


Emergency Medicine in the #MeToo Era

Catherine A. Marco, MD¹ , Joel M. Geiderman, MD², Raquel M. Schears, MD, MPH, MBA³, and Arthur R. Derse, MD, JD⁴

ABSTRACT

Sexual harassment is a serious threat to a safe and productive workplace. The emergency department (ED) environment poses unique threats, including stress, time constraints, working in close physical proximity, and frequent personal contacts with staff, colleagues, consultants, and difficult patients. Sexual harassment must be recognized and addressed in individual cases, in policy and in law, to protect staff members and patients.

This article addresses the scope of the problem of sexual harassment known to date. It describes the ED environment and culture and why they may be conducive to harassment or abusive behavior. The authors examine relationships among staff, legal and regulatory issues, and strategies for prevention and remediation of inappropriate behavior. The article ends with a call for future research.

Ensuring a professional and respectful working environment in medicine is crucial to patient care; the learning; the environment; and the success, health, and well-being of health care providers. Sexual harassment and related issues have recently received increased attention as serious threats to the professional workplace. Since medicine, like most professions, strives to regulate and govern itself, professional organizations, publications, health care administrators, and individual practices have a duty to address the issue. This article will focus on the definition, history, and law of sexual harassment; the emergency department (ED) environment and culture; sexual harassing and other inappropriate behaviors in the ED; proper, improper, and questionable relationships among staff; prevention and remediation of inappropriate behavior; and future directions in emergency medicine (EM), including a call for future research.

HISTORY

The term “sexual harassment” is often attributed to Mary Rowe, PhD, Chancellor for Women at Work at

the Massachusetts Institute of Technology (MIT), who used the term in 1973 in her work entitled, “Saturn’s Rings.”¹ Others claim that credit is due to author and journalist, Susan Brownmiller, and other activists who brought this issue to the forefront more than 45 years ago.² Another seminal work is that of Catherine MacKinnon in her book, *Sexual Harassment of Working Women* (1979).³ The concept advanced and regulations and case law further defined this behavior. The problem of inappropriate sexual behavior by physicians has been recognized as a deplorable practice in medicine for ages, as noted in the Oath of Hippocrates: “Whatever houses I may visit, I will come for the benefit of the sick, remaining free of all intentional injustice, of all mischief and in particular of sexual relations with both female and male persons, be they free or slaves.”⁴

As early as 1998, sexual harassment was called out for its prevalence in medicine but received little attention.⁵ Increased public awareness of the societal scope of the problem has occurred recently. In October 2017, reports of the alleged abuse by media magnate

From the ¹Department of Emergency Medicine, Wright State University, Dayton, OH; ²Ruth and Harry Roman Emergency Department, Department of Emergency Medicine, Cedars-Sinai Medical Center, Los Angeles, CA; the ³Department of Emergency Medicine, University of Central Florida College of Medicine, Orlando, FL; and the ⁴Center for Bioethics and Medical Humanities and Department of Emergency Medicine, Medical College of Wisconsin, Milwaukee, WI.

Received March 31, 2019; revision received June 2, 2019; accepted June 3, 2019.

The authors have no relevant financial information or potential conflicts to disclose.

Author contributions: drafting of the manuscript—CAM, JMG, RMS, and ARD; and critical revision of the manuscript for important intellectual content—CAM, JMG, RMS, and ARD.

Supervising Editor: Tammie E. Quest, MD.

Address for correspondence and reprints: Catherine A. Marco, MD; e-mail: cmarco2@aol.com.

ACADEMIC EMERGENCY MEDICINE 2019;26:1245–1254.

Harvey Weinstein called public attention to the problem of harassment that is all too common and often the result of abuse of power. Following Weinstein's rapid fall from grace, many others in the fields of film, television, business, politics, sports, academia, and medicine have been accused of sexual misconduct and many have been removed from their jobs or even gone to jail.⁶ The majority, but not all, of these cases involved alleged male-on-female abuse.

Recently, Pope Francis admitted for the first time that "priests and even bishops" had sexually abused nuns and subsequently held a 4-day conference at the Vatican to address sexual abuse. Whether or not these actions were a direct result of the #MeToo movement is unknown, but temporally it follows a pattern of alleged victims speaking out and institutions and organizations forced by the disclosures to examine their environments and practices.

Adding to this milieu is the 2018 report by the National Academies of Sciences, Engineering, and Medicine (NASEM) on the harassment of women in academia.⁷ The report was a pivotal account of the pervasiveness of this behavior, describing it as common, especially in medicine, with sobering accounts specifically among medical trainees. One quote from a resident in the NASEM report was particularly disturbing as it described sexual harassment as part of a continuum of what residents were expected to endure: "But the thing is about residency training is everyone is having human right violations. So it's just like tolerable sexual harassment (sic)".

