



Research Paper

Sexual Harassment of Canadian Medical Students: A National Survey[☆]
 Susan P. Phillips^{a,*}, Jenna Webber^a, Stephan Imbeau^b, Tanis Quaife^c, Deanna Hagan^c,
 Marion Maar^b, Jacques Abourbih^b
^a Queen's University Department of Family Medicine, 220 Bagot St., Kingston K7L 5E9, Canada^b Northern Ontario School of Medicine, 935 Ramsey Lake Rd., Sudbury P3E 2C6, Canada^c University of Alberta Faculty of Medicine, 8440 112 St. NW, Edmonton T6G 2R7, Canada

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ABSTRACT

Background: Despite explicit policies and reporting mechanisms in academia designed to prevent harassment and ensure respectful environments, sexual harassment persists. We report on a national survey of Canadian medical students' experiences of sexual harassment perpetrated by faculty, patients and peers, their responses to harassment, and their suggestions for improving the learning environment.

Methods: With ethics approval from all 17 Canadian universities with medical schools, an invitation to participate in an anonymous, electronic survey was included in three Canadian Federation of Medical Students' newsletters (2016). Narrative information about sexual harassment during medical training, perpetrators, ways of coping, sources of support, formal and informal reporting/discussion, and suggestions for change was sought. Three authors then conducted a qualitative analysis and identified emergent themes.

Findings: When asked to estimate the number of occurrences of SH experienced during medical school, 188 students reported 807 incidents perpetrated by peers, patients, and, to a lesser extent, faculty. Perpetrators were almost always men and 98% of victims were women. What emerged was a picture of social, educational, and individual conditions under which sexual harassment becomes normalised by faculty, peers and victims. Students often tried to ignore harassment despite finding it confusing, upsetting, and embarrassing. They offered strategies for schools to raise awareness, support students, and prevent or mitigate harms going forward.

Interpretation: Sexual harassment is a part of the Canadian medical education environment where most who reported harassment are subject to the dual vulnerabilities of being learners and women. Although survey respondents recognised the systemic nature of the problem, as individuals they often described shame and self-blame when victimised, came up with solutions that implied they were the problem, and often reported thinking silence was less risky than confrontation or official reporting. Many participants believed in the transformative power of education – of themselves and faculty – as a means of improving the medical environment whilst we await social change.

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1. Background

Sexist remarks, uninvited touching, stalking, and sexual assault – all examples of sexual harassment (SH) – are unacceptable or illegal in most countries. Nevertheless, these behaviours persist. In the decades since sexual harassment was formally defined [1] it has remained embedded in the experiences of medical students [2–10], residents [11], female medical faculty [12], women physicians [1,13], students of other health professions [14], and in many educational and work environments [15]. Women are the predominant victims of male perpetrators.

Gender vulnerability to sexual harassment seems to cross class and profession.

Medical education and practise bring exposure to touching, physical contact, and discussion of sexual function beyond that of most academic or work settings. For students who generally strive to excel, medical education environments can also bring fear of repercussions and poor assessments that are intimidating, isolating, and silencing. Canadian medical education accreditation standards explicitly prohibit sexual harassment at the individual and systemic level, and policies that could be summed up by the term 'zero tolerance' are the norm [16]. However, despite this, reports of sexual harassment in medical professional training perpetrated by peers, patients and faculty continue to surface [14, 17].

Missing from the literature is a contemporary investigation of medical students' interpretations of and responses to sexual harassment

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* Corresponding author.

E-mail address: phillip@queensu.ca (S.P. Phillips).

Research in context

Evidence before this study

A search of indexed medical articles (starting with terms sexual harassment, medical education, medicine, and then expanding to papers related to key studies) and grey literature (e.g. news reports) showed that sexual harassment, almost always of women by men, occurs across countries, workplaces and academia. In the medical context reports dating back 3 decades document victimisation of medical students, residents and female physicians by patients, peers and faculty. Added value of this study

Our national survey explores medical students' responses to, and interpretations of, sexual harassment, and offers recommendations for prevention of sexual harassment experienced in the course of medical education. The data, collected prior to current media attention to high profile perpetrators, include detailed responses from Canadian medical students thanking us for exposing what they perceive to be a real but hidden problem, describing their experiences, confusion, self-blame, embarrassment, and recommending individual and institutional responses that might minimise sexual harassment from peers, faculty and patients. Despite robust policies and reporting mechanisms at all Canadian medical schools, the experience of survey respondents highlighted a divide between official stances and a reality of sympathetic inattention to reports of sexual harassment. Survey respondents offered many feasible suggestions for institutional change, most of which reinforce their belief that education can change behaviour. Implications of all available evidence

