



Review

An Institutional Approach to Harassment

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ABSTRACT

Harassment is commonly experienced within the hierarchical world of medicine by both learners and faculty. There are different types of harassment; however, all types of harassment have a negative impact on individuals professionally and personally. Harassment also negatively impacts groups, by impacting team dynamics, perceptions of leaders, and upon workplace psychological safety and wellness. To address harassment, the Faculty of Medicine and Dentistry (FoMD) at the University of Alberta (UAlberta) has developed a structured institutional response to harassment through: (1) providing institutional members and leaders with explicit expectations of behaviour, outlining types of harassment, and starting to integrate psychological safety priorities at all levels of the institution; (2) through aiding, training, selecting, and evaluating workplace leaders in psychological safety, workplace wellness, and harassment interventions, guiding leaders through options of: coaching types of interventions, investigations, and

In 2013, Canadian standards for psychological health and safety in the workplace were created to ensure that workers interact safely and without harassment.¹ Therefore, Canadian healthcare institutions are obligated to deal effectively with harassment. In this paper, definitions of different types of harassment are provided; the article also highlights the prevalence of harassment within medicine, and its impacts within today's medical setting. The unique aspects of racial and sexual harassment are addressed, and the online setting is touched upon as well. Finally, the approach to harassment followed by the Faculty of Medicine & Dentistry (FoMD) at the University of Alberta (UAlberta) is presented as an example of one institution's method of dealing with harassment, using a case vignette to illustrate the institutional process. A broader outline of the harassment-reporting mechanism used in Alberta has been recently published.² In this paper, the author reviews common forms of harassment

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See page S127 for disclosure information.

RÉSUMÉ

Les expériences de harcèlement sont courantes dans le milieu hiérarchisé de la médecine, tant au sein des apprenants que du corps enseignant. Il existe différents types de harcèlement; cependant, tous les types de harcèlement ont des répercussions sur les personnes, tant sur le plan professionnel que personnel. Le harcèlement a également des répercussions négatives sur les groupes, en nuisant à la dynamique de groupe et à la perception des dirigeants, ainsi qu'à la sécurité et au bien-être psychologiques au travail. Pour lutter contre le harcèlement, la Faculté de médecine et de dentisterie de l'Université de l'Alberta a élaboré une réponse institutionnelle structurée au harcèlement à l'aide des moyens suivants : (1) en fournissant aux membres et aux dirigeants de l'établissement des attentes explicites en matière de comportement, en décrivant les types de harcèlement et en commençant à tenir compte des priorités en matière de sécurité psychologique à tous les niveaux de l'établissement; (2) en aidant les

and presents a case example of an approach to addressing harassment used at UAlberta.

Definitions of Harassment

The FoMD utilizes UAlberta definitions of harassment for institutional legal implications and consistency in application of broader UAlberta policies. The UAlberta defines harassment as follows: "conduct or comment ... that: is demeaning, intimidating, threatening or abusive ... causes offence and should have reasonably been expected to offend; ... impairs work or learning performance, or limits opportunities for advancement or the pursuit of education or research, or creates an intimidating, hostile or offensive work or learning environment" (p. 4),³ and it specifies that "...the person(s) engaged in harassment need not have the intention to harass" (p. 4).³

This definition overlaps with the definition of harassment used by the Canadian government.⁴ The UAlberta outlines various types of harassment.³ Bullying is defined as an aggressive type of harassment that can be physical, verbal, or emotional.³ Racial harassment is that experienced by a person or group based on their race, ethnicity, place of birth, or religion.³ The FoMD has gone further in defining racism within their recently approved anti-racism policy as one group of people dominating another based upon race.⁵ Racial microaggressions are subtle, sometimes unintentional forms of

when there is a duty to report to formal bodies; (3) educating and providing tools for workplace members to deal with harassment situations either; directly or by reporting; and (4) being aware of, and addressing, unique aspects of: racial, sexual, and online harassment. Through such iterative institutional process improvement and reflection, we are moving towards effectively addressing harassment within all learning and working environments. Our ultimate institutional goal is to eradicate harassment occurrence within our institution, thus creating a psychologically safe, transparent, and accountable culture for individuals, workplaces, and groups.

discrimination based upon race.^{6,7} Sexual harassment is defined as “unwelcome conduct or comment of a sexual nature which detrimentally affects... or leads to adverse consequences” for an individual.⁵ Sexual harassment is one type of sexual violence, as outlined by the UAlberta Sexual Violence Policy.⁸ Types of harassment can be combined and can overlap with and intensify unique individual experiences,⁹ as for those who have intersecting identities, defined as the “inextricable way that factors such as race, class, gender, disability, and sexuality intersect to shape each other within broader structures and processes of power” (p. 857).^{10,11}

The Prevalence of Harassment in Medicine

Harassment is a common and current problem in the field of medicine. A systematic review and meta-analysis of 57 cross-sectional and 2 cohort studies in 2014 showed that the majority of medical trainees (59%) had personal experiences of harassment and discrimination. Verbal harassment was the most commonly reported experience (63% prevalence), mostly from consultants.¹² These findings have been supported by other authors such as Hu and colleagues,¹³ who reported various types of discrimination and harassment among 7409 surgery residents: 31.9% felt discriminated against based upon gender; 16.6% reported racial harassment experiences; 30.3% reported verbal or physical abuse; and 10.3% reported sexual harassment experiences. Attending physicians were the most common source of abuse (51.9%).¹³ Harassment and abuse have been reported by emergency residents in another study as being even more prevalent (91%), with similar types of harassment reported.¹⁴ However, the reported prevalence of harassment varies among training specialties in studies, confirmed in the systematic review and meta-analysis published in 2014.¹² Such variation is seen in one 2019 survey of internal medicine trainees (n = 24,104 responses of 26,201 trainees), in which only 13.6% of residents had experiences of bullying.¹⁵ This result stands in contrast to national survey results of bullying experiences across 16 residency specialties and 9 different internal medicine subspecialties in the United States, with 48% reporting bullying within the preceding year (2158 responses).¹⁶ In Chadaga and colleagues’ study,¹⁶ demeaning behaviours, undermining of work, and unjustified criticism

