

# Sexual Harassment and Gender Bias in Family Medicine: Divergent Experiences of Men and Women

Mechelle Sanders, PhD; Colleen T. Fogarty, MD, MSc; Holly Ann Russell, MD, MS; Kevin Fiscella, MD, MPH; Anne Nofziger, MD; Elizabeth Naumburg, MD; Tziporah Rosenberg, PhD; Susan McDaniel, PhD

**BACKGROUND AND OBJECTIVES:** Awareness of sexual harassment (SH), gender bias (GB), and gender discrimination (GD) has spread throughout popular culture and has been highlighted at universities across the United States. More nuanced data is needed to inform policies that address these issues. However, there are currently limited qualitative studies examining the nature of SH, GB, and GD in academic medicine, particularly family medicine.

**METHODS:** In 2018, we conducted a series of gender-specific focus groups with faculty and residents in a department of family medicine (DFM) to understand their experiences with and responses to SH, GB, and GD. The focus groups were transcribed verbatim. We used immersion-crystallization and an adapted SH Experiences model to review the transcripts and identify patterns or themes during the immersion process.

**RESULTS:** Participants identified the potential for patients, colleagues, faculty, and themselves as perpetrators and victims of SH, GB, and GD. Results suggested that GB was often implicit. SH was experienced verbally and physically. Women participants, especially, reported that both SH and GB occurred frequently and had lasting psychological effects. Gender, age, and position (faculty vs trainee) moderated SH and GB experiences. The effects seemed to be mediated by moral distress.

**CONCLUSIONS:** This study emphasizes the importance of recognizing differences in experiences across gender, age, and position of SH, GB, and GD in academic family medicine. Our findings can be leveraged to develop anti-harassment policies and set cultural expectations.

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ranged from 3% to 28% among medical trainees.<sup>3</sup> Stratton et al found that GD and SH influenced medical trainees' choice of specialty and residency program rankings.<sup>4</sup> These experiences have implications for emotional well-being and long-term career outcomes.

To our knowledge, few qualitative studies of SH, GB, and GD in academic medicine exist.<sup>4</sup> We previously described barriers and facilitators to reporting and responding to SH and GB in family medicine (FM).<sup>6</sup> We found that one of the strongest facilitators for breaking the silence around these experiences was a culture that supported discussion and action around SH and GB.<sup>6,7</sup> Wendling et al's supporting commentary noted the

need to shine the light on our institutions and understand how our people—all of our people—are being treated, for to face that truth is to take our first step toward change.<sup>8</sup>

Especially after #MeToo, sexual harassment (SH), gender bias (GB), and gender discrimination (GD) have been reported within academic medicine across discipline and academic position. Ceppa et al found that among attending surgeons, 81% of women vs 46% of men had experienced

sexual harassment.<sup>1</sup> At a large academic medical center, the majority of faculty women (82.5%) and faculty men (65.1%) experienced at least one incident of sexual harassment from staff, students, or faculty within the previous year.<sup>2</sup> A systematic review of SH and discrimination found a prevalence of verbal harassment

From the Department of Family Medicine, University of Rochester Medical Center, Rochester, NY (Drs Sanders, Fiscella, Naumburg, Rosenberg, and McDaniel); Department of Family Medicine, University of Rochester School of Medicine and Dentistry, Rochester, NY (Drs Fogarty, Russell, and Nofziger); and Institute for the Family in Psychiatry, University of Rochester Medical Center, Rochester, NY (Drs McDaniel and Rosenberg).

The literature on SH among physicians uses primarily quantitative methods and characterizes the frequency and type of harassment<sup>3</sup> but provides little context or nuance. Further, the few qualitative studies tended to include homogenous gender (primarily women) and position (trainees or faculty) samples. We need a more nuanced and comprehensive understanding of the nature of SH, GB, and GD experienced in FM across gender and position in order to develop all-inclusive strategies and policies that mitigate these issues.

In this paper, we present the lived experiences of our participants in order to begin to address this need. We use qualitative data to better understand and characterize the nature, pervasiveness, and responses to SH, GB, and GD between and within men and women faculty and residents in a department of FM.

