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Family Medicine

BRIEF REPORT

Addressing Sexual Harassment and Gender Bias: Mandatory Modules Are Not Enough

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ABSTRACT

Background and Objectives: Despite decades of new policy guidelines and mandatory training modules, sexual harassment (SH) and gender bias (GB) continue in academic medicine. The hierarchical structure of medical training makes it challenging to act when one experiences or witnesses SH or GB. Most trainings designed to address SH and GB are driven by external mandates and do not utilize current educational techniques. Our goal was to design training that is in-person, active, and directed toward skills development.

Methods: Our academic family medicine (FM) department began by surveying our faculty and residents about their lived experiences of SH and GB. We used these data, incorporating principles of adult learning, to deliver voluntary, experiential, interactive workshops throughout 2019. The workshops took place during faculty development meetings and an annual retreat. We used interactive techniques that included case-based and Theater of the Oppressed formats.

Outcomes: Eighty percent of faculty and residents participated in at least one of our voluntary training sessions. In April of 2020, we administered a retrospective, pre/postsurvey on confidence in recognizing, responding to, and reporting SH and GB. We found significant improvements in all domains surveyed; many participants reported using the skills in the 6 months prior to completing the surveys.

Conclusion: We demonstrated that voluntary, interactive training sessions using the recommendations of the National Academies of Science Engineering and Medicine Report on the Sexual Harassment of Women improve participants' reported confidence in recognizing, responding to, and reporting SH and GB in one academic FM department. This training intervention is practical and can be disseminated and implemented in many settings.

INTRODUCTION

Sexual harassment (SH) and gender bias (GB) continue to be problems in academic medicine. Our department of family medicine (FM) found that SH and GB were frequently experienced by most women, yet most were hesitant to report or respond.[1] Respondents cited fear as a barrier on a continuum of interpersonal-level fear of reporting, from being seen as someone who "takes the fun out" of work, to "losing opportunities for career advancement."[1] Respondents' experience of SH and GB is associated with lasting psychological effects that mainly spared the men in our department.[2] These findings are consistent with those reported in other disciplines.

Organizations have responded to SH and GB with mandatory trainings and policies intended to mitigate both. The literature on trainings about SH and GB is based on workplace and college campus interventions and not guided by any theoretical model.[3] There is no long-term data on whether participation in these trainings changes culture or behavior.[4]

The National Academy of Science, Engineering and Medicine (NASEM) Report, The Sexual Harassment of Women, states "...the cumulative result of sexual harassment in academic sciences, engineering, and medicine is significant damage to research integrity and a costly loss of talent in these fields."[5] The authors encourage structural interventions to improve transparency and accountability, cultivate respect and civility, diffuse the power structure, and reduce isolation.

Based on encouraging results from the diversity training literature, the NASEM monograph recommends that trainings occur in-person, be tailored to group needs, include active participation, and change knowledge and behaviors rather

than only attitudes. We believe it is also critical to include the role of bystanders (encouraging upstanders who actively respond despite potential personal or professional risks),[6] and to address the context.

METHODS

We explored the lived experiences of our faculty and learners through focus groups.[1,2] We then presented our findings to faculty and triangulated data with faculty feedback and discussion of the data. Based on these results, we developed trainings to reinforce the department's stance against harassment and discrimination, to develop shared behavioral expectations and to educate all members of our department about policies and procedures.

We used an annual resident and faculty retreat to practice skills in addressing SH and GB from patients. We started with a patient focus, believing these scenarios were psychologically safer than experiences with colleagues/faculty, and then moved to experiences with colleagues. Faculty trained in Theater of the Oppressed (TO), or Forum Theater techniques[7,8] led this workshop. The facilitators established an atmosphere of emotional safety to collaboratively develop and practice responses.

During two regularly-scheduled faculty meetings, we assigned small groups to examine case scenarios of SH and GB drawn from our data, asking teams to develop responses. Then the groups came together to discuss strategies and recommendations. This exercise focused on building skills, while acknowledging a range of individual responses, the importance of recognizing shared values and developing a community of proactive bystanders. See Table 1 for demographics and Table 2 for workshop and case details.

We conducted a χ^2 test to determine how well the survey sample generalized to the members of the department across the roles (eg, physician, nurse practitioner, and resident). Results indicated that the proportions of respondents by role were not statistically significantly different (P=.259).

We surveyed all residents and faculty (n=100) using a 16-item retrospective pre/postsurvey (See Appendix Table A).[9] We included "recognizing" as a separate category acknowledging that additional challenges may prevent responding or reporting even when the behavior is recognized. We surveyed all faculty and residents because our ultimate goal was to change the culture and experience of the department. The survey occurred in the following academic year and included respondents who had not attended trainings and interns who had not been present in the department at the time of the trainings.

RESULTS

Fifty respondents completed the survey, including 26 faculty (behavioral health, nurse practitioner, and physician faculty) and 24 trainees (family medicine physician- and nurse practitioner residents). Most (56%) of the respondents attended at least one training.