dirigeants en milieu de travail, en les formant, en les sélectionnant et en les évaluant relativement à la sécurité psychologique, au bien-être au travail et aux interventions en cas de harcèlement, et en aidant les dirigeants à sélectionner les bonnes options d’encadrement en matière d’interventions et d’enquêtes ainsi que le moment où ils doivent effectuer un signalement aux organismes officiels; (3) en informant les employés en milieu de travail et en leur fournissant des outils pour gérer les situations de harcèlement, soit directement, soit en les signalant; (4) en prenant en considération les aspects uniques du harcèlement racial, sexuel et en ligne, et en les abordant. Grâce à cette amélioration itérative des processus institutionnels et à cette réflexion, nous progressons vers une lutte efficace contre le harcèlement dans tous les environnements d’apprentissage et de travail. Notre objectif institutionnel ultime est d’éradiquer les cas de harcèlement au sein de notre établissement, créant ainsi une culture de sécurité psychologique, de transparence et de responsabilisation pour les personnes, les lieux de travail et les groupes.

were most frequently reported (44%), with other experiences of indirect insinuations and sarcasm (37%) and humiliation (32%). Again, attending physicians and nurses were cited as being the primary sources of bullying (29% and 27%, respectively).

Experiences of harassment persist after medical training, with multiple studies exploring experiences of different types of harassment within various medical groups and institutions with different survey questions.¹⁷⁻²² Sexual harassment had been experienced by 25% of faculty members, more women than men, at one academic centre.¹⁷ Another academic medical institution reported different types of sexual harassment experienced by women, by members of the lesbian, gay, bisexual, transgender, queer (LGBTQ+) community, and by underrepresented minorities from staff, students, and faculty, with differences in prevalence among department groups.¹⁸ A high prevalence of discrimination, sexual harassment, and bias was reported among acute care surgeons,²³ and 70% of both women and men physicians reported sexual harassment at a German academic medical centre (n = 737).²⁰ A 2018 study from the National Academies of Science, Engineering, and Medicine revealed that more than 50% of women faculty and staff reported being harassed in academic environments.¹⁹ And, in a recently published global survey of cardiologists (n = 5931), almost half of respondents reported the existence of a hostile workplace comprised of mistreatment and harassment.²¹ Emotional harassment was most common, reported in 29% of responses; discrimination was reported in 30% of responses, and sexual harassment was experienced by 4% (more common among female cardiologists). Overall, women and early-career cardiologists were the most likely to report hostile workplaces.²¹

Racial Harassment

In a systematic review of harassment and discrimination in medical training, racial harassment was reported at a prevalence of 26.3% across included studies.¹² This finding is consistent with rates of racial discrimination reported by Sharma and colleagues in a global survey of cardiologists (24%).²¹ Even higher rates were reported among surgeons of colour (48.6%), in a survey of a society of trauma surgeons.²³

Higher rates of racialized sexual harassment were reported by women from underrepresented minorities (43%) and by Asians (37%), compared with whites (29%), at an academic North American medical centre.¹⁸

Sexual Harassment

Sexual harassment has been reported to be a common experience for faculty at an academic medical institution, with 85.2% of female and 65.1% of male faculty reporting at least one incident of sexual harassment during the previous year, from “insiders” (staff, students, and faculty).²⁴ In 2018, the National Academies Press provided an extensive report examining sexual harassment within the fields of academic sciences, engineering, and medicine in relation to organizational climates.¹⁹ Three categories of sexual harassment were defined: (i) gender harassment (eg, behaviours of hostility, objectification, and/or exclusion based upon gender); (ii) unwanted sexual attention; and (iii) sexual coercion.¹⁹

Online Harassment

The UAlberta states that harassment can be committed by “phone, computer, or other electronic means” (p. 2).³ Online harassment and bullying has been suggested to be subtly different than traditional methods of bullying, possibly with increased psychological harm to recipients.²⁵ Cyberbullying is defined as harm inflicted upon others through the use of computers, and the use of electronic means of communication to bully others.²⁵ At this time, there is little mention in the literature of online harassment in the field of medicine. However, our institutional experience has been that there are increasing reports of online harassment over the past few years, with unique aspects and complexity.²⁶

Impacts of Harassment

The impacts of harassment are many, affecting individuals both personally and professionally, and affecting institutions in terms of professional collaboration, professional productivity, and patient care. Recipients of harassment may fear retaliation, lack of confidentiality, lack of belief by others that their story is true, and embarrassment, in addition to believing that they should endure harassment to fit into a group.^{12,27} Experiences of harassment have been reported to be associated with burnout and being unwell in multiple studies of medical trainees.^{13,15,28,29} Being harassed was associated with increased burnout and suicidal thoughts in a cross-sectional survey of general surgery residents (N = 7409),¹³ and with high rates of burnout (57%), poor performance (39%), and depression (27%) in internal medicine residents.¹⁵ For faculty physicians, harassment experiences among cardiologists was associated with reduced professional activity with colleagues (75% reporting some or significant impact on the work environment), in addition to adverse effects on their patient care (53% of reports).²¹ Finally, the scientific productivity of academic women faculty in science, engineering, and medicine was reported to be reduced after experiences of sexual harassment; women in such circumstances also adjust their work habits to withdraw from their professional environments, with diminished contact with collaborators and

mentors.¹⁹ These examples highlight the impacts of harassment and call attention to the importance of explicit institutional messaging at multiple levels that harassment is not accepted, harnessed with systematic education and options to support those subjected to harassment.