Despite official 'zero tolerance', sexual harassment persists. The results of this survey indicate that students in the Canadian medical education environment feel unable to respond, or are unwilling to report sexual harassment, and tend to look inward for causes of and solutions to the problem. At the same time, objectively, students recognise the systemic nature of sexual harassment. Rather than wait for social change to eradicate it survey respondents report a need for education, discussion, and other solutions at the medical school level that could minimise sexual harassment and the harms arising from it.

from patients, faculty/staff, or peers. We set out to examine the ways in which medical students respond to behaviours they consider to be sexual harassment, enablers and barriers to discussing and reporting of these, and their suggestions for relevant changes to the medical school environment.

2. Methods

Our conceptual starting point was that medical students are embedded in an environment that brings together the power imbalances between doctors and patients, teachers and learners, and men and women, all in a setting where exposure of body parts and discussion of sexual function are often appropriate. We, three medical Faculty members and four medical students, used thematic/content analysis to examine the nature of, impact, and potential solutions to the problem of experiencing sexual harassment in the context of being a medical student. The Canadian Labour Code's definition of sexual harassment as any conduct, comment, gesture or contact of a sexual nature that is likely to cause offence or humiliation to any employee; or that might, on reasonable grounds be perceived by that employee as placing a

condition of a sexual nature on employment or on any opportunity for training or promotion situates determining whether sexual harassment has occurred with the recipient of the behaviour in question. We, therefore, did not explicitly define sexual harassment for participants but did ask about each of the categories within the Labour Code definition, expanding those that seemed to be of particular relevance within medicine, and using as a guide earlier work in the field (see categories listed in results) [1].

Data were collected via an anonymous online survey of students from Canada's 17 medical schools (see Appendix 1). Participants responded in writing to open-ended questions about incidents of and responses to SH experienced in the course of their medical education and perpetrated by medical faculty/staff, patients, or peers. Suggestions on how to better prevent, respond to, and report sexual harassment were also solicited. The study was provided in French and English with prior back-translation to ensure common meaning. A focus group of medical students pilot-tested both language versions of the questionnaire (Appendix 1). Their responses were excluded from final data analysis.

Participants were invited via three electronic newsletters of the Canadian Federation of Medical Students, which included a link to the survey. Our aim was not to count incidents or calculate proportions experiencing SH but rather to collect qualitative data about its nature and possible responses.

Research Ethics Boards of all 17 Canadian universities with medical schools approved the study but schools, themselves, chose not to have it circulated directly to their students. Responses were anonymous and students were explicitly told they could opt-out any or all of the survey. No school-identifying information was collected. Because of the study's potentially distressing nature, links to local sources of support were provided. Data were collected using the Qualtrics (2018, Provo, Utah, USA) platform.

Three authors independently conducted a thematic analysis of written responses, generating initial codes and then themes, then reviewing these together to reach consensus. Their independent analyses showed almost total overlap. We used the Standards for Reporting Qualitative Research as a guide for describing the study here [19].

3. Results

Approximately 2000 of Canada's ~11,600 [18] medical students opened the Sept. 3, Oct. 15 or 29, 2016 newsletters. An average of 7% (total n = 420) clicked on links to a preamble describing survey confidentiality, anonymity, and that allowed them to link to the survey. From the responders (n = 327 overall although few answered the whole questionnaire) we were then able to identify those who had experienced sexual harassment and reported their responses to it.

Of the 327 students who opened the survey link, 270 completed the consent form. Participants were relatively equally distributed across years of training, mostly younger than age 26 (69%), and female (68%). 188 described whether, and how frequently they had experienced sexual harassment from patients, teachers or peers and the nature of that behaviour. For all categories the majority of students reported not experiencing harassment. However, those who had been exposed to SH described 807 such incidents (see Table 1). Perpetrators were predominantly patients (326/807) who made inappropriate comments and physical gestures, or other students (320/807), but also included faculty, teachers, and preceptors (161/807).