## Methods

We conducted focus groups (FGs) with faculty and residents in our department of FM to understand their experiences with and responses to SH, GB and GD. The University of Rochester's Institutional Review

Board deemed this study exempt (RSRB00072684). We used the consolidated criteria for reporting qualitative research as a guide to report the study findings.<sup>7</sup>

Research team members (S.M., K.F., H.R., T.R., E.N., A.N.) facilitated the faculty groups. The chief residents facilitated the resident groups out of concern that residents may feel vulnerable sharing their experiences with faculty. All participants self-selected into the FGs divided by gender (women or men) and position (resident or faculty). None of the FGs were nonbinary.

## Participants

We conducted six FGs. There were four, 1-hour faculty FGs that consisted of attending physicians, behavioral health faculty, and nurse practitioners, at different career stages. The two, 2-hour resident FGs consisted of physician residents (Table 1). The FG invitation emphasized that participation was voluntary, confidential, and nonremunerated. All faculty and residents were invited to participate.

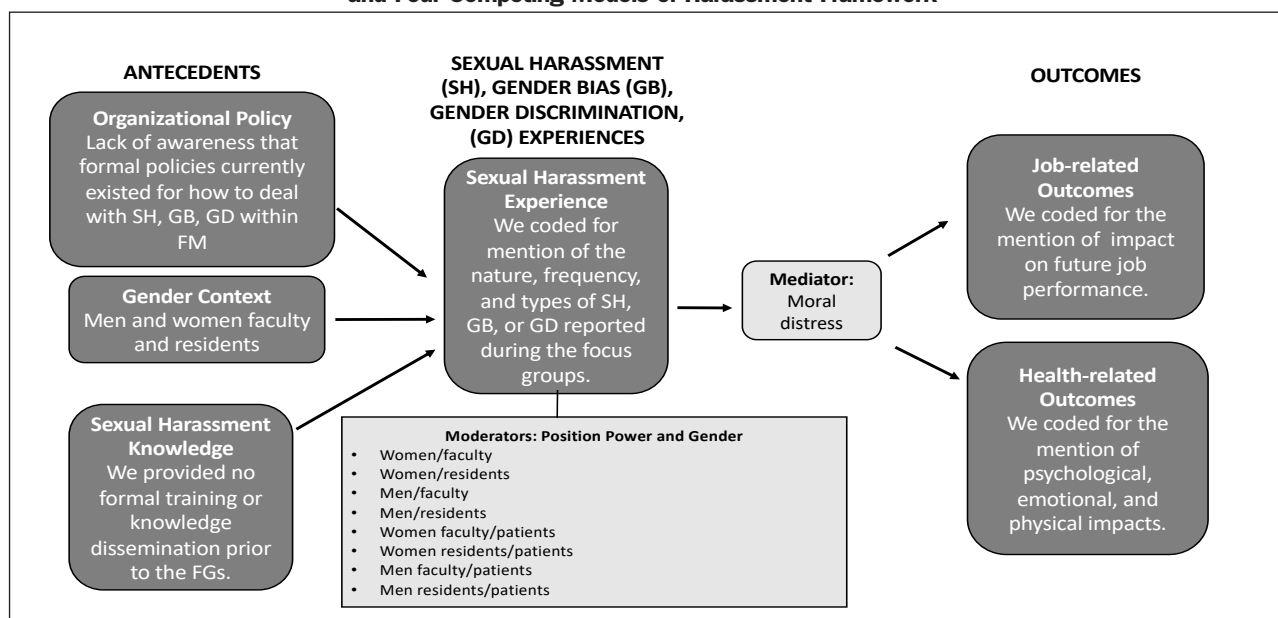
The facilitator's gender was concordant with the FG they facilitated. Facilitators began the sessions

with a review of voluntary consent for participation, assurance of confidentiality, and the expectation of confidentiality among participants. The semistructured interview began with the definitions of SH, GB, and GD from the US Equal Employment Opportunity Commission.<sup>9</sup> Facilitators first asked about experiences with SH, GB, and GD with patients, which we felt to be a safer conversation than experiences with colleagues or supervisors. We concluded by asking more generally about any other experiences with SH, GB, or GD they would like to share. Our semistructured interview guide has been previously reported.<sup>6</sup> We audio recorded each FG and had them professionally transcribed anonymously.

## Identification of Codes and Categories

We used an immersion-crystallization process whereby we immersed ourselves in the data, reflected collectively on the analysis experience, and identified patterns or themes noticed during the immersion process.<sup>10</sup> A concept was considered a code if it was noted more than once and present in at least two transcripts.