An Institutional Approach to Harassment

For many years, the FoMD at the UAlberta has publicly stated that it will not tolerate harassment in any setting.³ Despite official statements, harassment appears to be active and ongoing in our setting.²⁶

The FoMD at the UAlberta has designed a structured institutional approach to harassment. Our approach has the following goals: (i) to provide institutional members and leaders with an overarching clear set of behavioural expectations, guidelines, and interventions for psychological safety, to create a transparent, accountable, and just culture; (ii) to aid, train, evaluate, and select leaders in psychological safety and harassment interventions; (iii) to educate and empower individuals to deal with harassment directly or by reporting, via multiple avenues of support. Racial, sexual, and online harassment has required a specific institutional approach, with ongoing development.

Goal: To provide institutional members and leaders with an overarching clear set of behaviour expectations, guidelines, and interventions for psychological safety, to create a transparent, accountable, and just culture

The FoMD has created an institutional definition of professionalism and guiding values to serve as our goals and ground rules for behaviour.^{30,31} These values overlap with physician codes of conduct.^{32,33} Our institutional approach to harassment is encompassed within larger FoMD psychological safety priorities, centred around: (i) faculty structure; (ii) faculty development; (iii) individual stressors; and (iv) faculty communication strategy (see Fig. 1). Psychological safety is defined as “a climate in which people are comfortable expressing and being themselves,” and as an environment where people feel safe to take interpersonal risks by speaking up, and by having difficult conversations, and to intervene as bystanders (p. xvi, introduction).³⁴ Psychological safety has been recommended to be part of all working and learning environments across Canada,³⁵ and it is measurable.^{36,37} Professionalism stakeholders within and outside of the FoMD identified our priorities through brainstorming at a psychological safety workshop; these are now integrated within the FoMD strategic plan and will be measured as part of the FoMD strategic plan goals.³⁸

Goal: To aid, train, evaluate, and select leaders in psychological safety and harassment interventions

To increase trust and promote a just culture, guidance has been developed for leaders to deal with harassment consistently and compassionately, following our institution’s professionalism values.³⁰ We have structured guidelines for harassment concerns, outlining the following: (i) when a coaching approach might be appropriate, and what a coaching approach looks like; (ii) when to consider gathering more information about a concern before taking action and implementing interventions; and/or (iii) when there is a duty

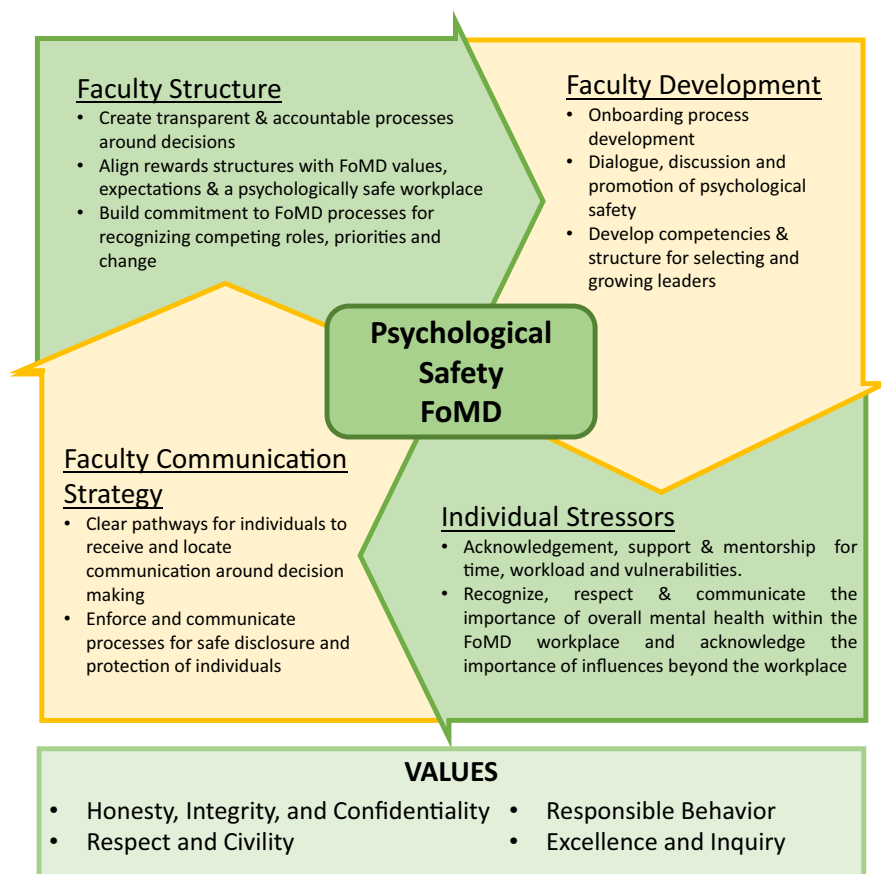


Figure 1. University of Alberta Faculty of Medicine & Dentistry (FoMD) psychological safety priorities.

to report to formal bodies for formal investigations with possible disciplinary sanctions of an individual’s professional practice (see Fig. 2) At the UAlberta, FoMD faculty leaders carry out informal, coaching interventions³⁹ (see Table 1). For students, if there is a potential violation of the Code of Student Behaviour, then the concern is submitted to the Dean of Students.⁴⁰ If there is a need for formal investigation, with implications for possible disciplinary sanctions/actions, formal disciplinary bodies are involved—central UAlberta Faculty Relations, the Dean of Students, Alberta Health Services (AHS)/Covenant Health, and/or the College of Physicians and Surgeons of Alberta (CPSA) investigate and implement outcomes, depending on the setting (see Table 1).