Varying numbers of participants described aspects of their responses to the one incident of harassment that stood out most in their memories. Eighty-four reported discussing 184 incidents with friends, family or others. A few incidents (n = 24) were discussed with a preceptor, six were reported officially to school authorities, and one was reported to each of the police and the regulatory authority for physicians. Of 135 respondents to the question asking whether they had confronted the perpetrator, 21 (16%) answered affirmatively.

Table 1
Frequency and nature of sexual harassment experienced by respondents to this section of survey (n = 807).

Experience	Number reporting harassment by category and perpetrator [N of students responding]			
	Patients [188]	Faculty/staff [188]	Peers [188]	Total Incidents
Inappropriate remarks	103	56	78	237
Suggestive looks	79	38	63	180
Inappropriate sexualisation of physical examinations	39	8	n/a	47
Suggestive physical gestures	27	18	43	88
Soliciting or pressuring for dates	25	11	25	61
"Inadvertent" brushing or touching	17	12	35	64
Request for unnecessary physical examination of sexual organs	9	n/a	n/a	9
Grossly inappropriate touching, fondling, grabbing	9	5	15	29
Inappropriate gifts	9	1	8	18
Inappropriate contacting by social media, emails, or phone	7	6	25	38
Rape or attempted rape	1	2	4	7
Stalking	1	2	5	8
(not asked for but reported) Sexual blackmail or bribery		2	4	6
(not asked for but reported) Exposure of body parts in a sexually suggestive way			15	15
Total reports	326	161	320	807

Sexual harassment by patients, peers, and medical school personnel occurred in clinics, at school, and in social settings. Participants described experiences of harassment ranging from subtle comments to overt behaviours, aggressive assaults and attempted rape (see Panel 1 for a few examples). One wrote of repeated and escalating sexual overtures from a classmate who eventually said he dreamed she was his patient and that he jumped on top of her and stabbed her in the neck to perform a tracheotomy. In the specific examples described, none of the perpetrators was female. However, two male students reported that they felt reticent to name their experiences as SH or identify the sex of their harassers, thinking that they might be seen as instigators in a world "where men are always the perpetrators". The second wrote: "...as a male, society says that you cannot be sexually harassed in any way. Furthermore, I am more scared that by bringing attention to it I would be somehow blamed. I do not need that stress in my life."

Four categories emerged from students' descriptions, experiences, and understandings of sexual harassment. These were the social conditions under which SH becomes normalised, its impact on students, strategies for coping, and perceptions of what is to be done to address sexual harassment.

Sexual harassment is normalised: In the medical school context sexual harassment became normalised in several different ways. Some participants identified the problem as being embedded in, and very much a part of broader social norms, and therefore outside the control of individual students or medical schools.

"I am a woman and I've been dealing with inappropriate comments (and occasionally much worse actions) since I've been a teenager. Additionally, my attending did nothing about it. I didn't want to make a big deal over something literally every woman experiences, or get angry at a sick patient."

Others wrote of normalisation by role models and teachers whose condoning of, lack of response to, or actual perpetration of SH left students feeling abandoned, embarrassed, confused, powerless, or unsupported.

"My preceptor did not stop his verbal harassment when I told him 'No' repeatedly in response to sexually suggestive remarks to me and about me to patients in my presence. He also did not accept my shrugging away from touching in front of others as an indication he should stop."

"I reported the incidents to a preceptor who laughed and said - oh, he'll never change, one time he did this... and another time he did this..."

"The supervising preceptor diminished the incidents (inappropriate/sexist/homophobic/racist remarks), simply giving the explanation that the perpetrator was 'old school', though reluctantly agreed to relay feedback to the perpetrator (his peer)."

Patients' conditions were often seen by preceptors and by respondents, themselves, as reasons for redefining, dismissing, and normalising the SH behaviours experienced. Two students dismissed incidents as follows:

"It was an elderly gentleman who had signs of mental illness or dementia, but there was little to no follow up/debrief from our preceptors."

"He was a patient. I wasn't terribly bothered by it. He was just a dirty old man making comments, I think in an effort to cover up the grief of recently losing his wife."

Panel 1

Examples of SH reported by respondents.

"A patient insisted on hugging me goodbye despite giving a handshake to the two other male students in the room"

"...patient grabbing my backside when I was attempting to stitch up his face. I was alone with him on night shift in a separate area in the emergency room."

