

Time's Up for Medicine? Only Time Will Tell

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The National Academies of Sciences, Engineering, and Medicine (NASEM) recently released a report on sexual harassment of women working in academic sciences, engineering, and medicine.¹ Its findings are deeply disturbing: sexual harassment is common across scientific fields, has not abated, and remains a particular problem in medicine, where potential sources of harassment include not just colleagues and supervisors, but also patients and their families. To highlight one statistic, as many as 50% of female medical students report experiencing sexual harassment. Imagine a medical-school dean addressing the incoming class with this demoralizing prediction: "Look at the woman to your left and then at the woman to your right. On average, one of them will be sexually harassed during the next 4 years, before she has even begun her career as a physician."

The report's conclusions are consistent with the lack of progress in closing gaps between men and women in salary,² career advancement,³ and leadership⁴ in medicine. One can simply add sexual harassment to the list of enduring gender-based inequities. An editorial responding to the NASEM report stated, "Tolerance of sexual harassment must not continue to be the price that women pay for a career in medicine."⁵ Indeed, the conditions seem ripe for change. Women may soon constitute more than half the physician workforce, and the outcry for safety and equity in the workplace is occurring in other industries. If there is anything the report makes clear, however,

it is that medicine is ill prepared to take meaningful steps toward actually ending harassment.

To begin with, scientific and medical institutions tend to focus on formal complaints and legal cases related to overtly sexual behavior. Yet sexual harassment encompasses an array of verbal and nonverbal behaviors that "convey hostility, objectification, exclusion, or second-class status about members of one gender."¹ Since all forms of harassment have negative effects on women's careers and on their physical and psychological health, there is no clear rationale for ignoring the full range of behavior that falls under this umbrella. Failure to take into account the vast majority of incidents of sexual harassment compromises our response to the problem.

But the reason we are tempted to be literal about sexual acts is obvious: it allows us to ignore not only the scope of the problem but also the fact that every form of discrimination places women at greater risk for sexual harassment. For example, stories of academics who perpetrate abuse for years without punishment almost invariably proceed directly from an account of offenses to an accounting of research funding the offender has brought in for the institution. For a female researcher, a lower salary translates into less fringe funding and a lower indirect cost contribution, thereby making her less valuable to the institution than a male peer who is paid more (assuming that salaries are at or below the cap for researchers receiving National Institutes of Health grants). When women are systematically

devalued, promoted later than men, and paid less, this treatment undermines their institutional power and their ability to report or defend themselves against ongoing sexual abuse, particularly at the hands of male superiors, including those in control of their salaries, promotions, and opportunities. In this and other ways, persistent disparities in pay and career advancement are an integral part of the machinery that facilitates gender-based abuse of all kinds.

Correcting inequities in salary, career advancement, and leadership positions requires more global fixes than even those who are deeply committed to eradicating sexual harassment in the workplace may be willing to consider. Because these problems are inextricably linked, however, it may be that our lack of progress on any one of them is in fact rooted in our habit of addressing them one by one, in isolation. Just as it is difficult to correct the potassium level in a magnesium-depleted patient, interventions targeting sexual harassment are sure to fail in an environment that fosters the devaluation of women in every other sense.

The report also makes clear that scientific and medical institutions too readily consider harassment an individual problem rather than an organizational one. The narrative that sexual harassment occurs because of the psychopathology of a single person overlooks the critical role of institutional permissiveness, fosters a sense of futility (How can we root out sporadic, unique, unpredictable events?), and absolves institutions of responsibility. Fur-

thermore, when organizational culpability in gender-based harassment (whether explicitly sexual or not) is acknowledged, it becomes clear that punishment of individual offenders, even when swift and harsh, does not constitute an adequate response. We believe institutional responses must also include an automatic and thorough investigation of the structures that enabled the harassment to happen in the first place.

Using a framework in which harassment is an organizational problem and one that stems from, and is cultivated by, a broad range of gender-based inequities has the potential to change the tone of this discussion. The NASEM report makes clear that sexual harassment is highly prevalent, a reality that will become unavoidable if we adopt the report's recommendations to perform more rigorous and wide-ranging assessments for it. Therefore, it may not be practical or sustainable to advocate a scorched-earth response to each and every incident. By making discussions of gender-based harassment routine and system-focused — taking a preventive approach that seeks a broad range of solutions well before the point at which sexual-harassment charges are made and legal actions taken — we gain the opportunity to examine harassment openly and frankly. Such a strategy would allow us to shift our attention to primary and secondary prevention of sexual harassment and away from our current approach of waiting for full-blown, metastatic manifestations of harassment, then bemoaning our inability to eradicate it. Sexual harassment is the medical community's chronic, debilitating disease, and we would do well to apply what

we have learned combating other diseases to our efforts to address it.

The NASEM report reveals a damning truth at the heart of our lack of progress on this front: organizations do not perceive sufficient endogenous incentive to reform their practices. The report recommends greater involvement of external organizations, including professional societies and collaborative research entities, in establishing standards to guide academic institutions. But shouldn't it be reasonable to expect that medical organizations, which exist primarily to advance health, would wish to purge a phenomenon within their own walls with such recognized negative effects on their employees' mental and physical health? Even if the obvious hypocrisy is not sufficient motive to inspire change, there are other compelling internal incentives, including the fact that sexual harassment results in "significant and costly loss of talent" from the medical workforce.¹ Moreover, the report makes clear that negative effects of sexual harassment extend beyond targeted individuals to witnesses of harassment, working groups surrounding those involved, and even entire organizations.

When a problem has been neglected for so long, the tendency is to dismiss it as not urgent. But an indolent problem can also be a critical one. In this case, what began as a smoldering fire is now scorching the curtains and the roof, threatening the integrity of the entire house of medicine. We believe that those in the medical field must make a decision: Join the movement, or stand by and fall behind. Address the failings laid out in the NASEM report, or contend with the even more insurmountable consequences of

inaction. Combat all types of gender-based harassment, or accept the vast costs of continuing to undervalue, dismiss, and exclude women.

The declaration of "Time's Up" for medicine feels at once urgent and aspirational. Putting an end to the culture of gender-based harassment is key to recruiting, retaining, and realizing the full potential of the female-majority health care workforce, including 1 in 3 physicians, and feels long overdue. Actually running down the clock on harassment, however, will depend on our willingness to undergo a complete transformation in how we conceive of, approach, and prioritize this problem.

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