Upon receiving reports of mistreatment and harassment, FoMD leaders follow graduated levels of intervention, originating from the Vanderbilt Model of Professionalism Intervention,⁴¹ and the Health Quality Council of Alberta Provincial Framework.⁴² The Vanderbilt Model outlines the fact that addressing unprofessional behaviours in a stepped manner is an effective way to intervene, can improve staff satisfaction, and contributes to both institutional reputation and more productive work environments.⁴¹ The steps involved are as follows:

- (1) **Level 1 Intervention: informal conversations** for single, isolated events;
- (2) **Level 2 Intervention: nonpunitive apparent pattern awareness interventions** for apparent patterns of behaviours;

- (3) **Level 3 Intervention: individualized coaching plans** for persistent patterns of behaviours despite previous interventions, for “can’t” professionalism behaviours, where the individual can’t fill role expectations because they do not know the rules of the role, or may not have skills to enact them, from J. Bolton, University of New Mexico, unpublished report⁴³; and
- (4) **Level 4 Intervention: imposition of disciplinary processes** through duty of reporting to formal bodies (Health Professions Colleges such as the College of Physicians & Surgeons of Alberta; provincial health authorities; Alberta Health Services or Covenant Health; and/or central University of Alberta Faculty Relations or Dean of Students), depending on whether the context of the concern is clinical vs academic, and whether it involves patients, colleagues, or learners.

We escalate levels of intervention in apparent egregious concerns “where there is concern for serious potential impact to others ... with regards to safety, mistreatment, or harassment.”²⁶ Occasionally, we have suspended faculty from interacting with learners during the implementation of coaching plans and during formal-body outside investigation. We have supported the graduated return of faculty to working with learners after completion of coaching plans or depending on outcomes of formal outside-body investigations. Grassroots stakeholders have pointed out that Level 1 and 2 interventions are not appropriate for situations of racial harassment. Therefore, we are in the process of creating a more responsible and

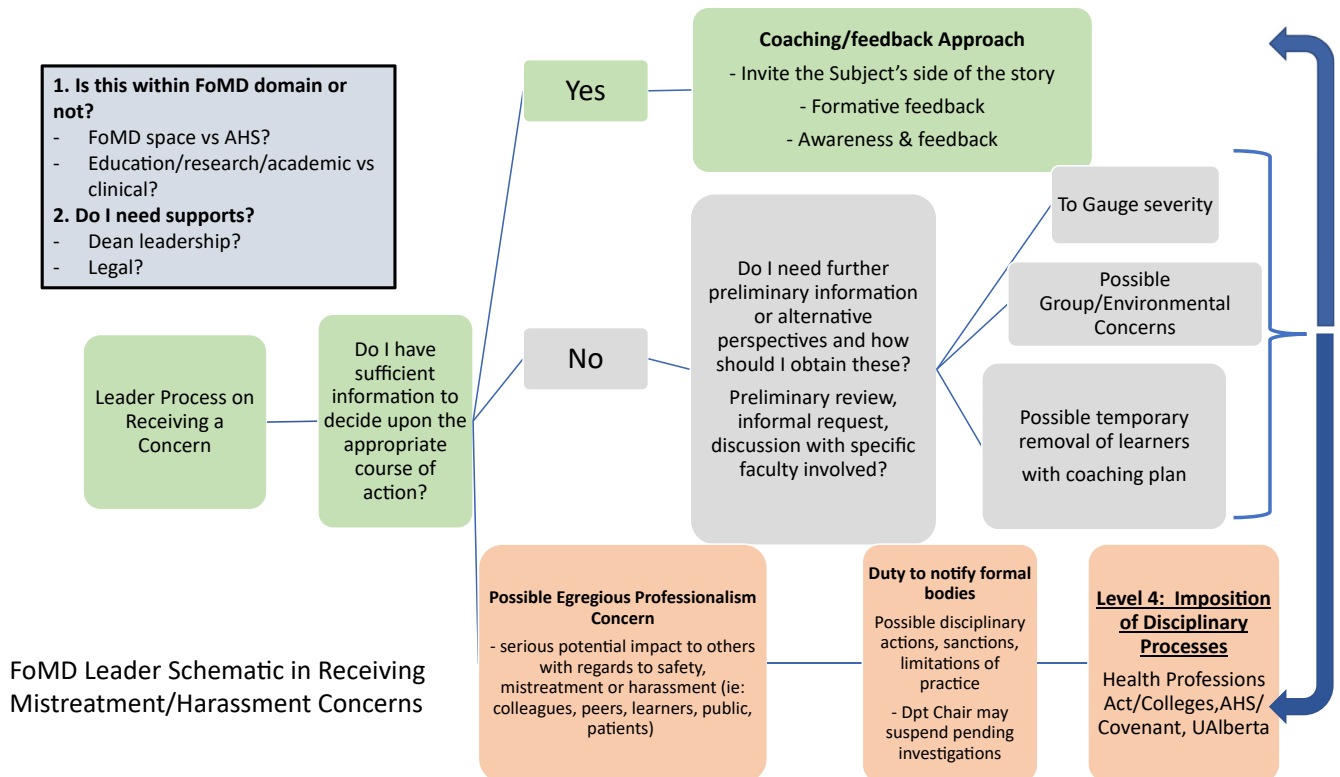


Figure 2. University of Alberta Faculty of Medicine & Dentistry (FoMD) leader schematic in receiving mistreatment/harassment notification of concerns. AHS, Alberta Health Services; Dpt, department; UAlberta, University of Alberta.

accountable approach, especially through an antiracism lens. Finally, for institutional transparency and accountability, we publish anonymized professionalism annual report summaries, with actions and outcomes, on the FoMD professionalism webpage.²⁶ Our leaders provide input to the FoMD process of approach to and interventions for harassment through an iterative, informal approach, especially as there appear to be unique aspects to each situation, providing insights and knowledge from their group dynamics and environments.

