues to be largely a male preserve. In 1992, 78 percent of full-time faculty positions were held by men.

Data from the Association of American Medical Colleges illustrates the slow progression of women through the academic ranks. Of physicians who first became faculty members in 1976, 25 percent of the men but 19 percent of the women were tenured or on a tenure track by 1987. In addition, 12 percent of the men but only 3 percent of the women had become full professors.

Women not only rise more slowly through academic ranks, they also find it very difficult to reach the highest positions. Compared to men, women are still more likely to be assistant professors and less likely to be full professors. In 1991, 50 percent of female professors were at the assistant professor level compared with 34.8 percent of male professors. On the other hand, 9.6 percent of female professors and 31.5 percent of male professors were at the full professor level. Indeed, in a period of ten years from 1978 to 1988, the percentage of female professors at the assistant level grew from 41 percent to 49 percent, but the percentage of female professors at the full professor level only increased from 8 percent to 9 percent.

Only about 3 percent of all medical school departments are chaired by women, and internal medicine, which has the largest number of women physicians, has no female department chairs. While there were 202 female associate and assistant deans of medical schools in the 1989-90 school year, there was just one female dean.

Some of these disparities reflect the poor representation of female physicians in tenure track positions. One study at Columbia University's College of Physicians and Surgeons found that, while women were becoming better represented in the clinical track, they continue to lag in the tenure track.

Women made up 43 percent of assistant professors on the clinical track but only 30 percent of assistant professors on the tenure track. According to the researchers, "[t]he observation that women were disproportionately represented on the nontenure clinical track suggests that some women may not choose to pursue more demanding tenure track positions because of perceived obstacles." Data from this study and others indicate that women "believe that their professional opportunities are more limited than those of their male colleagues."

3. Representation in Medical Research

The inadequate representation of women in academic positions is paralleled by similar representation in medical research. In general, women researchers tend to have less financial support and less assigned research space. One study found that of the 40-59 age group, 16 percent of the women and 30 percent of the men had grant support from the National Institutes of Health, the major source of funding for scientific research. Women generally publish fewer original scientific papers, report fewer research efforts than men, and are more likely than men to have had no research training. Fewer publications lead to fewer promotions of women. In turn, fewer women in leadership positions results in decreased involvement of women researchers.

POSSIBLE CONTRIBUTING FACTORS

1. Inadequate Accommodation of Pregnancy and Family

The demands of family are frequently cited as an explanation for the existence of the glass ceiling effect in medicine. In general, women physicians tend to accept a larger amount of responsibility for the family and its daily upkeep than do male physicians and therefore generally have less time to pursue career goals. In one recent study, full-time female and male pediatricians were surveyed. Female pediatricians performed 66 percent of child care and 63 percent of their household's duties while male pediatricians performed 19 percent of child care and 26 percent of their household's duties. Apparently, little flexibility in parenting roles or workplace structure has developed to accommodate the greater presence of mothers in medicine.

Often there is both little informal validation of women's dual role as physician and mother, and few formal policies which appropriately accommodate the needs of pregnant women and families. Having children is still viewed in many professions as an indication of a lack of seriousness and commitment on the part of women. The formulation of a second tier of career women with lower pay and lower status has been the response to human reproduction in many fields.

In academia, women who bear children early in their professional years can lose their chance for tenure if they choose to spend time with their children and publish less. Most universities require a certain number of publications within the first four to seven years after becoming a faculty member in order to earn tenure. Inherent in the unwritten rule of "publish or perish" may in fact be the requirement that one devote all attention to work, research, and writing for an uninterrupted, substantial period of time. Such a requirement would effectively discriminate against and weed out women physicians, who are more likely than men physicians to have time constraints due to the demands of a family. In all areas of medicine, career advancement of women has been slowed because of the absence of policies that extend tenure decisions or reinstate, retrain, or otherwise accommodate physicians who become mothers without penalty.