All differences between perceived pre/post confidence and skills were statistically significant (P<.05). The largest changes were in recognizing GB and confidence in reporting both SH and GB (Table 3).

Respondents reported frequently using skills learned in the 6-month posttraining period, with 55% recognizing GB during this interval. Many reported responding in the moment as a target (22%) or a bystander (30%). Eleven percent of respondents reported GB to a departmental leader and 5% reported GB to an institutional leader. Similarly, 17% recognized SH during the 6-month time period, 7% reported to a departmental leader and 2% reported to an institutional leader.

DISCUSSION

In academic medicine, a one-time series of trainings is unlikely to yield long-term change, as faculty and residents turn over. Mandatory online training modules may increase short-term knowledge and fulfill regulatory obligations, but are unlikely to reduce the frequency of GB and SH.[3] Our results must be considered in light of the goal to transform institutional culture and improve the behavior of all members with regard to SH and GB.

We surveyed all faculty and residents, regardless of training attendance. We observed increased confidence in each domain surveyed although statistical significance was reached only among attendees. This may indicate that informal conversations outside the trainings changed behavior. We believe community awareness of the ongoing conversation in the department is itself an intervention and departmental prioritization of this work helps to decrease fear of retaliation. We assessed changes once, approximately 6 months after the last training. Additional research is needed to determine whether similar interventions result in longer-term change.

LIMITATIONS

Some department members who may have benefited from attending voluntary training did not participate, highlighting a challenge for all institutions. Mandatory education conflicts with the main tenets of adult learning[10] and Self-Determination Theory, in which autonomy is a key driver of an individual's motivation to make a behavioral change.[11] We suggest that those who require corrective action be managed and mandated through the relevant institutional process. Additionally, we did not ask if confidence in this behavior is at different levels when the behavior involves a colleague, personal behavior, or a patient.

A retrospective, pre/postdesign eliminates a problem with traditional pretests in that participants may not be aware of what they do not know. This design can introduce bias as individuals resist reporting lower or unchanged skills. Further, a person's reported knowledge prior to the training may not be accurate, as internal standards or values may have changed through participation in the training.[12]

Moving Forward

Ongoing trainings represent a challenge within academic medicine given competing priorities for educational time. Our department is committed to at least annual workshops for

all faculty and learners that are in-person, tailored to group needs, include active participation, and build skills. To further reinforce individual accountability, we now require specific discussion of diversity, equity, and inclusion contributions in all faculty annual reviews. Culture and behavior change take time and resources; understanding the lived experiences of the group allowed us to create valid, tailored trainings.

This work occurred within one FM department at one large academic medical center. We recommend that other departments and institutions adopt similar processes. When all faculty and trainees are aware of institutional expectations and confident speaking about their concerns, we will be closer to the culture we all deserve.

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Presentations

Preliminary data analysis of this material was presented in presentation form at Society of Teachers of Family Medicine National Conference in Toronto, Canada in April 2019 and in poster form at North American Primary Care Research Group National Conference in Toronto, Canada in November 2019.

Ethical Approval

This study was reviewed and considered exempt by the University of Rochester's Institutional Review Board, RSRB#6649, 10/08/2021

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TABLE 1. **Survey Respondents' Demographic Data**

Demographic	Overall	Faculty (n=26)	Trainees (n=24)
Gender (n=50)			
Female	68% (34)	58% (15)	79% (19)
Male	26% (13)	35% (9)	17% (4)
Other	0%	0%	0%
Prefer not to answer	6% (3)	8% (2)	4% (1)
Years since completed training mean (std)	n/a	15 (13)	n/a
Years since joining the faculty mean (std)	n/a	12 (12)	n/a
I feel that the amount of time spent on issues related to sexual harassment and gender bias has been:			
Too much	6% (3)	8% (2)	4% (1)
About right	66% (33)	77% (20)	54% (13)
Too little	8% (4)	8% (2)	8% (2)
Unaware of this work	20% (10)	8% (2)	33% (8)
Attended the SH/GB Training in:			
Apr 2019	56% (28)	63% (16)	42% (10)
May 2019	n/a	77% (20)	n/a
Oct 2019	n/a	62% (16)	n/a
Dec 2019	n/a	0%	n/a
Role (n)	**Female**	**Male**	**Prefer Not to Answer**
Role and Gender			
BHS faculty	1	0	1
Fellow	1	0	0
NP faculty	6	2	0
NP resident	1	0	0
Other faculty	0	1	1
Other trainee	2	0	0
Physician faculty	10	7	0
R1	7	0	0
R2	4	2	0
R3	4	2	1
Total	36	14	3

Abbreviations: SH, sexual harrassment; GB, gender bias; BHS, behavioral health science; NP, nonphysician.

