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3 Title: Address Sexual Harassment in Medical Training
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5 Introduced by: Brent Oldham for the Medical Student Section
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7 Original Authors*: Nardin Derias and Rachel Saban
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9 Referred to: Reference Committee E
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11 House Action: **APPROVED AS AMENDED**
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14 Whereas, recent literature has highlighted the pervasiveness of sexual harassment in medicine^{1,2}, and

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16 Whereas, medical students experience sexual harassment more often than their peers in sciences
17 and engineering, by a substantial margin³, and

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19 Whereas, the presence of sexual harassment creates a stressful and hostile learning environment
20 that counters the optimal aim of medical education and can lead to attrition⁴, and

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22 Whereas, all medical schools in the state of Michigan are part of public universities which often
23 receive state and federal funding that carry requirements to provide a safe environment, equal access, and
24 address reasons for student attrition, and

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26 Whereas, recognition of the ongoing prevalence of sexual harassment in medical training would
27 help to implement preventive measures⁴, and

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29 Whereas, current surveys of sexual harassment often use inconsistent definitions and fail to measure
30 the breadth of sexual harassment experiences, thus not accurately capturing the prevalence of these
31 behaviors³, and

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33 Whereas, Michigan medical schools are only required by the Liaison Committee on Medical
34 Education and Association of American Medical Colleges (AAMC) to collect data on this subject by offering
35 the AAMC Year 2 Questionnaire (Y2Q) and the AAMC Graduation Questionnaire (GQ) to students at the end
36 of their second and fourth year, and

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38 Whereas, sexual harassment is only a small portion of both Y2Q and GQ surveys and fails to
39 comprehensively evaluate the multiple facets of this issue, and

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41 Whereas, the Administrator Researcher Campus Climate Collaborative (ARC3)⁵ is a validated
42 evidence-based survey that allows institutions to comprehensively evaluate their sexual misconduct
43 prevalence rates, key predictors, and effectiveness of ongoing preventative measures⁴, and

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45 Whereas, institutions implementing evidence-based surveys such as ARC3 will be able to compare
46 results in a collaborative effort to better understand and thus potentially reduce rates of sexual harassment
47 and misconduct; therefore be it

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49 RESOLVED: That MSMS encourage medical schools in Michigan to implement periodic surveys of all
50 their students about sexual harassment using the Administrator Researcher Campus Climate Collaborative
51 for more standardized and adequate data collection; and be it further

52 RESOLVED: That MSMS encourage collaborative efforts by medical schools in Michigan to better
53 understand the effectiveness of ongoing prevention efforts in pursuit of ultimately reducing rates of sexual
54 harassment in medical training.
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57 WAYS AND MEANS COMMITTEE FISCAL NOTE: \$5,000 or more as this resolution requires MSMS staff to
58 engage in collaborative/other outreach efforts.

Relevant MSMS Policy:

Sexual Harassment Guidelines

MSMS advocates that guidelines for prevention of sexual harassment be integrated into the medical work place.
(Res12-93A)
– Edited 1998

Inappropriate Sexual Behavior and Abuse

MSMS denounces unsafe, inappropriate, unprofessional, or sexual behaviors toward patients.
MSMS supports a streamlined, confidential reporting system for medical personnel and patients to report any
suspected inappropriate sexual behavior involving health care professionals and patients, with directives to report
suspected criminal activity, such as sexual abuse and assault, to law enforcement, without risk. (Res77-18)

Relevant AMA Policy:

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.

Teacher-Learner Relationship In Medical Education H-295.955

The AMA recommends that each medical education institution have a widely disseminated policy that: (1) sets forth the
expected standards of behavior of the teacher and the learner; (2) delineates procedures for dealing with breaches of
that standard, including: (a) avenues for complaints, (b) procedures for investigation, (c) protection and confidentiality,
(d) sanctions; and (3) outlines a mechanism for prevention and education. The AMA urges all medical education
programs to regard the following Code of Behavior as a guide in developing standards of behavior for both teachers
and learners in their own institutions, with appropriate provisions for grievance procedures, investigative methods, and
maintenance of confidentiality.