**Figure 1: Adapted Version of Fitzgerald et al's Conceptual Model of SH Experiences and Four Competing Models of Harassment Framework**



**Table 1: Composition of the Focus Groups**

Group Mix	General Flow of Discussion	Gender and Role of Facilitators	Total No. of Focus Grups	No. of Participants Per Focus Group
Women faculty	<ul style="list-style-type: none"> <li>Remind participants that FG is voluntary, nonremunerated, and confidential</li> <li>Definition of SH, GD, and GB from US Equal Employment Opportunity Commission*</li> <li>Provide an opportunity for participants to share experiences of SH, GD, and GB that they may have experienced or witnessed with patients</li> <li>Provide an opportunity for participants to share experiences of SH, GD, and GB that they may have experienced or witnessed with colleagues (and or faculty for the resident groups)</li> </ul>	Women faculty	2	n=7-12
Men faculty		Men faculty	2	
Women residents		Woman chief resident	1	
Men residents		Man chief resident	1	

Abbreviations: FG, focus group; SH, sexual harrasment; GD, gender discrimination; GB, gender bias.

\* US Equal Employment Opportunity Commission. Preventing employment discrimination against lesbian, gay, bisexual or transgender workers (brochure). US Equal Employment Opportunity Commission. Published 2014. Accessed November 23, 2021. <https://www.eeoc.gov/laws/guidance/preventing-employment-discrimination-against-lesbian-gay-bisexual-or-transgender>

We adapted Fitzgerald et al's model by incorporating known moderators of reported experiences with SH, GB, and GD, and a mediator of reported outcomes. We used our adapted model to explain differences in reported experiences based at the intersections of gender and/or position power among FG participants.

The team met regularly to develop the coding structure; discuss additional themes, gaps or discordances; and review continued strategies for analyses. We approved the final coding structure after four iterations. Once consensus on the coding structure occurred, each transcript was read and independently coded by two study team members. Each coder entered their independent codes into a MAXQDA database where the codes were summarized and collated for analyses. We member-checked<sup>9</sup> the validity of our findings with faculty during regularly scheduled faculty meetings. Study team members did not code any of the transcripts for groups they facilitated. We used Fitzgerald et al's SH Experiences model as a guiding framework to map antecedents and outcomes related to SH, GB, and GD. We adapted the model by incorporating known moderators of reported experiences

with SH, GB, and GD, and a mediator of reported outcomes (Figure 1).<sup>12</sup> Specifically, our model was used to explain differences in reported experiences based on the intersections of gender (men vs women)<sup>13</sup> and/or position-power (trainee vs faculty vs patient vs age), as well as the impact of moral distress<sup>14</sup> (ie, when clinicians cannot accomplish what they believe to be ethically appropriate actions) on outcomes.<sup>15</sup> In medical training, trainees are typically, although not always, younger than attending clinicians. It was difficult to separate the effect of age and of power status, so we present the combination of these as "position-power."

## Results

### Participants

Twenty-eight faculty and 24 residents took part in the six FGs (Table 1). We did not collect demographic information to ensure anonymity. Professional role representation of the FG participants was comparable to the overall DFM roles (Table 2).

### Analyses: Codes and Themes

We identified four main themes: (1) SH and GB occurred frequently to women, particularly while in training, (2) GB was often implicit and

disproportionately affected women, (3) SH had differential impact by age (of the offender or offende) and gender (of the offender or offende), and (4) GB and SH left lasting effects, sometimes mediated by moral distress. Illustrative quotes related to each code are shown in Table 3. Examples of quotes related to the more specific themes are listed in Table 4. We observed variation within some themes based on the gender of the offende and the type of offender (patient, colleague/faculty). While the transcripts were deidentified, the gender of offender and offende were often stated or obvious from context.

### Theme 1: SH and GB Occurred Frequently to Women, Particularly While in Training.

All women FGs reported frequent firsthand experiences of SH and GB. Women faculty and residents had similar experiences, but faculty reported more frequent SH when they were younger and/or in training.

Sometimes when I think about this, I feel like this happens literally almost every single day. I feel like personally I get very numb to it. Just happened to me yesterday

**Table 2: Department of Family Medicine Clinician Characteristics**

	DFM, Overall	DFM, Focus Group Participants
Faculty	N=47	N=28 (59.6% participation rate)
Residents	N=30	N=24 (80% participation rate)
Total	N=77	N=52 (67.5% participation rate)

Abbreviation: DFM, department of family medicine.