The NASEM report spurred a cluster of articles on this problem across various fields of medicine, not including EM.⁸⁻¹⁰ The NASEM report did single out surgery and EM as potentially problematic areas during residency due to their isolated "hierarchical and authoritative workplaces" although this claim was based on a report from 1998. In that study, women physicians who had completed residency training and were in practice reported the same rates of harassment as in other fields, although none of it is acceptable. As well, the National Institutes of Health (NIH) recently apologized for its failure to address sexual harassment.¹¹ All these morally repugnant acts run counter to the moral norms to which modern Western societies subscribe.

Increasing national attention to the pervasiveness of sexual harassment in the workplace led to the "MeToo" movement, originally founded in 2006, and gained momentum through social media in recent

months with the popular "#MeToo hashtag."¹² The vision of this movement is "... to address both the dearth in resources for survivors of sexual violence and to build a community of advocates, driven by survivors, who will be at the forefront of creating solutions to interrupt sexual violence in their communities." A recent study identified that Internet searches for sexual harassment or assault were 86% higher than expected from October 2017 through June 2018, reaching record highs.¹³ Recently, TIME'S UP Healthcare was founded to address harassment and protect from retaliation and to promote equitable compensation for women and men at every level in the health care industry, specifically asking organizations to confront obstacles to prevent and solve these problems.^{14,15}

THE ED ENVIRONMENT

The ED environment is distinctive among practice settings, including elsewhere in the hospital, clinics and offices although there are some similarities to operating rooms and catheterization labs. The ED is characterized by large staffs, often working side by side; not uncommonly a stressful environment and sometimes a casual atmosphere, it can be described as a "fishbowl" of openness but is often practiced behind closed drapes or doors. Emergency physicians and coworkers work shoulder to shoulder and conversations often go on into the late hours of night or early morning, when one's guard may be down, perhaps due to fatigue, stress, or the unique ED environment. Physicians and staff may at times use humor, inappropriate language, or inappropriate behavior as a coping mechanism. A recent study of New York EDs found that most residents had experienced verbal harassment (97%), verbal threats (78%), and/or sexual harassment (52%).¹⁶ Another recent study of 10 EM residencies found that most residents had experienced verbal abuse (86%) and verbal threats (68%) and significant numbers had experienced physical threats (50%), physical attacks (26%), sexual harassment (23%), or racial harassment (26%). In this study, women were more likely to encounter sexual harassment (37% compared to 8%, $p < 0.001$).¹⁷

A recent study identified significant issues of disruptive behaviors in the ED. In this study over 50% of respondents had witnessed disruptive behavior by physicians and/or nurses. In addition, respondents believed that these behaviors could be linked to

adverse events, medical errors, poor quality, compromises in patient safety, and patient mortality.¹⁸ Another recent study demonstrated significant incidence of horizontal violence (malicious behavior of health care workers against each other), ranging from 1% to 34%.¹⁹

This phenomenon is not limited to emergency physicians. Emergency medical services (EMS) providers have also experienced harassing behaviors. A 1999 study of EMS personnel found 69% of women in EMS reported workplace sexual harassment by supervisors, coworkers, and patients.²⁰

An attorney-EMT-P reported in 2018 that his law firm has been dealing with EMS harassment complaints for 30 years and has seen a recent increase in harassment complaints.²¹ News accounts of EMS personnel filing workplace harassment complaints show a public discussion of concern.²²⁻²⁴

The ED environment also includes many patients who are intoxicated by drugs or alcohol.^{25,26} Mental health conditions, addiction, and social issues are also common and may in some cases lead to disrespectful, abusive, or disinhibited behavior. This behavior may be more common in the ED where preexisting and ongoing relationships usually don't exist. A recent study demonstrated that emergency physicians in Michigan have experienced verbal threats (75%) or physical assault (28%), and women physicians were more likely to have experienced physical assault.²⁷ Another study identified a high incidence of workplace violence against ED workers, with sexual harassment the only type of violence more prevalent against females.²⁸

In summary, the ED has the potential for harassment or abuse of providers as well as by providers. Educational, institutional, and departmental efforts must address both situations.

INAPPROPRIATE BEHAVIOR

Sexual harassment can be categorized as gender-based harassment (including use of suggestive language, crude jokes, or sexist comments or sharing sexist imagery); unwanted sexual attention (verbal or physical); and sexual coercion (whereby career advancement is contingent upon sexual favors).^{29,30} Research reveals that more women than men report having experienced sexual harassment when provided the full definition which includes an array of verbal and nonverbal behaviors that “convey hostility, objectification,

exclusion, or second-class status about members of one gender.”³¹

One form of sexual harassment is “inappropriate touching.” Some may disagree about the definitions of appropriate and inappropriate touching in the workplace. Because of wide variability in what physical contact is welcomed or unwelcome, most physical contact should be avoided or limited in the workplace. Handshakes are an exception, as commonly accepted and in many cases expected. In general, personal space should be respected, and in most cases, physical contact with coworkers should be avoided.