CODE OF BEHAVIOR

The teacher-learner relationship should be based on mutual trust, respect, and responsibility. This relationship should
be carried out in a professional manner, in a learning environment that places strong focus on education, high quality
patient care, and ethical conduct.

A number of factors place demand on medical school faculty to devote a greater proportion of their time to revenue-
generating activity. Greater severity of illness among inpatients also places heavy demands on residents and fellows. In
the face of sometimes conflicting demands on their time, educators must work to preserve the priority of education
and place appropriate emphasis on the critical role of teacher.

In the teacher-learner relationship, each party has certain legitimate expectations of the other. For example, the learner can expect that the teacher will provide instruction, guidance, inspiration, and leadership in learning. The teacher expects the learner to make an appropriate professional investment of energy and intellect to acquire the knowledge and skills necessary to become an effective physician. Both parties can expect the other to prepare appropriately for the educational interaction and to discharge their responsibilities in the educational relationship with unfailing honesty.

Certain behaviors are inherently destructive to the teacher-learner relationship. Behaviors such as violence, sexual harassment, inappropriate discrimination based on personal characteristics must never be tolerated. Other behavior can also be inappropriate if the effect interferes with professional development. Behavior patterns such as making habitual demeaning or derogatory remarks, belittling comments or destructive criticism fall into this category. On the behavioral level, abuse may be operationally defined as behavior by medical school faculty, residents, or students which is consensually disapproved by society and by the academic community as either exploitive or punishing. Examples of inappropriate behavior are: physical punishment or physical threats; sexual harassment; discrimination based on race, religion, ethnicity, sex, age, sexual orientation, gender identity, and physical disabilities; repeated episodes of psychological punishment of a student by a particular superior (e.g., public humiliation, threats and intimidation, removal of privileges); grading used to punish a student rather than to evaluate objective performance; assigning tasks for punishment rather than educational purposes; requiring the performance of personal services; taking credit for another individual's work; intentional neglect or intentional lack of communication.

On the institutional level, abuse may be defined as policies, regulations, or procedures that are socially disapproved as a violation of individuals' rights. Examples of institutional abuse are: policies, regulations, or procedures that are discriminatory based on race, religion, ethnicity, sex, age, sexual orientation, gender identity, and physical disabilities; and requiring individuals to perform unpleasant tasks that are entirely irrelevant to their education as physicians.

While criticism is part of the learning process, in order to be effective and constructive, it should be handled in a way to promote learning. Negative feedback is generally more useful when delivered in a private setting that fosters discussion and behavior modification. Feedback should focus on behavior rather than personal characteristics and should avoid pejorative labeling.

Because people's opinions will differ on whether specific behavior is acceptable, teaching programs should encourage discussion and exchange among teacher and learner to promote effective educational strategies. People in the teaching role (including faculty, residents, and students) need guidance to carry out their educational responsibilities effectively.

Medical schools are urged to develop innovative ways of preparing students for their roles as educators of other students as well as patients.

¹ Fnais N, Soobiah C, Chen MH, et al. Harassment and Discrimination in Medical Training. *Academic Medicine*. 2014;89(5):817-827. doi:10.1097/acm.000000000000200.

² Jagsi 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.

³ Dzau VJ, Johnson PA. Ending Sexual Harassment in Academic Medicine. *New England Journal of Medicine*. 2018;379(17):1589-1591. doi:10.1056/nejmp1809846.

⁴ National Academies of Sciences, Engineering, and Medicine. *Sexual harassment of women: Climate, culture, and consequences in academic sciences, engineering, and medicine*. Washington, DC: National Academies Press, August 2018. <https://www.nap.edu/catalog/24994/sexual-harassment-of-women-climate-culture-and-consequences-in-academic>. Accessed on November 2nd, 2018.

⁵ Swartout KM, Flack WF, Cook SL, Olson LN, Smith PH, White JW. Measuring campus sexual misconduct and its context: The Administrator-Researcher Campus Climate Consortium (ARC3) survey. *Psychol Trauma*. 2018; Aug 6. <http://dx.doi.org/10.1037/tra0000395>, accessed February 25th, 2019

* Claire Duvernoy, MD, and Gustavo Patino, MD, PhD, also contributed.