Many of our leaders have not been trained in psychological safety, in sensitive conversations, or in skills to build workplace wellness. One of our psychological safety priorities is leadership skill development in psychological safety, workplace wellbeing, and coaching. We are beginning to train leaders and mentors in the philosophies of coaching, in how to support those disclosing experiences of harassment, and we are initiating periodic leadership evaluation related to workplace wellness and psychological safety.³⁸

Similar to other medical institutions, we have implemented equity, diversity, and inclusion processes in leader selection, especially over the past couple of years.^{38,44,45} We wish to install institutional leaders at all levels who reflect our communities, and to look at our policies and procedures through an equity, diversity, and inclusion lens.

Goal: To educate and empower individuals to deal with harassment directly or by reporting via multiple avenues of support

Education and discussion around psychological safety for individuals and in group settings may encourage individuals to

step forward in speaking out. Dr Edmondson speaks about how to frame messages to empower individuals in the Leaders' Toolkit in *The Fearless Organization: Creating Psychological Safety in the Workplace for Learning, Innovation and Growth*.³⁴ She emphasizes use of proactive inquiry to invite participation and openness. Within the past 6 months, we have adapted her question to encourage medical students in reporting, with a monthly individualized prompt during clerkship: "Was everything as safe as you would have liked it to have been over the past month in terms of your learning environment?" If they answered "no," students were linked to the online reporting system.

When we teach institutional members about mistreatment and harassment, and on the FoMD professionalism website, we outline various options with pros and cons for FoMD members around harassment (as recipients or bystanders).²⁶ These options include the following: (i) ignoring the behaviour; (ii) approaching the person; and (3) reporting the experience, as well as (iv) guidelines for those to whom a recipient discloses experiences of harassment; and (v) approaches to those who are harassing others.

Case Vignette Example

A cardiologist reaches out to you, stating "Enough is enough! I can't take it anymore! I am ready to leave this place!" She has been feeling harassed by male colleagues within her subspecialty group in the division. She discovered that the "guys" have a series of research initiatives ongoing, where each subspecialty cardiologist is included except for her. They have regular research meetings to

Table 1. University of Alberta Faculty of Medicine & Dentistry (FoMD) leader options in approaching concerns

Responsibility	Within FoMD		Outside FoMD	
Approach	FoMD	FoMD	FoMD notification of health authorities	FoMD notification of outside governing bodies (formal investigative/disciplinary) Potential egregious concern
Responsibility of FoMD leader in approach	Coaching	To gather more information to decide coaching approach vs duty to report	If concern originates in a clinical setting	
Goals in response to concern	<p>To understand perceptions</p> <ul style="list-style-type: none"> - By reporter - By subject <p>Share knowledge of concern</p> <p>Empathy (validation & hearing subject's side of the story)</p> <p>Strategy & summary (shared decision as to next steps/actions/outcomes)</p> <p>Discussion & agreement (follow-up meeting re: delayed reflections, next steps, & actions)</p>	<p>To gather more information/perspectives, including by subject</p> <ul style="list-style-type: none"> • To gauge degree/severity of behaviours • Possible group/environment concerns • When behaviours persist despite prior interventions/meetings • Possible removal of learners (temporary) • Consider suspension/withdrawal of learners (temporary or permanent) 	<p>Duty to notify health authorities</p> <ul style="list-style-type: none"> - Alberta Health Services (AHS) - Covenant Health 	<p>Duty to notify formal outside bodies</p> <ul style="list-style-type: none"> - Health Professions Colleges - Health Authorities - AHS/Covenant Health - University of Alberta (eg, Faculty Relations, Dean of Students) through Article 7 (official complaint) <p>Meet with subject</p> <ul style="list-style-type: none"> • Offer support during investigation • Encourage reflections (ie, is there a blind spot?) • Check on wellness (ie, presence of burnout?) • Consider suspension/ withdrawal of learners during investigation (for safety of subject & learners)
FoMD leader goals for outcomes	<p>Formative—coaching</p> <ul style="list-style-type: none"> • Encourage reflections (ie, is there a blind spot?) • Check on wellness (ie, presence of burnout?) • Consider an apology 	<p>Formative—coaching</p> <ul style="list-style-type: none"> • Encourage reflections (ie, is there a blind spot?) • Check on wellness (ie, presence of burnout?) • Consider an apology • Discussion of possible professionalism teaching/coaching plan and possible removal of learners (temporary) 	<p>Collaborative approach with AHS/Covenant</p> <ul style="list-style-type: none"> • Health authorities may perform an investigation with possible summative evaluation of performance +/- disciplinary sanctions • +/- FoMD leader coaching approach 	<p>Formal bodies</p> <ul style="list-style-type: none"> • May perform an investigation with possible summative evaluation of performance +/- possible disciplinary sanctions • Consider removal of learners during investigation
Levels of professionalism intervention	Levels 1 & 2	Levels 1, 2, & 3	Levels 1, 2, 3, & 4	Level 4

which she has never been invited. She led a clinical innovation, only to see her director's name as the only name associated with the innovation on a subsequent presentation to hospital donors. When she tried to speak to her divisional director, it was suggested that she should enter mediation with her male colleagues. When she raises different points during meetings, she is seemingly ignored, only to have the same suggestion from a male colleague be accepted minutes later. More recently, she contributed to national COVID vaccine guidelines. When she shared the national guidelines with her colleagues, instead her colleagues proposed independent COVID vaccine messaging to patients. She is feeling alone and isolated. What are her options moving forward in dealing with her concerns?