Informal attitudes about women and pregnancy can also negatively impact a woman's likelihood of success. One critic has noted that within academia, "a man who does less teaching because he serves on editorial boards is excused as normal, whereas a woman who asks to do less teaching to help raise a child is viewed as a burden." Negative attitudes about a woman's effort to combine motherhood with career can create stress for the female physician, often casting doubt on her professional competence and commitment. Negative attitudes held by a woman's colleagues and superiors can also decrease her likelihood of promotion or receiving other professional rewards.

Pregnancy can be a source of resentment when a woman's absence creates more work for her colleagues. For example, taking time to give birth during one's residency is sometimes seen as an unfair burden on other residents who must compensate for her maternity leave. Inflexible policies which do not anticipate and accommodate for the real possibility of pregnant physicians can, in fact, burden others, while also bringing harm to the medical careers of women.

There are also societal costs for negative attitudes about professional women who are mothers. When childbearing and rearing are devalued, the health and strength of the family are generally weakened. When forced to choose between profession and family by virtue of inflexible policies and standards, women and men who choose to be doctors are not able to satisfy fully their parenting obligations. As one doctor has commented, "Certainly a strong case could be made that we suffer more from lack of parenting than from lack of doctoring." Some compromise may inevitably occur even under the most enlightened policies, but a rigid imposition of the traditional division of labor between the sexes is not the answer, particularly as women's place in the profession of medicine shows no sign of diminishing. Instead, more flexibility on the part of medical schools and institutions would give significant support to the many men and women who play the dual roles of parent and physician. Medicine, and society as a whole, will benefit from institutional policies that value family and childbearing.

Beginning August 5, 1993, the Family and Medical Leave Act of 1993 will require employers of 50 or more employees to provide up to 12 weeks of unpaid leave in one year for the birth, adoption, or illness of a child. Additionally, in academic medicine, other improvements could include stop-the-clock programs that delay tenure decisions for women or men who take parental leave; extend the clock programs on grants; and on-site day care.

There are two tenure tracks implemented at Harvard Medical School which could also serve as models for other institutions. The choices of clinical-teacher track and clinical-research track not only allow greater flexibility for parents, they encourage individuals to pursue that track which best utilizes their talents. There is potential for tenure in either track, and the value of teaching, as well as research, is recognized.

2. Ongoing Discrimination

Sex discrimination is another frequently cited explanation for the glass ceiling. According to one survey, 55.8 percent of women vs. 2.1 percent of men felt that career progress had been delayed due to sex discrimination. Broadly speaking, gender discrimination refers to "behaviors, actions, policies, procedures, interactions, etc., that adversely affect a woman's work due to a disparate treatment, disparate impact, or the creation of a hostile or intimidating work or learning environment."

Harmful sexual stereotypes or biases against women can have a profound influence on a woman's professional experience. Such biases affect the informal relationships between women and their male colleagues, women's likelihood of finding a male mentor, the flexibility of maternity leave policies, and the level of support felt by a woman physician balancing her career with family obligations. Harmful stereotypes can also influence whether women's work is rewarded equally with men's, with commensurate pay, grades, verbal encouragement and opportunities for advancement. Women's competence and "place" in positions of authority can also come under question due to sexual stereotypes about the intellectual capacity or professional commitment of women. One psychology study about male and female reactions to female leaders demonstrated that "both men and women in group situations were likely to respond to women leaders with scowls and frowns, whereas they responded to men leaders who were saying the same things with smiles and nods."

Mary Rowe, PhD, of MIT has described the discrimination encountered most often by women as nonactionable "micro-inequities." These involve unconscious slights, conscious slights, women's invisibility, and exploitation. Some examples include assigning women in disproportionate numbers to clinical positions that offer no hope of academic advancement, stating that pregnancy is an act of disservice to the department, openly discouraging women physicians from entering certain fields like surgery and openly questioning a women's stamina, strength, commitment or suitability to the profession of medicine. Other micro-inequities are not crediting women's ideas or ignoring their suggestions, unconsciously eliminating women from consideration for professional opportunities, excluding women from informal peer networks, and ignoring women at rounds or in discussions of patients.