Hugging is a complicated issue. One source states that hugging should be reserved for “family time.”³² In the authors' opinion, depending on specific relationships and cultures, hugging between two old friends or colleagues may be allowable if welcomed by both parties and occasional. Contacts that should be avoided include such things as touching a pregnant women's gravid abdomen; buttocks pats; shoulder and neck massages; or the caressing of heads, ears, or hair. Although pats to the head, back, or shoulder may seem innocuous, the physical proximity can be misconstrued and has resulted in sexual harassment claims in healthcare settings.³³ In general, it is also wise to recognize that the use of words and kindness can make an impact without touching and may be the safer strategy to deliver care and empathy in workplace.

PERSONAL RELATIONSHIPS AMONG STAFF

Personal relationships among staff members are controversial. Some believe that policies that discourage or disallow fraternization and personal relationships can reduce sexual harassment in the workplace, while others believe that such restrictions on relationships violate personal freedom. Many do not object to personal relationships between two single individuals but object if one of the parties is married to another person or in a committed relationship. Relationships based on a power mismatch can be fraught with personal and professional harm. Close personal relationships can be a distraction in the workplace, especially in the ED where teamwork is essential. Although some institutions prohibit romantic relationships between staff,^{34,35} such policies may be unrealistic and are often violated. When such relationships do occur, it should be required that personal relationships

remain professional in the workplace and do not interfere with patient care and teamwork. Some institutions have specific policies to govern relationships in the workplace. For example, the NIH has such a policy:³⁶

Personal relationships (including romantic and/or sexual) between individuals in inherently unequal positions, where one party has real or perceived authority over the other in their professional roles, may be inappropriate in the workplace and are strongly discouraged. If such a relationship exists or develops, it must be disclosed. This applies to all individuals in the NIH community, including employees, contractors, students, trainees, and fellows and includes anyone who holds a position of authority or perceived authority over another individual from a scientific or administrative perspective.

Personal relationships with patients or former patients are susceptible to negative consequences. Relationships with patients clearly involve a mismatch of power and vulnerability and may compromise the patient–physician relationship. The American Medical Association Code of Ethics provides guidance on professional self-regulation, including the following statement regarding relationships with patients:

Romantic or sexual interactions detract from the goals of the patient–physician relationship and may exploit the vulnerability of the patient, compromise the physician’s ability to make objective judgments about the patient’s health care and ultimately be detrimental to the patient’s well-being. A physician must terminate the patient–physician relationship before initiating a dating, romantic, or sexual relationship with a patient.³⁷

TEACHER AND LEARNER RELATIONSHIPS

Relationships that have a clear conflict of interest or power mismatch should be avoided. Teacher–learner personal relationships are not appropriate because of the inherent vulnerability of the learner. Supervisor and subordinate relationships are similarly generally inappropriate. Such inappropriate relationships may compromise the role of educator or supervisor, may harm the vulnerable individual, and may negatively affect the workplace.

ORGANIZATIONAL POLICIES AND GUIDELINES

Ensuring a professional and respectful working environment in medicine is crucial to patient care; the learning environment; and the success, health, and well-being of health care providers.^{10,20,38} The medical profession has an obligation to patients and providers to recognize and eliminate sexual harassment.³⁹ Several organizations have provided guidance on the topic of sexual harassment including The American College of Emergency Physicians has stated in policy:⁴⁰

The American College of Emergency Physicians advocates tolerance and respect for the dignity of each individual and opposes all forms of discrimination against and harassment of patients and emergency medicine staff on the basis of an individual’s race, age, religion, creed, color, ancestry, citizenship, national or ethnic origin, language preference, immigration status, disability, medical condition, military or veteran status, social or socioeconomic status or condition, sex, gender identity or expression, sexual orientation, or any other classification protected by local, state or federal law.

The American Medical Association has a policy on the issue that includes reporting, investigations, disciplinary actions, and confidentiality:

The AMA is committed to a zero tolerance for harassing conduct at all locations where AMA delegates and staff are conducting AMA business. This zero tolerance policy also applies to meetings of all AMA sections, councils, committees, task forces, and other leadership entities (each, an “AMA Entity”), as well as other AMA-sponsored events.⁴¹

The Liaison Committee on Medical Education has published a general standard regarding the learning environment.⁴² However, despite widespread education and standards to ensure a professional learning environment, breaches still occur. The American Association of Medical Colleges graduation questionnaire includes assessment of the learning environment. In 2018, 5% of graduating U.S. medical students reported that they have been subjected to unwanted sexual advances (once, occasionally, or frequently).