1. Ignoring the behaviour and letting it go

This is the route chosen by many recipients of harassment, and bystanders. It may be safer for the individual if they are able to remove themselves and avoid that person or situation going forward. Downfalls of this approach are that silence endorses the destructive behaviour, the harasser will likely continue with harassing behaviours, and the lack of institutional opportunity to intervene with the harasser or effect culture change.⁴⁶

2. Approaching the person (in the moment or after)

We provide tools to empower a recipient of harassment or a bystander witness to harassment in directly approaching the person who is harassing others. We advocate approaching the harasser if the recipient or bystander feels safe in doing so, asking them to consider whether the person would be open to being approached, when there is little risk for retaliation, and little power differential (eg: among peers). The benefits of this approach are to provide the harasser with proximate feedback and education.⁴⁶ This approach is not advised in situations in which there is a power differential, and when the harasser may have a lack of insight, causing potential for retaliatory behaviour.^{46,47} We refer to multiple published approaches in the medical literature that address mainly racial harassment,^{46,48-50} such as the "XYZ" framework, in which a person states "I feel X when you say Y because Z."^{48,50} These frameworks concentrate on observed behaviours, and the recipient's feelings about the behaviours, to limit defensiveness and promote open discussion and understanding.^{48,50}

3. Reporting the harassment

We emphasize multiple avenues for people in reporting their experiences, recognizing that individuals will pursue the avenue that feels safest and most accessible. We then educate FoMD members and leaders regarding how to respond and support the recipient of harassment, including reporting as a third party. These various routes feed into a final common reporting and intervention pathway through the Office of Professionalism.²⁶

An online professionalism and mistreatment reporting system was created in 2013 as one of the avenues to report harassment, using the confidential server and medical education platform MedSIS.⁵¹ Our process has evolved over time to provide increased support and safety to recipients, and to try to intervene within entrenched toxic environments. Since

2018, we have increasingly acted upon third-party submissions, where a trusted third party submits a report of harassment on behalf of others (eg, residency program directors on behalf of residents), as a final common pathway of harassment reporting and tracking of reports. This approach has been especially helpful in identifying faculty who have entrenched, longstanding harassing behaviours, who usually are well established in the workplace and who wield considerable power. Our institution also acts on anonymous concerns for increased safety of recipients, with constructive feedback prompts to FoMD leaders.²⁶ Having multiple avenues available for reporting increases recipient safety and support (eg, Advocacy & Wellness Office, supervisor, course coordinator, program director, trusted faculty person). This approach is similar to the "no wrong door" approach, as outlined by the University of Manitoba's anti-racism policy.⁵² Additional responses to the recipients include exploring their wellness, connecting them to the FoMD Office of Advocacy & Wellbeing,⁵³ and exploring accommodations—that is, workplace adjustments that need to be put into place for personal safety.³ This approach is easiest when dealing with medical student/resident or administrative staff, and it is difficult to implement for instances of faculty-to-faculty harassment, or for graduate students (depending on the supervisor and in the same setting for years).

If the cardiologist approaches a trusted clinical colleague for advice, how should her colleague respond to her disclosure of harassment?

4. Guidelines for those to whom a recipient discloses experiences of harassment

We have created guidelines for any individual within FoMD regarding how to support someone who discloses an experience of harassment. These were adapted from the UAlberta Sexual Violence Resources Help for Supporters.⁸ We emphasize the importance of responding compassionately, outlining the steps to: (i) Listen (without judgement, providing a safe space, acknowledging the person's courage in speaking about their experience, providing empathy, not questioning the person's experience); (ii) believe (statements include "Thank you for telling me," "I believe you," "I'm sorry that happened to you"); (iii) ask how they can be helped; and (4) explore options, guided by the recipient's wishes.

If the cardiologist decides to submit a concern of harassment, what supports does the FoMD have for helping those who are perceived as harassing her?

5. Guidelines and supports for those harassing others

Since the FoMD educates individuals to confront those harassing others one-on-one, then guidelines must be provided to those who are informed that their behaviours are considered harassment. For direct, informal one-on-one interactions within the institutional workplace, we ask those harassers to: (i) acknowledge the statements; (ii) listen to the person's point of view; (iii) empathize with the person (eg, acknowledge how hard and emotionally difficult it was for him/her to approach you, trust that the person is telling you the truth of their experience, not questioning their experience or descending into argument); (iv) reflect upon a possible blind spot (eg, implicit or unconscious bias); (v) consider an

apology⁵⁴; and (vi) consider participating in education initiatives around harassment.