There are several possible correlations between gender discrimination and what has been described as the glass ceiling, or women's underachievement. When women's work is consistently treated as less valuable, is underpaid, underrewarded or otherwise designated as less competent, women become discouraged and have a lower level of self esteem and career ambitions. Discouragement and open hostility against women can force them to leave their specialty or the profession of medicine altogether.

There is legal protection against sex discrimination in employment and educational opportunities under Titles VII and IX. Guidelines were also adopted in 1980 by the Equal Employment Opportunity Commission which clarify the types of situations that violate these laws. Progress has been made, but it is difficult to gauge how much the spirit of these guidelines has been adopted and enforced.

3. Sexual Harassment

Sexual harassment is a serious form of gender discrimination which hinders the advancement of women. As described in an earlier report of the Council, sexual harassment is characterized by unwelcome sexual advances, requests for sexual favors and other verbal or physical conduct of a sexual nature where submission to such conduct is made either explicitly or implicitly a term or condition of an individual's employment or academic success, submission to or rejection of such conduct by an individual is used as a basis for employment or academic decisions affecting that individual, or such conduct has the purpose or effect of interfering with an individual's work or academic performance or creating an intimidating, hostile or offensive work environment.

Sexual harassment is prevalent at all levels of professional training and practice. According to a January 1993 survey of over 2,000 women physicians by the American Medical Association, 74.8 percent reported having experienced an incident of sexual harassment at some point in their careers. Of those who experienced harassment,

79 percent experienced it in medical school, 64.2 percent in residency training and 41.8 percent in their practice. The majority of these women identified the source of the harassment as either colleague or management staff.

Similarly in a recent study of residents in an internal medicine training program, 73 percent of women and 11 percent of men who responded reported that they had been sexually harassed at least once during their training. About half of the reported incidents occurred during medical school and half during residency.

Other studies about medical students have indicated that sexual harassment is a fairly common experience. One study found that 81 percent of female students reported having been subjected to sexist slurs, most frequently by clinical faculty and residents or interns. More than half (55 percent) of the women reported having been the object of sexual advances. Residents, interns and clinical faculty were cited most frequently as sources. Almost one-third (29 percent) felt they had been denied opportunities in their training because they were women. Forty-two percent claimed to have experienced other forms of discrimination, most frequently from classmates.

Despite the frequency of sexual harassment, appropriate responses are rare. In approximately 80 percent of cases in the recent AMA survey, women who experienced harassment stated that no corrective action was taken. In some cases, no action was taken because the harassment was not reported. The most cited reasons why women did not report the harassment were fear of negative impact (58.7 percent) and feeling that no action would be taken (46.1 percent). Another significant hindrance was the nonexistence of any sexual harassment policy at the institution in question (34.8 percent). In addition, existing policies may not be effectively or consistently enforced by institutions, making it prohibitively difficult to initiate the complaint process.

These studies provide several insights into sexual harassment in the medical setting. The most frequent offenders are women's teachers, supervisors and colleagues. Rarely is the source of harassment the patient. Sexual harassment is prohibited by law, but few women choose to take corrective action against their offenders, mostly for fear of negative impact on their careers. Also important is the perception that little will be done to correct the offending behavior and the fact that many institutions still lack formal sexual harassment guidelines. If women physicians are to feel comfortable working in the medical setting, more serious steps need to be taken to free women's environment of intimidation, hostility, and inappropriate sexual remarks and advances. Such a negative environment is not conducive to women physicians' success, and could be significantly contributing to the lack of women advancing to leadership positions within medicine.

Men also report experiencing sexual harassment; about 25 percent of men in a recent study reported some type of sexual harassment from clinical faculty and residents. According to this study, there were gay men who felt discriminated against because of their homosexuality. There were also men who felt that "women were shown favoritism on clerkship rotations, either by men who found them attractive or by women residents who wanted to help them along. The clear finding, however, is that women reported sexual harassment as much as four times more often than did men."