Some (16.5%) have been subjected to offensive sexist remarks/names.⁴³ Among academic faculty, women are more likely to report having experienced sexual harassment (30%, compared to 4% of men).⁴⁴

The Society for Academic Emergency Medicine (SAEM) has stated in policy:

Academic faculty in emergency medicine, as elsewhere, have an obligation to maintain appropriate boundaries in their relationships with those they supervise and teach, in particular, residents, fellows, and medical students, but also the many others who come to the emergency department to learn. Even the appearance of impropriety should be avoided.

This policy also suggests a balanced approach to management of such issues:

The Society for Academic Emergency Medicine expects each department to have a mechanism to address concerns and complaints about violations of appropriate boundaries by their faculty. Often, such a mechanism will be provided by the residency's parent institution. When no such institutional mechanism exists, the residency should implement one, with clear channels for the learner to safely lodge the complaint, with no fear of retribution, and a clear method for assessing and responding to such complaints.⁴⁵

LEGAL ISSUES

To better understand sexual harassment in EM, it is important to review the foundation of the law of sexual assault and the development of the law of sexual harassment. American law has long recognized several classes of unwanted intrusions as violations of law. An act of unconsented restraint or offensive touching can be a form of battery,⁴⁶ and an intentional act that creates an apprehension in another of an imminent, harmful, or offensive contact can be deemed an assault.⁴⁷ Sexual assault is any nonconsensual sexual act proscribed by federal, tribal, or state law and includes when the victim lacks capacity to consent.⁴⁸

State laws commonly define various degrees of sexual assault ranging from first to fourth degree, inversely ordered in degree of severity. For instance, in California, fourth-degree sexual assault is defined as sexual contact and with one of the following: 1) force

and/or coercion, 2) the victim incapacitated in some form, or 3) the perpetrator in a position of power over the victim.⁴⁹ Sexual contact is defined as intentional touching of another person's intimate parts (groin or buttocks or the breasts of a female) or the clothing covering the intimate parts of another person with the aim of sexual gratification or arousal. Punishment for the crime of sexual assault may result in imprisonment and fines³⁸ and potential civil judgments for assault, battery,⁵⁰ and intentional infliction of emotional distress.⁵¹ Sexual assault also encompasses sexual abuse consisting of verbal, visual, or noncontact behavior that forces a person to join in unwanted sexual activities or attention. Examples include voyeurism or peeping (viewing private sexual acts without consent), exhibitionism (public exposure), sexual harassment or threats, forcing someone to pose for sexual pictures, and sending someone unwanted texts or "sexts" (texting sexual photos or messages).⁵² Sexual assault is most commonly a state crime that must be proven by prosecutors beyond a reasonable doubt.⁵³

Sexual harassment is a more recently developed legal concept delineated as a form of discrimination. This has been elaborated through rulings based on Title VII of the Civil Rights Act of 1964.⁵⁴ Sexual harassment consists of unwelcome sexual advances; requests for sexual favors; and other verbal or physical conduct of a sexual nature where the 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. It is important to note that even though the most common sexual harassment may be by male supervisors of women employees, harassers and victims may be women or men, and both may be of the same sex.⁵⁵ Harassers can be any coworker, or even agents or nonemployees, of a "covered entity."⁴⁴ The victim can be anyone affected by the offensive conduct, and the law can be violated even if there is no economic injury or resulting harm to employment.⁴⁴

The U.S. Supreme Court first recognized sexual harassment that results in a hostile work environment as a form of discrimination under Title VII in *Meritor Savings Bank v. Vinson* in 1986.⁵⁶ Since sexual harassment is a federal violation, charges are made to the U.S. Equal Employment Opportunity Commission (EEOC) that has authority to investigate, using subpoenas, if necessary, if there is reasonable cause to believe harassment occurred. In contrast to the evidentiary

standard for sexual assault (beyond a reasonable doubt), the evidentiary standard for sexual harassment is the preponderance of the evidence (i.e., more likely than not). Plaintiffs may be awarded reinstatement, promotion, lost wages, damages for emotional distress, medical expenses, punitive damages, and attorney fees.⁵⁷

Physicians can be civilly liable for harassment of employees, fellow health care workers, trainees, or patients.^{58,59} These infractions and subsequent fines and damage judgments, if any, are generally not covered by malpractice insurance. Sexual harassment is a form of sexual misconduct subject to scrutiny and sanction by state medical boards and other credentialing bodies that may result in disciplinary action, limitation of license and subsequent loss of board certification by the American Board of Emergency Medicine.⁶⁰

MAINTAINING A SAFE WORKPLACE: PREVENTION, INVESTIGATION, REMEDIATION, AND NONRETALIATION

The hospital, the medical staff, and the departmental leadership should take steps to prevent harassment and should have zero tolerance if it occurs. Keys to doing this are clear policies that define a harassment free workplace, clear procedures for addressing policy transgressions, and education and training on harassment. These elements should focus on the cultivation, maintenance, and growth of a positive, safe, efficient, and harassment free workplace.

