Preventing Sexual Harassment in Medicine

by Jill Karatinos, M.D. , 1988/1989

When I was in medical school in the 1970s, exploitation of female medical students/residents by males higher in the medical hierarchy, was just considered an expected occupation hazard for women. There was no concept of "harassment" because men rationalized, as they have throughout time immemorial, that the women had brought it on themselves just by being there. Complaints to attendings only brought ridicule. Civil rights and personal dignity were not honored when it came to women subordinates. Women were socially stigmatized if they tried to support each other.

When I attended the Fourth Regional Conference for Women in Medicine in April 1986 in New York, I chose a workshop on "Sexual Harassment in the Medical Workplace" to see what had happened since I had finished training. Some of the women there had lost their places in training programs because of refusal to cohabit with superiors. An attorney who specialized in sexual harassment cases told the group that things were just beginning to change in the courts with regard to justice for women plaintiffs. Later in 1986 came the Supreme Court ruling on "Meritor Savings Bank v Vinson" wherein sexual harassment, simply defined as overtures making the workplace an unpleasant place to work, was illegal. Where before the burden of proof was on the woman victim to document an overt sexual proposition, now the woman need simply show psychological gender-related intimidation. A year later a government woman attorney won job reinstatement and back pay under the new ruling.

Now even the AMA has legitimized recognition of the problem. **American Medical News** December 16, 1988 carries two articles, "Sexual harassment in Medicine Subject of AMA Study" p. 9 and "Residents Stress, Sexual Harassment Top Discussion" p. 45. At the AMA June meeting a survey showed that two thirds of those surveyed reported "relationships" between attendings and residents. The vanguard of the conservative male establishment in medicine has belatedly given official credence to the fact that this is not an "attitude" problem of a few paranoid misfits.

Two consequences result from sexual manipulation. The woman victim suffers from post-traumatic stress disorder. The male perpetrator goes on to inflict his attentions on other women physicians and often on female patients, once having positive reinforcement in his power plays. As in rape, the real motivation for the male is power/control, not sexual gratification per se. Free consent from the woman cannot be seen as uncontrived under conditions of hierarchy. One can only surmise the ultimate effect of this continual humiliation of another human being on the humanity of the perpetrator. I have sought to understand the mind of this kind of man. One helpful source was a recent popular book called The Casanova Complex by Peter Tractenberg. To some extent, sexual pursuit may be an addiction just as are alcohol, drugs, overeating and workaholism. The activity dispels an inner emptiness. The woman is merely a symbol of something unattainable or forbidden. Interest ceases once the "unattainable" is attained. Something valued has been devalued. In male groups such as hospital hierarchies, the conquest of women serves as a male bonding ritual, substituting for brotherly intimacy in the way that winning a goal together does for a football team.

It is no longer fashionable or legal to deny or ignore sexual harassment. Every training program should institute a written grievance procedure and an office designated to implement that procedure. Women's support groups should be established on campus. Ideally, referral counselors should not be in the university's pay. An ethics course should be mandatory for students in the preclinical years. Some kind of student faculty dialogue should be held yearly on the problem.