"I had a peer follow me into my bedroom in a group setting and forcefully try to touch me inappropriately despite me repeatedly pushing his hands away and asking him to stop. It made me feel frightened and like he didn't respect me as an equal peer. Although I wanted to tell others about it, I felt humiliated and kept it secret for quite a while."

"I had a preceptor who would make sexually suggestive comments regarding myself with patients, would inappropriately rub my back, and would stare at my chest instead of my face."

At times, the participant redefined or normalised the behavior experienced.

“I do not consider the suggestive looks that I experienced to be harassment.”

“I wasn't very upset about it – it was a joke and I took it as such.”

While participants willingly overlooked comments from patients with mental health or cognitive problems they wondered whether they were expected to do the same when there was no clinical excuse for inappropriate behaviour.

Impact of sexual harassment is high: In general, the impact of sexual harassment as described by participants was deeply personal and internalised although, sometimes was dismissed as the situational manifestation of a social or medical problem. Almost all experienced immediate intense emotions. Over and over, participants used words like confused, angry, betrayed, uncertain, disrespected, ashamed, embarrassed, degraded, to describe their feelings. “I was felt up in the OR during a visiting elective, by a preceptor who holds a lot of power in the faculty. I felt embarrassed and confused and didn't feel like I had the power or space to do anything about it.”

Experiences often left participants feeling helpless and powerless, not only in relation to faculty perpetrators but also with respect to offending patients. “As medical students we are often powerless. We have to be alone with patients, we have to be alone with preceptors.” Another student highlighted her powerlessness writing:

“It is extremely frustrating when a preceptor/supervisor laughs along with the patient... I know he/they are choosing their battles but having a preceptor stand up for my intellect as a young woman working my heart out to achieve my dream of practicing medicine rather than agreeing with an inappropriate comment about my appearance and youth would mean a great deal.”

Peers' perceptions were also of concern:

“The perpetrator is a fellow student in my class who is very popular among friends. I was worried that the confrontation would endanger my relationship with other students.”

Perhaps the most troubling impact of sexual harassment on participants was that, fearing repercussions, they were immobilised and silenced.

“I did not want to get a bad evaluation. I also had to work with this preceptor for 2 weeks so I didn't want him to treat me poorly for the rest of the elective.” Reporting was often seen as counterproductive:

“(It) would not benefit me, there could be retaliation, this student has family members in the medical field and I fear confronting him could have consequences for me in furthering my education or gaining residency spots.”

Students learned to cope with sexual harassment: This was the third emergent category. While some tried to dismiss the harassment as a joke (“In retrospect it angered me that I felt like I was unable to do much about it and just laughed it off”) many remained silent. One participant summarised this succinctly: “Students will continue to feel hesitant to come forward as they do not want to be perceived as overreacting and risk having a poor evaluation”.

Trying to decrease vulnerability by changing personal behaviour was another common response.

“I am very careful about what I wear, careful about how I come across with patients and much less tolerating of sexual commentary from them. I find myself very emotionally closed off to any male patient who has made any sexualising comments towards me or other female students, doctors, nurses, etc. I get a bit more nervous when attending physicians ask about my personal life or are 'too nice' to me as I worry it is for the wrong reasons.”

“I dress more conservatively. Like I am told, less provocatively.”

Many participants talked to classmates, friends and family about their experiences however very few used official reporting channels as they were wary of power differentials, vulnerability, and being labelled as over-reacting or unprofessional. ‘I didn't know how’, fear of receiving a poor evaluation, and thinking it was easier to ignore it summarise the many comments with respect to discussing incidents with faculty. Several stated that both peers and faculty/staff are more likely to respond that victims should learn to cope than to offer help. By not reporting, many participants felt they could minimise the negative impact of the experience on themselves and get on with life.

Better strategies to address sexual harassment are needed (see Panel 2): When considering what schools and other students could do to address or reduce sexual harassment respondents generally located problems and solutions at a societal level.

“There is no way to change the actions of others. With broad generation and cultural gaps, what is seen as harassment by some is not perceived as harassment by others. A larger societal discussion needs to take place to prevent sexual harassment in day to day life before it will be prevented in medical school. As long as ‘boys will be boys’ women will be sexually harassed. I cannot speak for men in this regard.”

For those who viewed the problem as systemic rather than local there was little room left for solutions at the school level:

“I have no idea (how to prevent) but I wish I did. I wish I did.” However, students did have advice for others facing sexual harassment.