Despite the often chaotic conditions of the ED work environment (sometimes portrayed on television as a turbulent, jungle-like atmosphere), the tone should remain serious with the focus on maintaining the welfare of patients and coworkers. This may help reduce or eliminate inappropriate jokes or behaviors, which may constitute harassment or contribute to an environment where harassment occurs.

Once a complaint is filed, it must be fully investigated.^{61,62} A full discussion of the institutional process is beyond the scope of this paper but much of it is prescribed by federal and state laws and should be contained in institutional policies. Complaints should promptly be passed along to the human resources (HR) and legal departments who should engage in fact finding, usually through interviews. This should be done by professionals in the field. False allegations are reprehensible; can needlessly damage reputations,

often permanently; and may also undermine effective responses to legitimate complaints. Because of the subjective nature of these allegations, direct proof of events may be difficult to establish. It is best to gather facts as close to the time of the alleged event as possible.

WHEN THE ALLEGED VICTIM IS A PHYSICIAN, ALLIED HEALTH PROFESSIONAL, OR OTHER AGENT OF THE HOSPITAL

If the situation involves a supervisor, a coworker, or a workplace issue, the process described above should be initiated. In some situations, the accused party may be put on leave and in general, if possible, it is best to limit interactions between the parties (in a nonpunitive fashion) at least until the matter is resolved. As mentioned, the HR department, legal department, and other professionals should be involved. Department leaders should not do this on their own. In some cases, the EEOC will be involved.⁶³ This organization offers free mediation services. Ideally, both parties will agree to a remediation plan. A safe reporting environment is essential and it must be assured that retaliation is not allowed no matter how the investigation comes out.

As noted earlier, it is not uncommon that a physician or other provider will experience sexual harassment or abuse by a patient or family member who may be intoxicated, psychiatrically disturbed, a sociopath, or simply just abusive. In such cases, physicians should seek protection from physical harm from security officers or others. The provider may ask another provider to take over the care of the patient and once EMTALA requirements are satisfied the patient or other party may be removed from the premises.⁶⁴

WHEN THE ALLEGED PERPETRATOR IS A PHYSICIAN, ALLIED HEALTH PROFESSIONAL, OR OTHER AGENT OF THE HOSPITAL

If a claim is brought against a physician, the same process will occur. While the law provides certain automatic protections for alleged victims, the same is not true for alleged perpetrators. Accused perpetrators may wish to seek their own independent legal advice. Parallel processes may occur at the level of the hospital, the medical staff, the employer or contracting entity, and

in the legal system. If inappropriate behavior has been found to occur, there may be mandatory reporting to state medical boards. For all of these reasons, physicians would be wise to avoid even the suspicion of inappropriate behavior. The authors strongly recommend the use and documentation of chaperones for the examination of any intimate body parts of both male and female patients, as well as documentation of the clinical reason for the examination.

If assault is alleged, and there is credible evidence, law enforcement may need to be involved and in some cases the event must be reported to Centers for Medicare and Medicaid Services as a “never” event.⁶⁵ If a felony is established, physicians can expect to lose their licenses, medical staff privileges, and board certification.

FUTURE DIRECTIONS

Future directions to reduce or eliminate inappropriate behavior should include measurement of the problem through carefully constructed surveys, increased awareness through mandatory education, and more published reports and recommendations by those working in the field. Future research should better define the scope of the problem in the ED environment, including both witnessed and perceived incidence of harassment, types of harassment, and approaches to incidents. Additionally, solutions to the existing problems should be developed and investigated. Educational sessions on the subject by EM organizations

Table 1
Actions to Promote a Professional Workplace in the ED

1. Set an example of professional behavior.
2. Address unprofessional behavior early, and privately, if a minor infraction.
3. If safety of patients or staff are at risk, or if unprofessional behavior continues, report to supervisor.
4. Ensure that learners and other vulnerable staff feel comfortable discussing and addressing inappropriate behavior.
5. Ensure that staff are familiar with the concept of sexual harassment, the relevant law, and any relevant institutional policies.
6. Carry out investigations with the assistance of institutional human resources, and the legal department, if appropriate.
7. Remove providers accused of inappropriate behavior from patient care during the investigation, if the safety of patients or staff are considered at risk.
8. Consider avoiding situations in which the accusing and accused providers work as the investigation is under way.
9. Ensure protections and nonretaliation for victims bringing forward complaints.
10. Provide appropriate counseling and support services for victims throughout the investigation process.

may be helpful in raising awareness and proposing solutions.

CONCLUSIONS

Ensuring a professional and respectful working environment in medicine is crucial to patient care; to the learning environment; and to the success, health, and well-being of health care providers. Actions to promote a professional workplace in the ED should include professional behavior, appropriate communication and reporting of infractions, and ensuring that learners and other vulnerable staff feel comfortable reporting inappropriate behavior (Table 1). Allegations must be investigated and appropriate actions taken in a fair and consistent application of justice.

