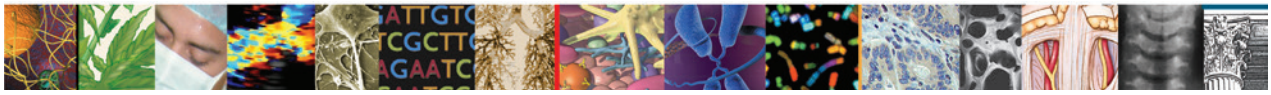

The NEW ENGLAND JOURNAL of MEDICINE

Perspective

APRIL 9, 2020

Standing Up against Gender Bias and Harassment — A Matter of Professional Ethics

Michelle M. Mello, J.D., Ph.D., and Reshma Jagsi, M.D., D.Phil.

A female attending physician and a male resident respond to a call to the emergency department (ED). The ED staff direct questions about medical decisions to the man, addressing only logistic logistic requests to the woman. The resident looks awkwardly at the attending but says nothing. Gesturing at the attending, the patient says he hopes "the hot new nurse is going to be mine." Everyone ignores the comment.

To many clinicians, this scenario is wearyingly familiar. Sexual harassment (including sexist remarks and crude behaviors as well as sexual coercion and unwanted advances) and gender bias (manifested in discriminatory behavior that, though not necessarily consciously recognized by the perpetrator, is sexist) are highly prevalent in medicine, ranging from the type of banal, undermining comments in the above scenario to aggressive, highly pernicious misconduct.[1] Though there is growing evidence of damaging effects of these behaviors on physicians' well-being, careers, and quality of care, the moral imperative for individual action to end sexual harassment and gender bias has had surprisingly little discussion.

Much attention has rightly focused on organizations' responsibilities to address inequity and harassment. But though robust organizational processes are necessary, they are insufficient to transform cultures. The profession must also articulate the ethical obligations of individuals who witness harassment and inequitable treatment. We believe health professionals have a moral duty to practice "upstanding" — intervening as bystanders — in response to sexual harassment and gender bias and that this obligation should be described in codes of medical professional ethics and supported with institutional training. We focus here on women as targets, but much of our argument applies more broadly to mistreatment based on gender, race, or other characteristics.

Respect for persons is a bedrock principle of medical ethics that also supports fair equality of opportunity to attain sought-after professional positions. Because sexual harassment and gender bias disrespect persons, there is a strong deontological basis (i.e., a duty-based argument) for characterizing them as an ethical issue. There are also compelling consequentialist arguments, not limited to the direct effects on the targets of mistreatment.[2] Half of U.S. medical students are women, and considerable evidence supports the importance of women's inclusion to high-quality medical research and, in some contexts, quality of care and patient outcomes.[3] Sexual harassment and gender bias undermine the mutual respect and trust among colleagues that are essential to team-based care and may chill the open dialogue and adverse-event reporting needed to address patient-safety problems.

Identifying sexual harassment as an ethical issue promotes self-reflection and increases the likelihood that individuals and organizations will recognize the harm it causes. Such identification helps organizations shift focus from policies that minimally comply with the law to those that meaningfully express their values. It also promotes individual action: bystanders who view harassment as an ethical issue are more likely to form intentions to intervene.[2] Overcoming inertia and diffusion of responsibility is important because bystander intervention can be effective in combating harassment and bias; it's especially useful for conduct that is not severe or sustained enough to trigger in-

stitutional investigations. Although not all instances of harassment and bias are witnessed, witnessed incidents abound in medicine, and upstanding is therefore critical.

Many medical professional societies' ethical codes now mention sexual harassment; nearly all fall short, however, in enunciating expectations for professionals to respond to these behaviors. Their focus is typically on physicians' obligations to comply with institutional policies prohibiting sexual harassment.[1] Codes rarely articulate an affirmative obligation to intervene when physicians become aware of harassment or discrimination by others. Those that do so generally direct physicians to report the behavior to institutional or disciplinary bodies; they do not speak to other forms of intervention. Among policies issued by nine large specialty societies and the American Medical Association (AMA), only one — that of the American Association of Orthopaedic Surgeons — contains broader, "aspirational advice" to "strive to stop sexually harassing behavior by others."