“You aren't wrong. You know what happened and how that made you feel. Ignore people when they try to belittle, downplay, or deny your experiences. Reporting can be arduous & extremely frustrating,

Panel 2

Recommendations.

1. Faculty training to
 - a. understand what SH is and to recognise it in the behaviours of others and themselves
 - b. behave in ways that are not and cannot be perceived as SH
 - c. speak up when SH happens, name it, discuss it, and support the victim
2. System readiness to acknowledge that SH exists in the medical school environment and to develop reporting mechanisms that 'hear' this without isolating and marginalising the person who reports.
3. Student training and dialogue with repeated discussions or role playing about what to do both in the immediate situation and after, who to talk to, implications etc.
4. Robust, clear, documented penalties for perpetrators

especially if you choose to involve the police, but remember you are doing this for yourself as well as the others your offender may victimise.” They also offered ideas for immediate education and action by schools and preceptors. These included making what is invisible visible, talking about SH, educating students and their teachers and having robust penalties to deter harassment.

“(We need) strategies for how to address sexual harassment as it may be difficult to prevent (particularly sexual harassment coming from patients). We really received no training on this.” One thought addressing the attitude of entitlement was important for change to happen:

“I think that there needs to be a better job of humbling medical students and especially male medical students, though I admit I’m biased. Yes, we’ve worked hard to get here, but there is a sense of entitlement that I’ve encountered, from deserving to be here/to be a doctor that extends to a power over the patient’s life and body and to other people’s lives and bodies. I think that better education is important. As it stands we receive no training in sexual harassment. None. So anything would be an improvement.”

On the other hand, a few did not see education as a panacea.

“(We are) so, so saturated. We all know. We get it, we got it since we were 4.”

4. Discussion

4.1. Social Versus Individual Problems

Recent literature and media reports make it clear that sexual harassment is not unique to medical schools but permeates universities and society [20,21]. Whether it is harassment that is increasing, or the reporting of it, is difficult to determine. Some students in our survey reported that the roots of the problem extend well beyond the walls of medical school, commenting that their experiences parallel those of women and men everywhere. However, their narratives did not always reflect this awareness. Instead they sometimes looked inward, trying to normalise abnormal experiences, excuse the harassment (the perpetrator was drunk, cognitively impaired, or older) or minimise SH by laughing it off. Most importantly for medical students, the act of normalisation was frequently modelled by their preceptors who either ignored, condoned or dismissed SH. In many ways what participants reported mirrored the introspection of female physicians surveyed 25 years ago, who also often reflected upon whether they had brought SH by patients upon themselves and who tried to minimise subsequent provocation by dressing conservatively, avoiding certain people or settings, and monitoring language used [1].

Participants’ vacillation about whether sexual harassment in the medical school environment was a social or an individual problem was most evident in the contrast between personal responses and advice offered to others. When harassed, almost all participants described feeling shame, self-blame, confusion, humiliation, disrespect, fear, or self-doubt. However, when asked what they would tell a peer who had been sexually harassed they never offered inward-looking advice, explicitly emphasised that victims are blameless, encouraged reporting, and highlighted the systemic nature of the problem.

4.2. Power and Powerlessness

Students wrote about their vulnerability as learners, the risk of poor evaluations, of being labelled as weak or of lacking a sense of humour. Hardly any reported SH to school officials, regulatory authorities, or the police, despite awareness of school reporting processes. Students’ beliefs and experiences led them to think that such reporting would

result in no effective action and some personal risk or harm. Instead, and perhaps as a way of diminishing any individual impact, some survey respondents dismissed all but the most inappropriate of behaviours as inherent in power imbalances between teacher and learner, or in patients’ illnesses. Even when the harasser was a peer there was concern that speaking out might isolate the reporting student from classmates. As part of their silence, survey respondents sometimes reported rethinking whether what they’d experienced really had been sexual harassment.

Female survey respondents seemed to be doubly disadvantaged by their vulnerability as students and as women. Nevertheless, few named gender vulnerability as such, although the concept was threaded through their narratives. It was one male participant who came closest to identifying the gender power imbalance when he stated that no one would ever believe he could have been a victim of SH, and all would instead blame him as an instigator or perpetrator if he were to describe what happened to him.