Through reporting and consequent levels of intervention, we guide those identified as harassing others through formative and individualized coaching plans in Level 3 Interventions.⁴¹ These individuals are matched with peer faculty coaches (usually experienced faculty professionalism role models, carefully selected from other departments in matched pillars of education, clinical, administration, or research). Together, they complete reading and reflection modules around individualized professionalism challenges. Leaders consider temporary withdrawal from learners while the coaching plan is completed, followed by graduated reintroduction to learners with subsequent monitoring. The FoMD has undertaken about 3 to 6 coaching plans per year over the past 3 years, with 1 to 2 faculty per year being temporarily removed from learners.²⁶ Informal feedback has generally been positive from those who have undergone coaching plans, the coaches, chairs, and central Faculty Relations at the University of Alberta (unpublished). In egregious and/or repeated harassment cases, especially those involving racial or sexual harassment, we report to formal disciplinary bodies regarding investigations in which individuals could receive disciplinary sanctions (eg, UAlberta Faculty Relations, Dean of Students, College of Physicians & Surgeons of Alberta, and Alberta Health Authorities; see Table 1).

What if the cardiologist is an Indigenous woman? Are racial and gender harassment dealt with differently than other types of harassment?

The FoMD at the UAlberta is in the process of creating safe places for racism reporting and in effective racism interventions, needing to expand our accountability in recognition and intervention. In order to effectively address racism, anti-racism experts emphasize that incidents of racism be specifically labelled as such, instead of being grouped with other types of mistreatment and harassment.⁵⁵⁻⁵⁷ As an example of how racism persists within larger systemic structures that have been created by institutions immersed within a majority group perspective,⁵⁶ our equity, diversity and inclusion leaders and grassroots representatives have pointed out that the informal, initial levels of intervention (eg, Level 1 and 2 FoMD interventions for isolated concerns and apparent patterns of behaviour, respectively) do not work for instances of racial harassment. With their guidance, the FoMD is creating new and specific institutional response to individualized racial harassment at the same time as it is examining its policies and procedures through an anti-racism lens.⁵⁶ Our first step in accountability has been to create the FoMD Anti-Racism Policy, in 2021.⁵

At UAlberta, we follow an institution-wide sexual violence policy, developed in 2017.⁸ The policy outlines support for those experiencing sexual harassment in any setting related to the university, or any member of the university community. In recent years, the College of Physicians and Surgeons of Alberta has investigated complaints of professional boundary violations between faculty physicians and trainees. However, our institutional interventions have been mainly incident-based. The FoMD at UAlberta has yet to develop a structured, effective institutional approach to insidious environment-based forms of sexual harassment, such as gender harassment, let alone discrimination and unconscious bias affecting hiring, workplace collaborations, and promotion processes. This gap has been

recognized within the FoMD diversity goals in the FoMD strategic plan, Vision 2025.³⁸

What if the cardiologist had encountered online posts from her colleagues, where they appeared to question her professional credentials in online subspecialty forums?

Online Harassment

We at UAlberta have experienced increased reports regarding harassment in the online setting within the past 5 years,²⁶ even from concerned members of the public. We have been able to intervene, per our levels of intervention, when the harasser refers to his or her professional capacity, position or the UAlberta as credentials in the online account or post. Some cases have been reported to, and investigated by, the central Office of Protective Services at the UAlberta.⁵⁸ When we have been unable to identify the harasser through alias accounts, but when the author of the social media account appears to be part of a group, per the context of the post (eg, a student), we have sent generalized messaging out to the entire group, which has resulted in the social media post being removed anonymously.²⁶

The cardiologist decides to submit a report of harassment. She does not wish for accommodations to her work setting, and is connected with wellness supports. The chair decides to gather more information, then meets group members along levels of intervention along levels of intervention. FoMD leadership is aware, guiding the Chair, providing coaching plans for identified targeted education, and aiding in ongoing workplace monitoring of behaviours.

Discussion

Within the FoMD at UAlberta, we have built structure into our institutional approach to harassment. We have done this through: (i) defining our expectations of professional behaviour and our psychological safety priorities; (ii) starting to select diverse leaders, and guide, evaluate, and train our leaders at multiple levels regarding psychological safety; and (iii) increasing supports and options for recipients of harassment, options for bystanders and recipients when experiencing harassment, and aid for those harassing others.

When Archer and colleagues³¹ outlined a model for integrating professionalism training within institutions, they emphasized the importance of social institutional norms of behaviour, realigning those norms to professionalism as needed. As a part of the model, institutional expectations of professional behaviour must be explicitly outlined.³¹ Consistent messaging around our exemplars of behaviour helps to align our institutional social norms of practice to our professionalism ideals, as outlined by Archer and colleagues.³¹ Otherwise, social norms of medical practice have the potential to become sources for hidden curricula of harassment.⁵⁹ The FoMD will have minimized the hidden curriculum of harassment and moved toward an environment of psychological safety when individuals feel empowered to pursue various strategies of addressing harassment, by either directly addressing the harasser on their own behalf or as a bystander, and/or reporting harassment to someone to access structured institutional response and support. A psychologically unsafe workplace has been shown to negatively impact teamwork, trust in a leader, and reporting of medical errors,⁶⁰⁻⁶³ and

there are tools for healthcare institutions to build psychological safety into their settings.^{34,64,65} Finally, psychological safety is measurable and can be impacted by institutional leaders.³⁶ For these reasons, the FoMD has created and incorporated our psychological safety priorities into the FoMD “Vision 2025” strategic plan, considering these tools for measurement at this time.³⁸

It is our opinion that there are multiple people involved in harassment to be supported, centering around the recipients of the harassing behaviours (the recipient), the person or people harassing the recipient (the harasser), and often bystanders. Finally, there are leaders who are not educated in psychological safety or coaching approaches to interventions, and who may have knowingly or unknowingly supported entrenched harassment behaviours.¹⁰ Harassing behaviours can be unconscious, and not the direct intent of the harasser, but still harmful to others.³ Therefore, each of these people should be supported in different ways by the institution—the recipient and bystanders (if applicable) through support, with checks on wellness, and reporting options; and leaders through educating regarding coaching, psychological safety, and levels of intervention for harassment.^{41,42} For those with egregious and/or entrenched behaviours, institutional members and leaders have a duty to report to our formal bodies for investigation with possible disciplinary outcomes.

