EDITORIAL

Sexual Misconduct in Academic Medicine

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The Me Too movement began in 2006 but was popularized in 2017 by women in Hollywood who had been sexually harassed. Since then, the pervasiveness of sexual misconduct across many segments of society has become apparent, and medicine has not been exempt. Although many studies have described sexual misconduct from the point of view of the person who was the target of the sexual misconduct, few studies have focused on the perpetrators.

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In this issue of *JAMA*, Espinoza and Hsiehchen examine the characteristics and actions of faculty perpetrators in academic medicine.[1] Using the internet and the Academic Sexual Misconduct Database, the authors identified faculty at US higher education institutions in the biomedical and health sciences who were accused of sexual misconduct that resulted in institutional or legal actions that proved or supported guilt. Between 1982 and 2019, 125 faculty accused of sexual misconduct that affected at least 1668 targets were identified. These faculty were predominantly male (97.6%) and of high academic rank (51.2% were full professors and 16.8% were chairs, directors, or deans). The targets of the misconduct were women (91.5%), subordinates (72%), and clinical trainees (19.2%), and the offenses included sexual assault (29.6%) and sexual harassment (56%).

Although disturbing, these results are not surprising, as they echo findings published by the National Academies of Sciences, Engineering, and Medicine in 2018 that reported that close to half of female medical students have been sexually harassed. The rate is almost twice that reported by female students in sciences and engineering, marking academic medicine as having the highest rate of sexual misconduct among scientific fields.[2]

In fact, the academic workplace is surpassed only by the military, which has the highest rates of sexual harassment.[3] Like academic medicine, this environment is also typically characterized by hierarchical power imbalances and predominantly male leadership[4] and involves high-risk stakes of life and death.

What is surprising and concerning in the findings reported by Espinoza and Hsiehchen is that faculty perpetrators in the biomedical and health sciences were to a degree immune to consequences. While the misconduct often involved multiple persons as targets over many years, only 49.2% of accused faculty resigned and 20.8% were terminated. Fifty faculty remained in academia despite termination by the home institution, resignation, retirement, sanctions, or disciplinary actions. Reasons were not examined but may be due to clinical, research, or educational contributions that were wrongly judged to have outshone the transgressions of the faculty perpetrators, or insufficient knowledge by other institutions of the transgressions due to poor communication or nondisclosure agreements.

Although the true prevalence of faculty who commit sexual misconduct could not be determined in the study, the instances found likely represent only the tip of the iceberg in academic medicine. A 2019 study of 16 657 graduating medical students found that as little as 23.2% reported sexual harassment, mistreatment, or discrimination to faculty or administration charged with handling such issues.[5]

The significance of perpetrators not being identified or stopped has to do with the effect on the persons who are targets of sexual misconduct. Reports show that sexual misconduct contributes to increased risk of stress, anxiety, depression, and substance abuse among affected persons, and one study reported an association among discrimination, abuse, harassment, and burnout in general surgery residents.[6] There is no doubt that, as one article stated, "Sexual harassment poisons the water around an entire medical team."[7]

Clearly, sexual misconduct in academic medicine, as in other parts of society, cannot be tolerated, and institutions, individuals, and the culture must change. Transparent institutional practices that uphold a zero-tolerance policy and consistent consequences for inappropriate behaviors are essential, and are effective only when backed by an organizational climate in which all voices are valued and heard. As stated previously, "Every physician, female or male, should feel empowered and encouraged to speak up, without fear, if she or he ever experiences or observes behavior that betrays the values central to a person's identity."[8]

Standing up and speaking out must be central to the culture and collective mindset not only to stop sexual misconduct but to prevent such acts from happening in the first place. But how can such change be accomplished?

First, change who is in the room. More women than men now enter medical school, but there is a paucity of female leaders across the ranks of academic medicine, with 42% of faculty members[9] and fewer than 20% of department chairs and deans[10] being women. Diversifying talent through mentorship, sponsorship, and promotion alters the power differential and enhances patient care[11] while also nurturing the values of inclusion, trust, and respect that are so vital to cultural change.

Second, empower all individuals to intervene in instances of sexual misconduct. While shown to be effective on college campuses,[12] active bystander training is beginning to gain momentum in medicine and "it makes preventing harassment everybody's responsibility."[13] These trainings offer an approach to recognizing moments that should be interrupted and

handling them with professionalism. Through strategies ranging from deflection to questioning, inviting further conversation ("I'm sure you didn't mean that the way it came across. Can you explain?"), and even humor, bystanders can play an important role in prevention, awareness, and behavioral shifts.

Third, support persons who are the targets of misconduct. Neutral parties separate from the chain of command but versed in institutional policies and procedures, like a faculty ombudsperson, can provide safe and confidential opportunities to voice concerns. A faculty legal advisory committee that brings representatives from areas such as human resources, compliance, risk management, and legal affairs to the table can also ensure a fair and impartial arena for open dialogue.

As previously stated, "Now is the time for mutual respect, for utmost civility, and for women (and men) to be brave in putting an end to sexual harassment and abuse."[8] The charge to individuals in academic medicine continues to be to bravely stand up and speak out against sexual misconduct.

ARTICLE INFORMATION

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