None of the students reflected on the perceived power of the profession they would soon enter. Similarly, none reported wondering whether SH by patients might be a means of rebalancing a perceived power imbalance using the traditional gender power of being male to counter the vulnerability of being a patient [22]. It would appear that students felt a universal powerlessness.

4.3. Avoid Confrontation and Carry On

Perhaps normalising sexual harassment allowed students to not confront, report, or even acknowledge the behaviours experienced and to instead excuse or keep these secret. However, through silence perhaps they inadvertently colluded with what they perceived as an institutional wish to ‘turn a blind eye’ and offer sympathetic inaction. Thus, sexual harassment remained hidden from official view and decontextualised, with each incident being framed as a personal experience. This was exemplified by one student’s description of being doubly victimised when the school’s only response to her report was to cast her in the sick role and offer a leave of absence. The composite picture of official responses was a somewhat patronising ‘there, there, it will be alright and we will stand by you’ as an individual, rather than challenge the perpetrator. This was just what students reported fearing would happen if they named sexual harassment as such and what made them choose silent collusion, normalisation and avoidance.

4.4. Going Forward

Although individually, most students chose to avoid confrontation and tried to forget about what had happened to them, they were less passive about changes that could be made by their schools. Participants reported disappointment and concern that in a profession where there has been much introspection regarding equality and patient-centred care, sexual harassment persists, with limited discussion or effective deterrence. Despite this, and the systemic nature of sexual harassment, students ascribed to the transformative power of education. Despite never experiencing it, many advocated for discussions with students and faculty about appropriate behaviour and responses to inappropriate behaviour. Their endorsement of education hints at an underlying optimism or perhaps naivety that in the medical environment perpetrators (particularly patients) often act from ignorance rather than malice, premeditation, or power abuse and that education can change behaviour. No one described a specific method for preventing sexual harassment from patients. However, teaching supervising physicians and colleagues to intervene or even acknowledge such behaviours as unacceptable was seen as feasible and central to eliminating the distress associated with patient-initiated SH. In other words, participants saw merit in interim measures whilst they waited for social change to bring the big solution.

4.5. Limitations

Although allowing 'reasonable' participants to ascribe meaning to behaviours experienced is in keeping with standard definitions of SH, inevitably there will not be consensus around every definition. This would be of concern if data collection were primarily quantitative. Self-defined sexual harassment is, however, in keeping with legal and investigative approaches. Similarly, the likelihood of disproportionate participation by those experiencing SH precludes drawing meaning from proportions or frequencies identified, but does not bias descriptions of behaviours and responses to them. It is for this reason that we do not comment on the proportion of students who reported rape or attempted rape.

In this large national survey we reached saturation with more than 100 participants' reports of sexual harassment. However, the nature of qualitative methodology means we cannot generalise findings. We do not assume that the responses of those who chose to complete the survey represent the experience of all Canadian medical students.

The public awareness of sexual harassment that gave birth to the 'Me Too' movement occurred after our data collection was complete. Increased awareness associated with many high profile reports of sexual harassment may have changed the numbers of students who defined behaviours experienced as sexual harassment. However, as our aim was not to quantify but rather to describe findings these remain valid.

Although students in all four years of medical training participated, the experiences of junior students and their exposure to patients is somewhat limited. Regardless, what this study offers is a current picture of the nature of, responses to, and ideas for preventing sexual harassment in the medical school environment. It also draws attention to the ineffectiveness of, and students' lack of trust in current official policies and reporting procedures.

Sexual harassment perpetrated by medical educators, other students and patients persists despite official standards of zero tolerance. Victims are almost exclusively women and perpetrators are men. Although harassment contravenes school policies victims are reluctant to report, fearing either reprisals or dismissive responses. Instead they feel an implicit pressure to bury their experiences away, avoid confrontation, talk to sympathetic friends, consider how they can change who they are to avoid future SH, and redefine their experiences as normal in our society.

Author Contributions

SPP, JA, SI, TQ, JW and DH conceptualised and designed the study, did the background literature review and revised the questionnaire following pilot-testing. JA, MM and SPP did the qualitative analysis. SPP drafted the paper with advice from all others.

Conflict of Interest Statement

None of the authors has any conflict of interest to declare.

Ethics Approval

Ethics was received from each of the 17 Canadian universities with medical schools.

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Appendix A. Supplementary Data

Supplementary data to this article can be found online at <https://doi.org/10.1016/j.eclinm.2019.01.008>.

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