With the murder of George Floyd, the year 2020 brought enlightened awareness of entrenched societal racism, at the individual and system levels.⁶⁶ In 2019, the Royal College of Physicians & Surgeons of Canada stated that racism is “unacceptable in medical education and practice” in their Indigenous Health Values and Principles Statement. (p. 3).⁶⁷ With the Indigenous Physicians of Canada and the Canadian Indigenous Nurses’ Association, they developed 3 actions to address gaps in Canada’s Truth and Reconciliation Calls to Action; one action is specifically directed toward addressing racist behaviours by physicians.⁶⁷ However, despite developed frameworks and toolkits, multiple Canadian medical institutions have inadequately met Indigenous medical education goals and structural supports to meet the Calls to Action for Truth and Reconciliation in Canada, with medical Indigenous learners experiencing racism throughout their training.⁶⁸ Similarly, there are calls to action about dismantling anti-Black racism in Canadian medicine.⁶⁹⁻⁷¹

Anti-racism is defined as “action-oriented, educational and/or political strategy for systemic and political change that addresses issues of racism and interlocking systems of social oppression” (p. 13).^{57,72} In 2020, the University of Manitoba Rady Faculty of Health Sciences led the Canadian institutional commitment to anti-racism in creating the first specific anti-racism policy by a faculty or postsecondary institution in Canada.⁵² Frye and colleagues⁵⁶ have outlined the need for such specific institutional approaches to racism, concluding that although professionalism approaches can complement a system’s approach to racism, “professionalism may be one part of a larger, institutional effort to undo racism by applying explicitly antiracist approaches” (p. 862).⁵⁶ A comprehensive roadmap has been created by Hassen and colleagues for healthcare institutions in building anti-racism interventions.⁵⁷

Women medical professionals have started to speak openly about their experiences of sexual harassment after the societal movements of #MeToo and #TimesUp.⁷³ The FoMD at UAlberta has not yet examined the prevalence of sexual

harassment within our institution, nor has it created specific responses to naming and dealing with sexual harassment. In a national survey of Canadian medical students about sexual harassment in 2019 (survey sent to 11,600 students), 188 of 270 responses to 807 incidents were reported, mostly by women, involving peers, patients, and faculty. Recommendations centered around the need for faculty training in recognizing and dealing with sexual harassment.⁷⁴ With a high incidence of sexual harassment reported by faculty in another academic institution, affecting 82.5% of women, and 65.1% of men (705 responses of 2723 respondents), recipients of sexual harassment need to be better supported to come forward, and institutions need to be better educated and equipped to intervene effectively in situations of sexual harassment.²⁴ Experts on the extensive reporting of sexual harassment of women faculty in the science, engineering, and medicine fields have outlined a number of institutional recommendations and strategies in moving toward an environment that prevents sexual harassment altogether.¹⁹

Finally, we have had to learn innovative approaches and limitations in dealing with online harassment situations. Online harassment may be easy to identify directly in social media postings and comments, when it associated with a person’s name, FoMD position, and timestamp. On the other hand, when alias accounts are used by the harasser(s), it can be very challenging to track down the harassing individual; in these cases, it may be helpful to utilize the services of the Office of Protective Services of an institution, such as the one at UAlberta.⁵⁸ Another aspect of online media use in harassment cases arises when institutional members speak about their workplace harassment experiences online. It has been suggested that these individuals are driven to making online statements because of the poor institutional policies around harassment and institutional traditional silence around disciplinary processes.⁷⁵ McCall suggests that this type of online posting would be unnecessary if institutions were more transparent and accountable in how we deal with harassment, encouraging recipients of harassment to come forward in reporting.⁷⁵

Experience has shown us that the FoMD does not adequately address racial harassment and certain types of sexual harassment, with a consequent lack of institutional trust by recipients. Other limitations of our institutional approach include the level of dependence upon leaders such as Chairs for interventions around harassment. We are addressing this by supporting Chairs throughout the process, providing consistency of institutional approach, and establishing training in leadership regarding psychological safety and workplace wellness. However, there are still pockets of ongoing harassment throughout our institution that we have inadequately penetrated to this point. According to UAlberta administrative processes, the FoMD is not allowed to carry out formal investigative or disciplinary procedures. This policy has positives and negatives. We rely on an informal, formative approach that depends on the openness and goodwill of FoMD members to change behaviour. To address this limitation, we have built direct reporting avenues into our formal institutional bodies, with resulting appropriate formal investigations and possible disciplinary actions as outlined (see [Table 1](#)). We believe that the FoMD continues to face safety and accountability challenges in serving FoMD members experiencing harassment, requiring us to be open and to adapt

based upon stakeholder input. We are still looking into how to evaluate our approach and interventions objectively, beyond acquisition of informal feedback. Finally, instances of health professional harassment by patients and families are beyond the scope of this paper.

We, within the FoMD at UAlberta, recognize that our institutional processes must be continually improved to be more effective and accountable, engaging in an ever-evolving iterative process. We need to lessen the “hidden-curriculum” harmful effects of harassment upon individuals, teams, and professional contributions. This approach is what will hopefully result in a psychologically safe workplace in our institution, where honest and open dialogue will transpire at all levels, to intervene with harassment effectively, and ultimately, to prevent harassment from occurring altogether.

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