References

1. Rowe M. Saturn's rings: a study of the minutiae of sexism which maintain discrimination and inhibit affirmative action results in corporations and public institutions. *Grad Prof Educ Women*. Washington, DC: American Association of University Women, 1974:1–9.
2. Sexual Harassment. In: Wikipedia. Available at: https://en.wikipedia.org/wiki/Sexual_harassment. Accessed March 6, 2019.
3. MacKinnon C. *Sexual Harassment of Working Women: A Case of Sex Discrimination*, 19th ed. New Haven, CT: Yale University Press, 1979. p. 1.
4. Perez SG, Gelpi RJ, Rancich AM. Doctor-patient sexual relationships in medical oaths. *J Med Ethics* 2006;32:702–05.
5. Frank E, Brogan D, Shiffman M. Prevalence and correlates of harassment among US women physicians. *Arch Intern Med* 1998;153:352–8.
6. Heffenan V. Dr. Larry Nassar Was Not a doctor. *Los Angeles Times*, January 25, 2018. Available at: <https://www.latimes.com/opinion/op-ed/la-oe-heffenan-larry-nassar-20180126-story.html>. Accessed March 20, 2019.
7. Johnson PA, Widnall SE, Benya FF, editors; Committee on the Impacts of Sexual Harassment in Academia; Committee on Women in Science, Engineering, and Medicine; Policy and Global Affairs; National Academies of Sciences, Engineering, and Medicine. *Sexual Harassment of Women: Climate, Culture, and Consequences in Academic Sciences, Engineering, and Medicine*. 2018. The National Academies Press: 2018. Available at: <http://na.p.edu/24994>. Accessed February 22, 2019.
8. Jenner S, Djermeester P, Prügl J, Kurmeyer C, Oertelt-Prigione S. Prevalence of sexual harassment in academic medicine. *JAMA Intern Med* 2019;179:108–11.