**Table 3: Examples of the Coding Structure**

Category	Code	Exemplary Quote
Lived experience	Witnessed directly	“I see it in residents. I remember a resident that I was watching for direct observation, for primary care counseling, and the patient very explicitly made a number of comments about her, and the resident handled it beautifully and said, ‘That’s not appropriate. We’re not gonna talk about those things. If you can’t stop talking about those things, I’m gonna have to step out of the room.’”
Perceived frequency	Frequency of harassment	“I mean, there’s things like ... the labor and delivery resident ... had a little wooden box that had a faux vaginal canal that you could practice doing vaginal exams on and I can’t even tell you how many jokes there were about the vagina in a box. It was just like a common center of sexualized joking.”
Behavioral responses	Tried not to show it bothered you	“And I tried to laugh it off, tried to push it off. But I felt that I didn’t deal with it very well, and I told faculty that he [the patient] made me freaked out.”
Affective responses	Self-blame	“Yeah, it’s true. I harbor guilt to this day about it, though, because I never said anything to anybody, that that was a thing. And, only later, I found out much later, I found out that it was a known dynamic, shall we say.”

when I was in a patient room. [Resident woman]

Most of my examples are from when I was younger also, but I don’t think that’s because it doesn’t happen now. [Faculty woman]

There were few firsthand examples of SH and GB reported in the men’s FG. However, the men did comment on how frequently these experiences occurred among women trainees.

... persistent misogyny... there’s a particular faculty member in a prominent position ... who just does this over and over again. And students will tell you this. I mean, it’s just ... over and over and over and over and over again. [Faculty man]

Dozens of times. Precepting. Patients frequently comment ... I’ll say something like, ‘You’ve got a really good doctor,’ and [they] say, ‘She’s really hot, too,’ or, ‘She’s really good looking,’ or, ‘She dresses real nice ...’ [Faculty man]

**Theme 2: GB Was Often Implicit and Disproportionately Impacted Women.** Many participants described experiences where patients assumed the man in the room was the physician, regardless of their actual position. There was also a tendency among patients to attribute female stereotyped gender-roles to women.

We walked in this patient’s room ... The person addressed me as ‘doctor,’ and said to [the woman colleague], ‘Are you the TV lady?’ [Faculty man]

... when you walk in as a team with a female attending and perhaps a male medical student or resident and the patients will almost always address the man. [Resident woman]

A faculty woman described situations where women’s ideas are appropriated by men.

... some guy later makes your suggestion. And I say, ‘Well, I’m glad

you agree with (woman colleague). She mentioned that about 10 minutes ago ...’ [Faculty woman]

**Theme 3: SH Had Differential Impact by Age (of the Offender or Offensee) and Gender (of the Offender or Offensee).** Verbal SH was common, including statements with sexual connotations. Examples of verbal harassment included jokes, sexist remarks, and comments on physical appearance. Women commented on being distressed when being referred to with diminutive names such as “sweetness” and “cutie.” Faculty women mentioned that as they grew older and rose in academic rank, the instances of SH declined.

... when you have gray hair, you don’t get hit on as much anymore ... it definitely becomes protective. [Faculty woman]

There was some disagreement among participants about what constitutes SH when the situation involved age discordance (eg, a younger

Table 4: Examples of Codes Related to Each Theme

Theme	Exemplary Quote(s)
Theme 1: Sexual harassment (SH) and gender bias (GB) occurred frequently to women, particularly while in training.	"I get a lot of comments about my marital status on either end, when I'm gonna have a baby, when I'm gonna go out. I get a lot of comments about that and I don't know if that happens to the guys at all, but it's a common theme in a visit."
	"Okay. When I was a resident, there was an attending ... known to be over the line a fair amount. He would come over and put his arm around me. I know a difference when, if I'm hugging a woman or a man colleague, if it's a regular old hug versus something else, and this was clearly not a mutual thing. So, I just looked, and I said, ...'I need you to take your arm off me right now, and don't put it back.'"
	[examples from women residents]
Theme 2: GB was often implicit, and disproportionately impacted women.	[Regarding feedback about performance on an outside service]. "It was like 'great resident, except she looks disinterested on rounds, she needs to smile more, or something like that.'"
	[woman faculty]
	"... when my friends and I started applying to residency. A lot of my friends had comments on their dean's letters that they were too aggressive or too bossy. I think specifically to use the word bossy to describe someone, you don't use that to describe a male med student."
Theme 3: SH had differential impact by age (of the offender or offeree) and gender (of the offender or offeree).	"Anyway, the important part is... when I was younger that happened, and I lacked confidence and there wasn't a culture to talk about it. I didn't talk about it with my supervisor. Now I think, that was weird not to have."
	"I've had physicians throw things at me. I had one that tried to ... shut a door on my fingers, throw a phone at me. There's been lots of experiences like that, not so much, definitely not here. But as a younger nurse ..."
	[examples from women faculty]
Theme 4: GB and SH leave lasting effects, sometime mediated by moral distress.	"I think back and be like, 'Okay, that felt really weird. Okay, was that just me because we've been talking about sexual harassment and I'm looking for it all the time, or is it ...?' I feel like there's an inner check that I have to go through that sometimes would keep me from saying things."

