ORIGINAL ARTICLE

Sexual Harassment in Radiology

Aline Camargo, Li Liu, David M. Yousem

Abstract

Purpose: To gauge the prevalence of sexual harassment (SH) and to understand the issues regarding its disclosure among radiologists.

Methods: A questionnaire on ethics and SH was sent by e-mail to 1,569 radiologists and radiology trainees in an institutional database maintained for continuing medical education purposes on three separate occasions between September 17 and October 31, 2016. The link to the survey was also posted on social media sites via the authors' divisional and institutional accounts on Facebook, Twitter, Instagram, and Aunt Minnie, as well as on ACR and RSNA web blogs.

Results: Overall, 9.75% (39 of 400) respondents stated they had suffered SH, with more female (22 of 90 = 24.4%) than male victims (11 of 249 = 4.4%) ($P < .001$). Only 29.4% of SH victims said they would likely report SH ($P < .001$). Women (46 of 90 = 51.1%) said they were less likely to report SH than men (150 of 242 = 62.0%) ($P = .03$), and American medical school graduates (119 of 220 = 54.1%) were less likely than graduates from outside the United States (37 of 48 = 77.1%). Of 401 respondents to questions on SH, 28.7% (n = 115), including more women (38 of 91 = 41.8%) than men (61 of 249 = 24.5%) ($P = .002$), said they had witnessed SH.

Conclusions: By percentage responding, female radiologists are more frequently victims and witnesses of sexual harassment but are less likely to report such cases. Steps need to be taken to eliminate a culture that leads radiologists to tolerate SH without addressing it.

Key Words: Radiology practice, sexual harassment, sexual discrimination

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INTRODUCTION

The US Equal Employment Opportunity Commission (EEOC) states that "unwelcome sexual advances, requests for sexual favors, and other verbal or physical conduct of a sexual nature constitute sexual harassment (SH) in the workplace when this conduct explicitly or implicitly affects an individual's employment, unreasonably interferes with an individual's work performance, or creates an intimidating, hostile, or offensive work environment" [1]. The EEOC also states that SH represents sexual discrimination, and it violates Title VII of the Civil Rights Act of 1964 [1].

Women or men may be potential victims of SH, and the harasser may or may not be of the opposite gender [2]. Another essential point that characterizes SH is the harasser's behavior must be unwelcome [1]. There is no social or professional relationship hierarchy that defines and limits the concept of SH. Thus, the victim may be the harasser's supervisor, coworker, or subordinate [1]. In 2011 alone, more than 11,000 SH charges were filed by EEOC, which does not include the cases that were never reported [2]. In 2014, 18,900 military members were victims of unwanted sexual contact. Of those, only 6,131 reported the case [3]. Studies have shown that harassers usually find in their gender, race, and class positions power that "justifies" their abusive behavior, not only directed toward employees and subordinates, but also toward people who stand in a higher professional hierarchy level [4]. Additionally, harassers may use professional or social power, or even physical intimidation, to commit the SH and control their victims [5]. Physicians wield considerable professional and social power.

Previous research compared the rates of discrimination and SH among residents from several different medical specialties. A very low rate was reported in radiology, compared with other specialties, such as urology, family medicine, and psychiatry [6].

Division of Neuroradiology, The Russell H. Morgan Department of Radiology and Radiological Science, Johns Hopkins Medical Institutions, Baltimore, Maryland.

Corresponding author and reprints: David M. Yousem, MD, MBA, Johns Hopkins Medical Institution, 600 N Wolfe Street, Phipps B100F, Baltimore, MD 21287; e-mail: dyousem1@jhu.edu.

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To develop strategies to decrease the number of SH cases as well as to encourage the victims to report the cases, it is fundamental to understand the prevalence and risk factors involved in such practice in our profession [7]. The aim of this study was to estimate the prevalence of SH in the field of radiology. Understanding the current environment will allow analysis, review, and implementation of changes in SH policies, training, reporting, and education.

MATERIALS AND METHODS

Institutional review board approval was obtained before the study was initiated. The institutional review board approved a survey questionnaire on ethical issues designed after a literature review. The survey was piloted with six radiologists in our department (two trainees and four faculty members) to suggest changes to any ambiguous wording.

The questionnaire was available online through the Qualtrics (Provo, Utah, USA) platform. A link to the survey was sent by e-mail to 1,569 radiologists and radiology trainees in our institutional database maintained for continuing medical education purposes on three separate occasions over a 6-week period. The link to the survey was also posted on social media sites via the authors' divisional and institutional accounts on Facebook, Twitter, Instagram, and Aunt Minnie forums. The survey was also publicized on ACR and RSNA web blogs. Only radiology physicians were asked to answer the survey. The survey was conducted between September 17 and October 31, 2016.

The SH portion of the study was extracted from a larger bioethics survey that was administered to assess ethical issues in radiology. The survey overall consisted of true-false, multiple-choice, and free-text questions. Three questions addressed issues of SH. In addition, three open-ended questions allowed respondents to comment about ethical dilemmas, including SH or discrimination. The questions that were asked in regard to SH are listed in Appendix 1.

RESULTS

Four hundred one radiologists or trainees responded to the survey during the study period. Considering the 1,569 e-mails sent, the response rate was 25%. The characteristics of respondents are shown in Table 1. Because the survey allowed the respondents to skip questions if they preferred (to respect sensitivities on the subject), we report different numbers of respondents for different questions.

Witnessing SH

Of 401 respondents to this survey, 28.7% (n = 115) reported they had witnessed SH. The rate of witnessing SH increased with age. For each 10 years' increase in age, there was a 50% increase in the odds of witnessing SH (odds ratio [OR] =1.50, 95% confidence interval [CI] = 1.19-1.91).

Additionally, there was a higher rate of female (38 of 91 = 41.8%) than male (61 of 249 = 24.5%) SH witnesses ($P = .002$). Female respondents seemed about two times more likely to witness SH as a percentage of respondents (OR = 2.21, 95% CI = 1.33-3.67).

Regarding the years of experience and practice, we found that a higher rate of practitioners witness SH than trainees (33.5% vs 15.7%, $P = .002$). This is confounded, however, by increasing age. No significant difference was found in frequency of reporting the witnessing of SH among country of practice, country of medical school, and residency or work setting (Table 1).

Victims of SH

Thirty-nine (9.75%) of the respondents reported that they had been victims of SH. There was a higher percentage of female than male SH victims (24.4% [22 of 90] vs 4.4% [11 of 249], $P < .001$). A female respondent was seven times more likely to be an SH victim (OR = 7.00, 95% CI = 3.23-15.15).

No significant difference was found in the frequency of victimization among country of practice, country of medical school, and residency or work setting (Table 1).

Reporting SH

The responses to the question "If you were a victim of sexual harassment in your workplace, would you report it?" are shown in Figure 1.

Male respondents said that they were more likely to report SH, with 150 of 242 (62.0%) saying they were likely or extremely likely to report, whereas 46 of 90 (51.1%) women said they were likely or extremely likely to report ($P = .03$).

Victims of SH were less likely to report it (29.0% vs 62.5% of nonvictims, $P < .01$). Graduates from foreign medical schools were more likely to report SH compared with US graduates (77.1% vs 54.1%, $P = .01$).