The contrast to policies regarding an adjacent area — responses to impaired physicians — is striking. For sexual harassment, AMA Code of Ethics Opinion 9.1.3 requires only that physicians "promote and adhere to strict sexual harassment policies in medical workplaces" and ensure that grievance committees are broadly representative and have power; for impaired colleagues, by contrast, Opinion 9.3.2. requires that in addition to ensuring that appropriate institutional mechanisms are in place, physicians "intervene in a timely manner" to ensure that impaired colleagues stop practicing and get help, "report impaired colleagues," and "assist recovered colleagues when they resume patient care."

An audio interview with Prof. Mello is available at NEJM.org

By describing and affirming expectations, ethical codes have historically driven change in the profession.[1] They can do more here. Absent stronger exhortation from within the profession, the norm will continue to be that clinicians are lauded when they stand up to harassment or bias but do not feel obligated — and are not trained and equipped — to do so. The history of adverse-event disclosure suggests that once the profession recognizes an affirmative, individual obligation to act, professionals will demand — and institutions will recognize it as in their interest to supply — training, coaching, and other supports.

Just as physicians recognize an ethical obligation to intervene when they observe an impaired colleague, they have a duty to intervene when they observe sexual harassment or gender bias. This obligation attaches to individuals at all levels within the health care organization. Of course, upstanding entails risk, particularly for persons positioned lower in the hierarchy. Yet we can learn from other contexts in which health care professionals are expected to speak up — for example, when another clinician makes a harmful error. Recommendations in that context emphasize that when a situation is ambiguous, it is best to approach it from the vantage of curiosity and, when feasible, start with a colleague-to-colleague conversation.[4] Interventions can be escalated as needed to address the problem.

For sexual harassment and gender bias, several practical strategies can be used by people on all rungs of the medical ladder and in various scenarios (see table). They range from interrupting the behavior, to expressing solidarity with the target, to discussing behaviors with the perpetrator privately, to repudiating the behavior in the moment, to seeking institutional sanctions. The key is recognizing a duty to engage in some form of upstanding, with the aggressiveness of the intervention commensurate with the severity of the transgression, the relationships and power dynamics involved, and the likelihood of effectiveness. When the perpetrators are patients or patients' family members, responses must be carried out with sensitivity to their vulnerability, making clear that the care team's lack of tolerance for the behavior does not compromise their commitment to caring for the patient.

Reporting inappropriate behavior to the institutional body tasked with antiharassment or antidiscrimination processes is perhaps the most obvious strategy, but it may be insufficient. These processes usually revolve around legal definitions of harassment and discrimination, which are too narrow to capture the full spectrum of behaviors that undermine, dispirit, and marginalize women. Furthermore, the organization may have a track record of anemic action in response to complaints. Therefore, bystanders need other approaches.

Upstanding is not easy, but it can be learned. Professional societies and health care organizations have key roles in supporting professionals in discharging their ethical obligations. Their leaders can affirm the importance of these obligations and demonstrate them personally. It is also critical that they equip professionals with necessary skills and supports. Tip sheets describing various courses of action and suggested language to use in inter-