9. Fairchild AL, Holyfield LJ, Byington CL. National Academies of Sciences, Engineering, and Medicine report on sexual harassment: making the case for fundamental institutional change. *JAMA* 2018;320:873–4.
10. Dzau VJ, Johnson PA. Ending sexual harassment in academic medicine. *N Engl J Med* 2018;379:1589–91.
11. Facher L. NIH Apologizes for Its Failure to Address Sexual Harassment in Science. Available at: <https://www.statnews.com/2019/02/28/nih-sexual-harassment-science/>. Accessed February 28, 2019.
12. MeToo: About. Available at: <https://metoomvmt.org/about/>. Accessed February 22, 2019.
13. Caputi TI, Nobles AL, Ayers JW. Internet Searches for Sexual Harassment and Assault, Reporting, and Training Since the #MeToo Movement. *JAMA Intern Med* 2018; E1–2.
14. Medicine Has Its Own #MeToo Problems: Can Time's Up Healthcare Fix It? Available at: <http://fortune.com/2019/02/28/times-up-health-care-medicine-metoo/>. Accessed March 1, 2019.
15. Choo EK, Byington CL, Johnson NL, Jagsi R. From #MeToo to #TimesUp in health care: can a culture of accountability end inequity and harassment? *Lancet* 2019;393:499–502.
16. Schnapp BH, Slovis BH, Shah AD, Fant AL, Gisondi MA, Shah KH, Lech CA. Workplace violence and harassment against emergency medicine residents. *West J Emerg Med* 2016;17:567–73.
17. Li SF, Grant K, Bhoj T, et al. Resident experience of abuse and harassment in emergency medicine: ten years later. *J Emerg Med* 2010;38:248–52.
18. Rosenstein AH, Naylor B. Incidence and impact of physician and nurse disruptive behaviors in the emergency department. *J Emerg Med* 2012;43:139–48.
19. Volz NB, Fringer R, Walters B, Kowalenko T. Prevalence of horizontal violence among emergency attending physicians, residents, and physician assistants. *West J Emerg Med* 2017;18:213–8.
20. Honeycutt L. Girl talk: an EMS educator reports her findings on the state of women in the industry. *JEMS* 1999;24:50–53.
21. Wirth S. #MeToo: Sexual Harassment in EMS. *EMS Insider*. *JEMS*. Jan. 17, 2018. Available at: <https://www.jems.com/ems-insider/articles/2018/january/metoo-sexual-harassment-in-the-ems-workplace.html>. Accessed May 27, 2019.
22. Pierce P. Penn. EMS Supervisor Sued for Sexual Harassment. *Tribune News Service*. *EMS World*. Mar. 26, 2019. Available at: <https://www.emsworld.com/news/1222450/penn-ems-supervisor-sued-sexual-harassment>. Accessed May 27, 2019.
23. Gorner J, Sweeney A, Meisner J. Five Ill. Paramedics Sue for Alleged Sexual Harassment from Superiors. *Chicago Tribune News Service*. *EMS World*. May 2, 2018. Available at: [om/news/220382/five-ill-paramedics-sue-alleged-sexual-harassment-superiors](https://www.emsworld.com/news/220382/five-ill-paramedics-sue-alleged-sexual-harassment-superiors). Accessed May 27, 2019.
24. Hoffman M. Employee files sexual harassment lawsuit against Fayette EMS. *Herald-Standard*. Mar 25, 2019. Available at: https://www.heraldstandard.com/news/local_news/employee-files-sexual-harassment-lawsuit-against-fayette-ems/article_11a2c4844f14-11e9-9a32-8f313e5afac8.html. Accessed May 27, 2019.
25. Girgis C, Khatkhate G, Mangurian C. Patients as Perpetrators of Physician Sexual Harassment. *JAMA Intern Med* 2019;179:279.
26. Viglianti EM, Oliverio AL, Meeks LM. Sexual harassment and abuse: when the patient is the perpetrator. *Lancet* 2018;392:368–70.
27. Kowalenko T, Walters BL, Khare RK, Compton S; Michigan College of Emergency Physicians Workplace Violence Task Force. Workplace violence: a survey of emergency physicians in the state of Michigan. *Ann Emerg Med* 2005;46:142–7.
28. Gates D, Gillespie G, Kowalenko T, Succop P, Sanker M, Farra S. Occupational and demographic factors associated with violence in the emergency department. *Adv Emerg Nurs J* 2011;33:303–13.
29. Konik J, Cortina LM. Policing gender at work: intersections of harassment based on sex and sexuality. *Soc Just Res* 2008;21:313–37.
30. Choo EK, van Dis J, Kass D. Time's up for medicine? Only time will tell. *N Engl J Med* 2018;379:17.
31. National Academies of Sciences, Engineering, and Medicine. *Sexual Harassment of Women: Climate, Culture, and Consequences in Academic Sciences, Engineering, and Medicine*. Washington, DC: National Academies Press, 2018. Available at: <https://www.nap.edu/catalog/24994/sexual-harassment-of-women-climate-culture-and-consequences-in-academic>. Accessed February 24, 2019.
32. Jack B. 4 Principles on the Right Physical Contact in the Workplace. Available at: <http://coolconfidence.com/when-is-it-okay-to-touch-people-in-the-workplace-and-how-to-avoid-a-restraining-order-solution-20024>. Accessed February 20, 2019.
33. *Sexual Harassment of Physicians: Report 2018*. Available at: <https://www.medscape.com/slideshow/sexual-harassment-of-physicians-6010304>. Accessed May 22, 2019.
34. Gregg RE. Restrictions on workplace romance and consensual relationship policies. *J Med Pract Manage* 2004;19:314–6.
35. Taylor JC. Do I Have to Quit My Job if I Want to Date My Boss? Ask HR. *USA Today* Jan 7, 2019. Available at: <https://www.usatoday.com/story/money/careers/2019/01/07/workplace-relationships-do-have-quit-if-want-date-my-boss/2472215002/>. Accessed February 19, 2019.
36. NIH Policy Statement: Personal Relationships in the Workplace. Available at: <https://hr.nih.gov/working-nih/>