An important issue in sexual harassment, often not fully addressed, is the inherent abuse of power that gives the harassment its force. Sexual harassment should not be misinterpreted to mean mutual flirtation or flattering comments. Its effect, however unconscious the harasser may be of it, is to demean and devalue the target of the harassment and to contribute to women feeling intimidated and doubtful about their own abilities. If sexual harassment is to be eliminated from the medical profession, policies must be accompanied by a willingness to grant women fair access to the highest positions of power as well as a desire to challenge the most traditional hierarchies of medicine which have been inhospitable to women.

4. Lack of Mentorship for Women

Increasing the number of women entering the profession of medicine does not alleviate the problem of lack of female role models and absence of women in leadership positions. The number of women may increase in the lower levels of medicine, but without mentorship which specifically encourages their careers, women will be less

likely to gain access to the positions of power that could, in turn, allow them to serve as mentors for other women. According to a study by the American Medical Women's Association, "opportunities available to female protegees would increase if medical schools promoted more women to authority positions."

Women's career advancement can be greatly facilitated and accelerated by the help of a mentor. Because women constitute a minority of physicians and a small minority in some specialties, they experience professional loneliness and isolation that can significantly undermine their sense of comfort, confidence and belonging. Mentorship can provide a valuable resource to young physicians, providing contacts, inside information and other intangible aids to success. Mentors can have significant impact on one's professional advancement, and some physicians believe success "is impossible without a sponsor who will promote, protect, and in other ways enhance one's professional fortunes." With few female mentors and role models, many women physicians feel they have had to single-handedly find their own way.

While both men and women can act as mentors for female physicians, a sizable cohort of female mentors is essential. There is often an unwillingness or anxiety on the part of men to act as mentors for women. Also, studies show that women look to senior female physicians not only for career sponsorship, but also for an example of how to successfully combine career, family and personal life. Unfortunately, there are few departments in any medical school "in which a student can readily find a woman physician in a senior position who is happy with both her professional life and her personal life and available to give the student pointers and support." This absence has had a generally detrimental effect on the emerging female medical professional.

5. Exclusion from Peer Networks

Women are often excluded from peer networks that are an important conduit to advancement. For example, informal, collegial relationships can be an important source of power and career enhancement. Collegial relationships provide the opportunity for the exchange of information about appropriate behaviors and the power structures of medicine. These informal networks may also supply the young professional with future job contacts, referrals and privileges. Often excluded from these informal networks, women can miss out on opportunities for career advancement. Some criticize women for failing to utilize the networks available to them, the "political engine that can greatly accelerate one's career." Women may not be welcome in traditionally male peer networks. But whether by self-selection or conscious and unconscious discrimination in their environment, women have not generally found these resources of career advancement.

Exclusion of women can also occur at the peer review level, in which research grant proposals or articles submitted for publication are judged by other medical professionals or scientists in the field, who are often men. Little known women researchers or authors, who already lack the informal support of a mentor, may be again disadvantaged if the peer review process is not anonymous. Studies have shown that both male and female subjects have given less favorable ratings to identical articles and drawings when the author or artist is thought to be a woman. In addition, a study has demonstrated higher quality peer review when the reviewers are blinded to the identity of the author.

In other fields, peer review is blinded in order to discourage biases in favor of those persons already acclimated to the circles of power. Articles submitted to the Harvard Law Review, for example, are not identified by the author's name when undergoing peer review. Such a policy in the medical profession could reduce the biases against women, as well as the pressure to attach oneself to a prestigious mentor who will further one's success.

EFFECTS OF GENDER DISPARITY AND DISCRIMINATION ON THE MEDICAL PROFESSION

In addition to the effects on women's careers, many deleterious effects on the medical profession result from the inequality between men's and women's professional status. Patient care may be compromised in an environment which does not validate the competence and talent of women. Undermining the professional capabilities of women

damages the trust of patient in the physician. And an environment of harassment and hostility can distract attention and energy from care of patients.

