Sexual harassment of women in medicine: a problem for men to address

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In the last few months, disclosures by prominent women in politics and entertainment have given the issue of sexual harassment a higher profile than ever before. The huge number of further disclosures as part of the '#metoo' campaign, have made it clear that sexual harassment by men is endemic. The medical world is certainly not immune from this, as personal testimony from women doctors has shown.[1 2] There has been little research into the true scale of the problem in medicine, but one systematic review has concluded that nearly 60 per cent of medical students and trainees of all grades experience harassment or discrimination of some kind during their training, with females being targeted more than males.[3] Consultants are the the most common perpetrators, and sexual harassment is the most frequent form of abuse. Such harassment includes inappropriate sexual advances, requests for sexual favours, sexist jokes or slurs, the exchange of rewards for sexual favours, and other verbal or physical conduct of a sexual nature.[4]

The majority of incidents of sexual harassment appear to go unreported. This is mainly through fear of the consequences of protest or whistle-blowing on women's careers.[5] Women expect their experiences of abuse to be disbelieved, dismissed as exaggeration, blamed on their own behaviour and appearance, or told they are an understood condition of career progression in their specialty.[6] The personal and professional effects on them may be severe and enduring. Meanwhile, institutional procedures to deal with grievances and reduce harassment are often seen as tokenistic, and attempts to tackle the problem may be ineffective.[7] Only rarely and in the most shocking instances does a female victim fully pursue her legal rights, as in the case of a senior Australian oncology consultant who was sentenced to imprisonment after he invited one of his juniors to his home to discuss her career, and then drugged her wine with benzodiazepines in order to carry out an indecent assault.[8]

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There is little specific guidance on effective ways of dealing with sexual harassment in medicine, but there is helpful evidence and practical experience in relation to bullying by doctors, which overlaps with sexual harassment in many ways.[9] The crucial factor in tackling negative behaviour seems to be that someone in authority in an organisation accepts that it exists on a significant scale, believes in the seriousness of the problem, and is determined to challenge it.

MISMATCH OF PERCEPTIONS

From experience of leading anti-bullying programmes in hospitals, I would suggest that another requirement is for leaders to become alert to the different perceptions that people with or without power can hold of the same encounters, and the mismatch there can be between these. In the case of bullying, what some consultants regard as setting high standards or being firm, their juniors may experience as aggression or improper delegation. In the same way, when male clinicians consider they are indulging in harmless flirtation, women may see this as misogynistic, demeaning and scary. Unless leaders recognise that such mismatches are common, and accept their duty to encourage the less powerful to give voice to their views (however uncomfortable these can be to hear) bullying or sexualised behaviour will remain systemic.

There is a wider context to mismatches of perception around sex, and it has been the subject of a large amount of psychological research outside the medical world. Across most cultures, heterosexual males have a tendency to over-estimate their own attractiveness in the eyes of the opposite sex and to misinterpret women's responses to them as signifying more sexual interest than it does.[10 11] To put it bluntly, many men appear to confuse desire with desirability. One evolutionary explanation that has been proposed is that there is less risk for a man who makes a wrong assessment of an interaction, compared with a misjudgement by a woman, which can end in pregnancy and abandonment.[12] One consequence of male self-deception, however, is that misconstruing a woman's friendliness as sexual interest can end in coercion, or in some cases violence. In many cases, of course, such behaviour arises through causes that have little to do with signals and misinterpretation. These causes include engrained sexual stereotypes and expectations, a thrill in exerting power and control, and drunkenness.[13 14]

Outside the medical world, there is now an active debate about the best forms of intervention to reduce sexual harassment and coercive behaviour by men generally. On some college campuses in the United States, there are large scale programmes to educate all men about issues of consent, although these seem to have limited impact. The idea of tailored training for men with more negative perceptions of women has also been tried, but is fraught with many challenges. A major review of the field of sexual coercion concludes, unsurprisingly, that research so far provides only 'a preliminary foundation on which to build.'[11] Meanwhile, one message is entirely clear, for male doctors as much as for other men: the problem of sexual harassment is the responsibility of men to address, and it calls for us to exercise more psychological literacy, self-awareness and restraint.

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