- civil/nih-policy-statement-personal-relationships-workplace. Accessed February 19, 2019.
37. American Medical Association: Code of Medical Ethics 9.1.1: Professional Self-regulation Available at: <https://www.ama-assn.org/delivering-care/ethics/code-medical-ethics-professional-self-regulation>. Accessed February 19, 2019.
 38. Freischlap JA, Faria P. It is time for women (and men) to be brave: a consequence of the #MeToo movement. *JAMA* 2018;319:1761–2.
 39. Holroyd-Leduc JM, Straus SE. #MeToo and the medical profession. *CMAJ* 2018;190:E972–3.
 40. American College of Emergency Physicians. Non-discrimination and Harassment. Available at: <https://www.acep.org/patient-care/policy-statements/non-discrimination-and-harassment/#sm.0000lu36v11cvufysh9ltlknlyc0>. Accessed February 19, 2019.
 41. American Medical Association. Anti-Harassment Policy H-140.837. Available at: <https://policysearch.ama-assn.org/policyfinder/detail/Anti-Harassment%20Policy%20H-140.837?uri=%2FAMADoc%2FHOD.xml-H-140.837.xml>. Accessed February 24, 2019.
 42. The Liaison Committee on Medical Education (LCME): Standards: Learning Environment/Professionalism. Available at: <http://lcme.org/publications/#Standards>. Accessed February 20, 2019.
 43. American Association of Medical Colleges. Medical School Graduation Questionnaire. 2018 All Schools Summary Report. Available at: <https://www.aamc.org/download/490454/data/2018gqallschoolssummaryreport.pdf>. Accessed February 20, 2019.
 44. Jagsi R, Griffith KA, Jones R, Perumalswami CR, Ubel P, Stewart A. Sexual harassment and discrimination experiences of academic medical faculty. *JAMA* 2016;315:2120–1.
 45. Quest TE, Simon JR. SAEM Ethics Committee. Society for Academic Emergency Medicine position statement on teacher–learner relationships. *Acad Emerg Med* 2011;18:1188.
 46. The Law Dictionary. What Is BATTERY. Available at: <https://thelawdictionary.org/battery>. Accessed February 18, 2019.
 47. The Law Dictionary. What Is ASSAULT. Available at: <https://thelawdictionary.org/assault>. Accessed February 18, 2019.
 48. US Department of Justice. Office on Violence Against Women (OVW). What Is Sexual Assault? Available at: <https://www.justice.gov/ovw/sexual-assault>. Accessed February 18, 2019.
 49. California Code, Penal Code - PEN § 243.4. Available at: <https://codes.findlaw.com/ca/penal-code/pen-sect-243-4.html>. Accessed February 18, 2019.
 50. Assault and Battery. Legal Information Institute. Cornell Law School. Available at: https://www.law.cornell.edu/wex/assault_and_battery. Accessed March 31, 2019.
 51. Intentional Infliction of Emotional Distress. Legal Information Institute. Cornell Law School. Available at: https://www.law.cornell.edu/wex/intentional_infliction_of_emotional_distress. Accessed March 31, 2019.
 52. Sexual Assault. US Department of Health and Human Services. Office of Women's Health. <https://www.womenshealth.gov/relationships-and-safety/sexual-assault-and-rape/sexual-assault>. Accessed February 18, 2019.
 53. CALCRIM No. 220. Reasonable Doubt. Judicial Council of California Criminal Jury Instructions (2017 edition). Available at: <https://www.justia.com/criminal/docs/calcrim/200/220/>. Accessed March 24, 2019.
 54. Title VII of the Civil Rights Act of 1964 (Pub. L. 88-352) and its amendments. These amendments include The Civil Rights Act of 1991 (Pub. L. 102-166) (CRA) and the Lily Ledbetter Fair Pay Act of 2009 (Pub. L. 111-2) that amended several sections of Title VII. In addition, section 102 of the CRA amended the Revised Statutes by adding a section following section 1977 (42 U.S.C. 1981), to provide for the recovery of compensatory and punitive damages in cases of intentional violations of Title VII, among other statutes. Available at: <https://www.eeoc.gov/laws/statutes/titlevii.cfm>. Accessed February 18, 2019.
 55. Equal Employment Opportunity Commission. Facts About Sexual Harassment. Available at: <https://www.eeoc.gov/eeoc/publications/fs-sex.cfm>. Accessed February 18, 2019.
 56. *Meritor Savings Bank v. Vinson*, 477 U.S. 57 (1986).
 57. U.S. Equal Employment Opportunity Commission. What You Can Expect After a Charge Is Filed. Available at: <https://www.eeoc.gov/employers/process.cfm>. Accessed February 18, 2019.
 58. *Vance v. Ball State University*, 133 S. Ct. 2434 (2013)
 59. Tan YS. Sexual Harassment. *The Hospitalist*. January 9, 2018. Available at: <https://www.the-hospitalist.org/hospitalist/article/155826/practice-management/sexual-harassment>. Accessed February 18, 2019.
 60. Federation of State Medical Boards (FSMB). Addressing Sexual Boundaries: Guidelines for State Medical Boards. May 2006. Available at: http://www.fsmb.org/siteassets/advocacy/policies/grpol_sexual-boundaries.pdf. Accessed February 18, 2019.
 61. Tremblay EJ. Properly Instigating Complaints of Harassment. *ABA Business Law Section*. 18(1)1-5. September/October 2008. Available at: <https://apps.americanbar.org/buslaw/blt/2008-09-10/tremblay.shtml>. Accessed March 30, 2019.
 62. Hermle L; AllBusiness. 15 Key Steps for Companies Responding to Sexual Harassment or Discrimination Allegations. November 13, 2017 Available at: <https://www.forbes.com/sites/allbusiness/2017/11/13/15-key-steps-for-companies-responding-to-sexual-harassment-or-discrimination-allegations/#5188de824582>. Accessed March 30, 2019.

63. Kolligian JU. Workplace Investigations: Internal Investigation and EEOC Claims. April 16, 2018. Available at: <https://www.lorman.com/resources/workplace-investigations-internal-investigations-and-eoc-claims-16405>. Accessed March 30, 2019.
64. Emergency Medical Treatment and Active Labor Act. 42 USC 1395dd et seq.
65. CMS.gov. Eliminating Serious, Preventable and Costly Medical Errors-Never Events. May 18, 2006. Available at: <https://www.cms.gov/newsroom/fact-sheets/eliminating-serious-preventable-and-costly-medical-errors-never-events>. Accessed March 30, 2019.