Also, while there is no statistical correlation between numbers of women directing medical research and amount of research being conducted on women's health issues, it has long been suggested that a logical correlation exists. As more women direct their own laboratories or sit on review committees which award supporting grants, it seems likely that more research projects would focus on or incorporate women's health. With more women in leadership positions in medicine, there likely would be an increased balance in medical research, given the past tendency of a more male dominated research establishment to pay inadequate attention to the health needs of women and design their studies accordingly. As Bernadine Healy, first woman director of the National Institutes of Health, has observed, "gender disparities in medical treatment and research will be reduced by increasing the number of women in leadership positions in the teaching, research, and practice of medicine."

Many women are able to combine the challenges of career and family to their satisfaction. Still the collective costs of gender discrimination in the medical profession are substantial. There are immeasurable personal losses in women's lives, as women are forced to choose between good families or good careers. The profession of medicine needs talented and committed physicians and researchers and cannot afford to discourage valuable members. Medicine's future will be greatly influenced by the presence of women, and its future success may depend on a fair inclusion and accommodation of both genders in the medical workplace.

RECOMMENDATIONS

The Council on Ethical and Judicial Affairs recommends that the following policy statements be adopted:

1. Medical schools and other institutions should take immediate steps to increase the number of women in leadership positions, as such positions become open. There is already a large enough pool of female physicians to provide strong candidates for such positions.

2. Adjustments should be made to ensure that female physicians are equitably compensated for their work. Women and men in the same specialty with the same experience and doing the same work should be paid the same compensation.

3. In addition to implementing the parental leave requirements of the Family and Medical Leave Act of 1993, appropriate medical institutions should actively develop:

    a. Retraining or other programs which facilitate the reentry of physicians who take time away from their careers to have a family.

    b. On-site child care services for dependent children. Subsidies for day care and flexible hours may be necessary for physicians in training.

    c. Policies providing job security for physicians who are temporarily not in practice due to pregnancy or family obligations and who are not covered by the Family and Medical Leave Act of 1993.

4. To promote fairness and equity in the academic workplace, the following guidelines should be considered:

    a. Extension of tenure decisions through "stop the clock" programs, relaxation of the seven year rule, or part-time appointments that would give faculty members longer to achieve standards for promotion and tenure.

b. More reasonable guidelines regarding the appropriate quantity and timing of published material needed for promotion or tenure that would emphasize quality over quantity and that would encourage the pursuit of careers based on individual talent rather than tenure standards that undervalue teaching ability and overvalue research.

c. More even distribution of teaching, clinical, research, administrative responsibilities, and access to tenure tracks between men and women.

5. Where such policies do not exist or have not been followed, all groups and institutions should create strict policies to deal with sexual harassment. Grievance committees should have broad representation of both sexes and other groups. Such committees should have the power to enforce harassment policies and be accessible to those persons they are meant to serve.

6. The medical and scientific communities would benefit from further studies on sexual harassment. Such studies would provide more insight into human behavior, particularly how men and women might better relate to each other with mutual respect and understanding in a professional context.

7. Academic and other medical institutions should offer educational programs about gender and cultural issues to staff, physicians in training and students. Such programs would serve to sensitize these groups about harmful stereotypes and biases and work to prevent discrimination.

8. Academic institutions should consider formally structuring the mentoring process, possibly matching students or faculty with advisors through a fair and visible system.

9. To help prevent bias, grantors of research funds and editors of scientific or medical journals should consider blind peer review of grant proposals and articles for publication. Because the identity of an author may unduly influence the review process, it should not be disclosed to the reviewers. However, grantors and editors will be able to consider the author's identity and give it appropriate weight.

10. Referral of physicians with unacceptable behavior to a local physicians health committee is another alternative. Medical and psychiatric treatment of illness (substance abuse, behavioral illness, etc.) may be an effective solution.

(References pertaining to Report G of the Council on Ethical and Judicial Affairs are available from the Office of the General Counsel.)

H. ETHICAL ASPECTS OF ARTIFICIAL INSEMINATION BY ANONYMOUS DONOR

HOUSE ACTION: FILED

The Council routinely reviews its opinions and updates those that require revision. The following opinion is a revision of Opinion 2.05.