TABLE 2. **Faculty Development Retreat and Workshops Outline**

Retreat	Description
Setting	Annual, full-day retreat. All residents and faculty (including APP, Behavioral Health, and Physicians) are expected to attend if available.
Objective	Increase understanding of the lived experiences of faculty and residents as it relates to sexual harassment and gender bias in patient care
Framing	Faculty from the medical center trained in Theater of the Oppressed (TO), or Forum Theater, led this workshop* starting with presenting information about SH and GB policies at the University and medical center including that any retaliation against reporters is expressly forbidden.
Activity	In small groups, incidents of personally experienced or witnessed sexual harassment or gender bias were discussed. Each small group picks one scenario to act-out in front of the larger group and practices the script so the words used are consistent. In the large group, the facilitators let the scenario run through as it happened initially. Then the scenario is replayed, from the beginning with instructions for audience members to yell "stop" to halt the action if there is something they see as a problem or want to change. The facilitator then encourages the participant who stops the action to become an actor and show rather than tell the recommended change.
Workshops	
Setting	Routine monthly 1-hour faculty development meetings. All faculty (including APP, behavioral health, and physician faculty) are welcome.
Objective	Increase comfort responding to observed incidents of sexual harassment and gender bias
Framing	We have learned about our own faculty and resident experiences and now hope to build skills together with a goal of communicating support and improving culture.
Activity	Make sure everyone at your table knows first names and identify your group's scribe and your reporter (5 minutes) Open the envelope and review your case (5 minutes) [The cases were all taken from experiences reported in the initial focus groups.] Brief individual writing prompt: Place yourself in the scenario (5 minutes) Small group discussion and plan; write suggested responses (10 minutes) Large group discussion: review suggestions, provide feedback (15 minutes) Debrief: how did this go, suggestions for future workshops (5 minutes)
Case 1	You are in a clinical planning meeting comprised of men and women. The group energetically responds to a proposal from a male colleague, which you notice was first suggested 10 minutes ago by a female colleague, but others didn't seem to hear.
Case 2	You are on a task force working on a new clinical protocol. The member of the group with the most clinical expertise in this topic is a mid-career woman. The senior leader announces to the group that a younger, less experienced male colleague will be leading the implementation, saying "He is energetic and capable. He reminds me of myself at his age."
Case 3	You and a younger colleague are walking to an interdepartmental meeting. Your colleague says "I always dread meetings with Dr A—he is so friendly, but I know a regular old hug from something else."
Case 4	You enter a room to precept a level 4 visit. As the resident explains elements of the plan, the patient says to the resident: "You must be a heartbreaker—you have such beautiful eyes."
Case 5	You are working with a new female scribe. Your patient comments three times during one visit that the scribe is a very attractive young woman.
Case 6	A female resident asks for support. Her male resident from another service just gave her a neck massage during rounds. Last week he asked about the last time she had sex.

* Boal A. *Games for Actors and Non-actors*. 2 ed. Routledge; 2002.

TABLE 3. Retrospective Pre/Post Median Scores, 3-Point Scale

	All Respondents	Did Not Attend Training	Attended Training		
	Pre: Median (IQR)	Post: Median (IQR)	*P* Value	*P* Value (n=13 to 17 p er Question)	*P*Value (n=29 to 31 p er Question)
Gender Bias					
Recognize it (n=47)	1 (1,2)	2 (1,2)	.0047	.3173	.0082
Know how to report (n=46)	1 (0,1)	1 (1,2)	.0016	.3173	.0027
Respond in the moment, I am the target (n=46)	1 (0,1)	1 (1,2)	.0005	.1573	.0016
Respond as bystander, in the moment (n=46)	1 (1,1)	1 (1,2)	.0002	.3173	.0003
Respond as bystander, after it happens (n=45)	1 (1,1)	1 (1,2)	.0002	1	.0002
Assist colleague or learner (n=45)	1 (1,1)	1 (1,2)	.0001	.0837	.0003
Report to leader in department (n=44)	1 (1,2)	2 (1,2)	.0022	.0838	.0107
Report to leader in med center (n=43)	1 (0,1)	1 (0,2)	.0159	.1573	.0457
Sexual Harrassment					
Recognize it (n=42)	2 (1,2)	2 (2,2)	.008	1	.0082
Know how to report (n=42)	1 (1,2)	2 (1,2)	.00001	0.3173	.00001
Respond in the moment, I am the target (n=42)	1 (1,1)	1 (1,2)	.0009	0.3173	.0016
Respond as bystander, in the moment (n=42)	1 (0,1)	1 (1,2)	.00001	0.3173	.0001
Respond as bystander, after it happens (n=42)	1 (1,1)	1 (1,2)	.0003	1	.0003
Assist colleague or learner (n=42)	1 (1,2)	2 (1,2)	.0009	1	.0009
Report to leader in department (n=42)	1 (1,2)	2 (1,2)	.0001	0.3173	.0002
Report to leader in med center (n=42)	1 (0,1)	1 (1,2)	.0005	0.3173	.0009

Abbreviation: IQR, interquartile range.