Potential Responses to Observed Instances of Sexual Harassment and Gender Bias.*

Responses (from least to most aggressive)	Sample Language
Document details of behaviors in a diary for possible future use	10/30/19, 11:00: JB stated during surgery that female surgeons "are never good under pressure."
Remove the target from the situation	"Mr. King, I'm going to have Dr. Target assist with another patient." "So sorry to interrupt — I really need Dr. Target's help in exam room 5."
Provide support privately to the target of the behavior	"I thought what he said was unacceptable, and I'm really sorry it happened. How are you doing? What can I do to support you?" "I wanted to check in with you. Has Jim caused any further problems for you?"
Ask civil but pointed questions of the perpetrator in the moment	"Do you really mean that?" "What do you mean by that? It sounded like you were saying . . . ."
Deflect the behavior using humor	"Since this isn't a *Mad Men* office meeting, perhaps Jim would like to rephrase that."
Consult with personal or professional resources, with or without identifying the perpetrator	"What would you do if you heard something like that from a colleague?" "What can the hospital do to help prevent this from happening again?" "Do you think it's time to do something about Jim's behavior?"
Provide or request that the institution provide "generic" training or reminders about sexual harassment and gender bias	"I have become aware that female trainees are not consistently treated with respect and civility in our hospital. This is inconsistent with our values, and I will not tolerate it." "In response to multiple reported instances of uncivil conduct toward female trainees, we will have a mandatory meeting to discuss our institutional expectations for professional conduct."
Express disapproval of the behavior to the perpetrator in a private setting	"I was taken aback by what you said to Kate. It came across as sexist. We can't treat each other like that." "I didn't want to embarrass you in the meeting, but I thought your comment about the female applicant was over the line. I think it made people uncomfortable, and I hope you'll be more thoughtful in the future." "I was disappointed to hear something like that coming from you, because people really look up to you."
Engage others to help deal with the behavior if it recurs	"I think you're aware that Jim has made some of the female trainees uncomfortable with his comments. If I see it happening again I plan to tell him it's unacceptable, and I hope you'll do the same."
Name the behavior as unacceptable on the spot	"Mr. King, you can't speak to members of your care team like that. We can take better care of you without the distraction of offensive comments." "Hold on — that sounds like you're saying she can't do the job because she's female, which is not okay." "I think that comment is sexist, and it has no place here." "My sense is that you're trying to be purposefully inflammatory. We're going to move on."
Report the perpetrator to institutional sexual harassment officer	"I'm not sure whether his conduct is sexual harassment or not, but it made me uncomfortable and I was hoping to talk to someone about it."
Remove the perpetrator from duties that might prompt a recurrence of the behavior	"I'm going to give you a break from working with med students until we can work this out. Let's meet again in the fall to discuss your thoughts about how to make your lab a more welcoming environment for women."

* Strategies are adapted from Rowe.[5]

vening, formal training in bystander intervention, consultations with ombudspersons, and just-in-time peer-to-peer coaching can build professionals' skills and confidence and show respect and care for upstanders.[1,5]

Our recommendations complement the types of structural antiharassment and antibias measures emphasized in a recent report on sexual harassment from the National Academies of Sciences, Engineering, and Medicine.[1] Individual actions within unsupportive organizations may have low efficacy, and bystanders are more likely to intervene if they believe their organization has effective mechanisms for addressing the problem.[5] True culture change will occur faster, however, if combating harassment and bias is recognized as not just an institutional responsibility, but also as a personal ethical obligation of every health professional.

Disclosure forms provided by the authors are available at NEJM.org.

From Stanford Law School and the Department of Medicine, Stanford University School of Medicine, Stanford, CA (M.M.M.); and the Department of Radiation Oncology and the Center for Bioethics and Social Sciences, University of Michigan Medical School, Ann Arbor (R.J.).

1. 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, 2018.
2. O'Leary-Kelly AM, Bowes-Sperry L. Sexual harassment as unethical behavior: the role of moral intensity. Hum Resour Manage Rev 2001;11:73-92.
3. She Leads Healthcare. #BeEthical — a call to healthcare leaders: ending gender workforce disparities is an ethical imperative. 2018 (http://sheleadshealthcare.com/wp-content/uploads/2018/10/Be_Ethical_Campaign_101418.pdf).
4. Gallagher TH, Mello MM, Levinson W, et al. Talking with patients about other clinicians' errors. N Engl J Med 2013;369:1752-7.
5. Rowe M. Fostering constructive action by peers and bystanders in organizations and communities. Negotiation J 2018;34:137-63.

DOI: 10.1056/NEJMp1915351