2.05 Artificial Insemination by Anonymous Donor

Thorough medical histories must be taken of all candidates for anonymous semen donation. All potential donors must also be screened for infectious or inheritable diseases which could adversely

CEJA Report B – A-89
Sexual Harassment and Exploitation Between Medical Supervisors and Trainees

INTRODUCTION

Substitute Resolution 114 was adopted by the AMA House of Delegates at the 1998 Interim Meeting. The resolution asked that the AMA "study the ethical issues raised by the existence of sexual harassment and sexual exploitation between medical trainees (medical students and residents) and their faculty supervisors, with particular attention to the effect of such relation- ships upon the quality of medical training, patient care, trainee evaluation and the trainee's well-being."

The resolution further directed that "the AMA instruct its representatives to the Accreditation Council for Graduate Medical Education to encourage its Residency Review Committee to establish a mechanism to identify and eliminate instances of sexual harassment and/ or sexual exploitation *in clinical training programs."*

Sexual harassment may be defined as sexual advances, requests for sexual favors, and other verbal or physical conduct of a sexual nature when (1) submission to such conduct is made either explicitly or implicitly a term or condition of an individual's employment or academic success, (2) submission to or rejection of such conduct by an individual is used as a basis for employment or academic decisions affecting such an individual, or (3) such conduct has the purpose or effect of unreasonably interfering with an individual's work or academic performance or creating an intimidating, hostile, or offensive work or academic environment.

Examples of sexual harassment include inappropriate sexual advances, favoritism based upon gender, sexist jokes or slurs, the exchange of rewards for sexual favors, and malicious gossip or rumors. Sexual harassment also encompasses the use of sexist teaching materials, denied opportunities or poor evaluations because of gender, and punitive measures based upon the refusal of sexual advances.

Sexual harassment by faculty supervisors is obviously unethical and may, also be illegal under employment discrimination laws. Medical colleges and medical trainees are often perceived as sharing an educational rather than an employment relationship. However, the Equal Employment Opportunity Commission has ruled that interns and residents are indeed employees of the medical colleges that provide them with clinical training. As such, interns and residents have legal standing to file charges of sexual harassment and discrimination under Title VII of the Civil Rights Act of 1964. Sexual harassment is also widely prohibited under state law.

In addition to conduct that constitutes sexual harassment, a wide range of consensual sexual relationships are possible between medical supervisors and trainees. Such relationships raise ethical concerns even though characterized by mutual consent because of inherent inequalities in the status and power that medical supervisors wield in relation to medical trainees. Whenever a sexual relationship exists between a medical trainee and a supervisor who has professional responsibility for the trainee, the potential for sexual exploitation exists, despite the voluntary nature of the relationship. Even if no professional responsibility currently exists between a supervisor and trainee, there is a need to be sensitive to the constant possibility that the supervisor may unexpectedly assume a position of responsibility for the trainee.

THE PREVALENCE OF SEXUAL RELATIONSHIPS BETWEEN TRAINEES AND SUPERVISORS

Few studies of sexual harassment or other sexual involvement between medical trainees and their supervisors have been conducted and reported to date. The limited data that are available do not provide a clear indication of the prevalence of sexual conduct in medical training programs. Nevertheless, sexual harassment and sexual exploitation, if present to any degree, present significant problems.

Two recent studies of student perceptions of mistreatment and abuse during medical school examined patterns of sexual harassment in medical training programs. It is difficult to assess the validity of these studies because they have not been published yet. In the first of these studies, based on a survey of 580 fourth year medical students at ten medical schools across the country, many of the students reported some form of sexual harassment during their medical training[4]. The types of harassment encountered by the respondents included sexist slurs, favoritism and sexual advances. Other forms of sexual harassment reported by the respondents included exposure to sexist teaching materials, denied opportunities, and the exchange of rewards for sexual favors.