clinician and an elderly patient). A faculty man described experiencing the behavior differently based on the woman patient's age.

It makes me feel weird ... especially if they're young ... If they're older ... I'm kind of more comfortable with it. [Faculty man]

A faculty woman recalled an encounter in which a male medical student did not associate the elderly female patient's comments with SH because of her age.

... I said, 'But you know what, if an elderly man said that to a woman, a female doctor, we wouldn't be

okay. So were you really okay with it?' He's like, 'Oh she was just a cute little old lady.' [Faculty woman]

With patient-related SH, typically the offender was a man, and the victim a woman resident. The most commonly reported occurrence was exposure to male genitalia (eg, male patients sexualizing physical exams and having erections).

... when I was a resident in the ED ... I started doing an exam without a chaperone, and he totally had an erection. [Faculty woman]

... 'Dr [Resident's name], I have something to show you.' I walk back

in, had his pants down and he was masturbating. [Resident woman]

A few examples included gender-concordant SH encounters with patients. There were discussions around what, if anything, the clinician would have done differently if the patient had been from the opposite sex.

When I was doing the breast exam [she said], 'Oh that feels good.' And I went to do the pelvic and she's like, 'You know, I'm used to sticking things in me. I'll just insert the speculum myself.' ... If a man had behaved that way, I would've stopped the exam. [Faculty woman]



The one time I felt really uncomfortable was a very muscular, gay guy coming on to me, and I felt kinda scared, and I realized, reflecting on it, it was all about power, and that this guy was more powerful than me, and so it was the first time I got a little glimpse of what, for women, why that would be different, because it's somebody, often, more [physically] powerful than them, and that's scary. [Faculty man]

**Theme 4: GB and SH Have Lasting Effects, Sometimes Mediated by Moral Distress.** Participants commented on the psychological and emotional consequences of GB and SH, experienced directly or indirectly, leaving some participants feeling threatened and unsafe.

Some women participants struggled to resolve competing ethical principles, expressing self-blame for not setting limits with patients, placing patient care before one's own psychological safety.

Bystanders or witnesses to discussions of verbal sexual harassment

struggled with the impact of their lack of response in the moment.

A long time ago ... I was overhearing women interns talking about the porn that was readily shared on surgical rounds ... and how uncomfortable it made them feel ... I was mortified ... I feel guilty when I think about it. [Faculty woman]

A resident man reported concern about potentially being the offender in situations and not knowing it, such as making jokes that could be perceived as harassment.

My fear is that it gets to the point where nothing is safe and I'm afraid to make any comment whatsoever and I'm basically just a robot just going through the motions, ... there is a time and a place for comedy in medicine. Patch Adams showed us that. [Resident man]

Several women wore their white coats in hopes of preventing SH or GB among patients. They reported using the coat for safety, essentially, to cue the patient to their position as a doctor and to be addressed as a

professional. The men in our FGs did not discuss these types of personal protective strategies.

'Yes, I may be the same age as your granddaughter, but look at this white coat, I'm a doctor.' I don't know, I've kept that barrier. [Resident woman]

I used to keep a white coat for when I would see patients like him to put on over whatever I was wearing that day. [Faculty woman]

Several faculty men expressed doubt about the existence or pervasiveness of SH, GB, and GD in the department. A male member of the research team was surprised by the frequency of the women's experience and some of the content of the results (Figure 2).