In the second unpublished study, based on a more limited survey of 75 third year medical students at a single medical school, many students also reported sexual harassment by their supervisors. The students encountered sexist slurs, sexual advances, denied opportunities, malicious rumors, and other forms of sexual discrimination.

With respect to sexual exploitation in medical training programs, available data indicate that relationships with the potential for exploitation are not as prevalent as sexual harassment, but nonetheless are cause for concern. Findings from a nationwide survey of 548 psychiatric residents revealed that, during their four years of postgraduate medical training, 4.9% experienced some form of sexual involvement with psychiatric educators[1]. Sexual involvement was experienced more frequently by female (6.3%) than by male (3.9%) respondents. Similar studies of sexual contact between educators and trainees have been conducted in relation to training programs in psychotherapy and clinical psychology[2,3].

The above studies indicate that sexual harassment and exploitation between medical trainees and their supervisors are significant problems in medical training programs. The consequences of such contact may be severe for trainees and patients alike.

THE IMPACT OF SEXUAL HARASSMENT AND EXPLOITATION

Sexual harassment or exploitation by an educator is often harmful to the academic and professional advancement of medical trainees, and to professional working relationships. For example, one of the studies conducted has shown that many students who decline sexual advances from a supervisor report "not only significant subsequent harm to the working relationship but also punitive damage from educators.[2]"

Even trainees who have been involved in sexual relationships with educators often believe that such relationships are unethical and potentially harmful, and this perception tends to increase significantly over time. The findings from one survey indicated that 36% of respondents perceived professional and ethical problems at the time of the first sexual contact with an educator, whereas 56% perceived such problems at the time of the survey [2]. Similarly, 28% of respondents indicated that some degree of coercion was experienced at the time of initial contact, whereas 51% perceived such coercion at the time of the survey. Finally, 40% of those involved in sexual relationships with a supervisor perceived some hindrance to the working relationship at the time of initial sexual contact, whereas 51% perceived such hindrance at the time of the survey.

Patients may be exposed to potential harm when a medical supervisor and trainee become involved in a sexual relationship. Patient care may be jeopardized by a hostile, self-interested environment created by the caregivers responsible for treatment, or by the relationship interests of the supervisor and the medical trainee.

Fewer than 50% of residency training programs have developed and implemented policies that relate to sexual harassment and exploitation between trainees and supervisors. In comparison, more than 90% of medical schools have developed and implemented policies that address sexual harassment. To be effective, such policies must include a grievance procedure that is sensitive to the difficulties and potential repercussions experienced by those who report sexual misconduct by supervisors. These policies should acknowledge that both men and women may be subjected to sexual harassment or exploitation from members of the same or opposite gender, and that mechanisms for resolving inappropriate sexual conduct must be equally stringent in all cases. Policies that address sexual harassment and sexual exploitation must also assure the rights of both trainees and supervisors to due process and should protect the confidentiality of those involved to the greatest extent possible.

SUMMARY

Sexual harassment and exploitation: (a) abuse the rights and the trust of those who are subjected to such conduct; (b) may influence the academic and professional advancement of medical trainees in a manner that is unrelated to their scholastic or clinical performance; (c) may harm professional, working relationships; and (d) are likely to jeopardize patient care. Sexual harassment and exploitation in medical training programs are therefore highly unethical.

Consensual sexual relationships between a medical trainee and a supervisor, when the supervisor has professional responsibility for the trainee, are objectionable because of the potential for exploitation and the potential impact on patient care. Consensual sexual relationships between a medical trainee and a supervisor when no professional relationship exists may also be a cause for concern.

The Council on Ethical and Judicial Affairs recommends that:
All medical training programs develop and implement a policy that addresses sexual harassment and exploitation between educators and medical trainees.
Such policies include a discussion of consensual sexual relationships.
Such policies contain a grievance procedure, including a mechanism to assure that the rights of both trainees and educators to due process are rigorously observed.

The Council on Ethical and Judicial Affairs further recommends that this report be adopted by the House of Delegates and communicated to the Accreditation Council for Graduate Medical Education and other appropriate organizations.

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