## Discussion

The purpose of this study was to qualitatively identify SH, GB, and GD in an academic DFM practice. Furthermore, we aimed to identify factors that may explain the differential impact of these experiences. Most recent studies, conducted

**Figure 2: Quote From Male Faculty Member of the Research Team**

*Male privilege tends to insulate men from these experiences. I suspect that most men in family medicine recognize these events happen but have little idea of the phenomenological impact including fear, distraction, uncertainty and self-doubt from these patient and other encounters, fear of the next encounter with the same person, and continuing self-doubt and self-blame. Based on the affective tone from many of the women's transcripts, there is clear residual impact on the people involved long after the event. A key contribution of this work is sensitizing men to the frequency and impact of these female experiences of harassment and discrimination in family medicine.*

Quote by a male faculty member of the research team, reflecting on the differences in type and frequency of experiences of the men vs women focus groups.

across academic department specialties, explored homogenous groups (ie, trainees only) and are quantitative.<sup>2,15,16</sup> Similar to previous reports, our results reveal that SH and GB are common experiences.<sup>17-19</sup> All our FGs included physical and verbal examples that involved patients, faculty, and colleagues.<sup>21</sup> Other studies have shown that SH and GB are underreported,<sup>21-23</sup> and we assume that many other experiences went unspoken in our groups.

As in other studies,<sup>1</sup> women participants experienced most of the incidents. The participants reported a range of experiences from explicit harassment to gender-based microaggression. Our finding that women clinicians use their white coats as protection by reinforcing their professional status has also been reported in the literature.<sup>24-27</sup>

Despite the increased awareness of SH and GB, our findings show that men and women clinicians in the same department have different experiences and perspectives regarding the scope of these issues. Men remain largely shielded from the direct impact of these situations and rarely felt unsafe. Similar to Farkas' findings, among our participants, men experienced SH differently from women and struggled to define some of these events as harassment. In our study, men were generally more accepting of SH encounters with older women patients, and felt conflicted about how to respond to younger patients who communicated sexual attraction. With these exceptions, our male FGs struggled to recall personal experiences and instead spent more time discussing hypotheticals.

### Limitations

There are several limitations to our study. First, our findings are limited to one DFM in one academic medical center. However, some of the examples came from training experiences at other institutions throughout the country and are similar to those reported in the literature in other disciplines. Second, due to the voluntary nature of the FGs and

challenges with time and competing priorities, approximately 68% of residents and faculty attended these groups. As a result, our findings may not represent the entirety, in terms of frequency or quality, of all our faculty and residents. Finally, we did not have a nonbinary FG, and cannot comment on the impact of SH, GB, and GD on nonbinary gender identities.

### Implications

Our findings have important implications for research and policies related to mitigating SH and GB in academic medicine. Most studies have been gender-homogenous and focused on quantitative reports of SH and GB, while providing less qualitative context, nuance, or impact. Our descriptions of the multiple actors, contexts, and outcomes can help leaders and policy makers tailor strategies to anticipate and address these issues in multistakeholder environments such as FM.

First, we suggest patient care policies should include mitigation strategies for reducing moral distress in clinicians. For example, a policy that requires a clinician to continue providing care to a sick patient despite their inappropriate SH behavior (first do no harm) may in fact be harmful to the clinician. These situations are not trivial, as moral distress has been associated with perceived lack of support from peers, burnout, and lack of involvement in decision making.<sup>12,13,29</sup> Second, trainings should consider how to address gender stereotypes from patients, as well as responses to SH from gender-concordant and age-discrepant patients.

We recently published participants' experiences of barriers and facilitators to reporting.<sup>6</sup> Our next steps include department scenario training. Our goal is to develop a culture that encourages open conversations about SH and GB experiences, increases sensitivity through direct feedback, encourages help-seeking by any offender, decreases distress among those directly or indirectly

affected, and builds skills for all of us in responding to bias and harassment in clinical environments.

### Conclusions

This study emphasizes the importance of elevating the discussion of all-too-common experiences of SH and GB, especially for women in academic medicine. Our study identified the presence of patients, colleagues, and faculty as perpetrators and targets of SH and GB in clinical and educational settings. Policy efforts and institutional leadership can use these findings to set clear expectations for patient, faculty, and trainee behaviors.

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**CORRESPONDING AUTHOR:** Address correspondence to Dr Mechelle Sanders, Department of Family Medicine, University of Rochester Medical Center, 1381 South Ave, Rochester, NY 14620. 585-324-4566. Fax: 585-473-2245. mechelle\_sanders@urmc.rochester.edu.

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