Behaviour toward residents innocuous or intolerable?

I was disturbed to learn of the findings of Dr. Deborah J. Cook and associates regarding abuse at a Canadian teaching hospital, in the article "Residents' experiences of abuse, discrimination and sexual harassment during residency training" (*Can Med Assoc J* 1996;154:1657-65). The study is flawed in many ways, but the most glaring flaw is that the conclusions were based on an anonymous questionnaire. I wonder why the researchers did not use personal interviews to at least attempt to corroborate some of their conclusions. There have been many criticisms of questionnaires, not the least of which concerns the manner in which the questions are constructed. If the findings had been corroborated by direct confrontation, I would have had less trouble with them.

What surprised me more was the perception of abuse by the residents. Goodness, why would anyone consider it abusive if one person comments on the dress of another? Surely one would consider a positive comment in that regard as a compliment.

I suppose one person's cake is another's poison.

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Sexual harassment, discrimination and other forms of abuse are intolerable in any environment. However, the study by Dr. Cook and associates only serves to fuel anger and misperception. The definitions of abusive and harassing behaviour in this study are so broad and ill defined as to be meaningless. Much innocent behaviour may have been categorized as abuse or harassment.

Psychological abuse is defined as "behaviour that made people feel hurt, devalued or incompetent." This seems seriously overinclusive. Discussion of a resident's improper medical management, leading to death or admission to an intensive care unit, is appropriate, although it may make the resident feel "devalued."

Physical assault is defined as "rough handling, hitting or pushing." Of course, these are unacceptable. However, was there an attempt to put these into context? Were the struggles of a delirious or encephalopathic patient considered to be abuse?

Discrimination on the basis of sex and sexual orientation is defined as "less interest in or less respect for one's opinion . . . less attention to one's needs." These definitions appear to consider perception more important than the intention of the behaviour, which is enormously prone to misinterpretation and misplaced blame.

Most contentious are the definitions of sexual harassment. Sexual impropriety is defined as "gestures or expressions that demonstrated a lack of respect for privacy or were sexually demeaning," which is consistent with the College of Physicians and Surgeons of Ontario's recommendations. Included as forms of sexual harassment were "sexist jokes," "compliments on body or figure," "flirtation," "offensive body language," "sexist teaching material" and "unwanted compliment on dress." These made up the vast majority of instances of sexual harassment. Is a benign compliment on one's appearance or dress considered harassment? Many would consider this courtesy or friendliness. What defines offensive body language or sexist teaching material? Sexist jokes may be offensive and inappropriate, but are they harassment? I suspect that most of these episodes were innocuous.

Were the respondents aware of the nature of this study? Were they aware that only abusive behaviour, not merely offensive or innocent behaviour, was being ascertained?

This research adds little to our knowledge of the degree of abuse or harassing behaviour in our academic medical centres. The fact that the results of this study were widely reported in the popular media, without clarification of the nature of the "harassment" and "abuse," is an injustice to those who truly experience abuse and harassment in any context.

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[The authors respond:]

Dr. Hershfield missed the fact that we used personal interviews in conducting our study. In the methods section, we describe how we obtained items for our questionnaire from a comprehensive literature search. These items were ratified during face-to-face interviews with residents and were augmented by additional items that the residents mentioned spontaneously.

The need for an anonymous questionnaire was suggested to us by the house staff because of the upsetting nature of many of these experiences, the power imbalance inherent in supervisor–trainee relations and the discounting and active denial of these problems by certain members of the medical community. We agree with Hershfield's implicit suggestion that qualitative research methods would enrich this work. We are currently conducting such a project to better understand the experiences of gay and lesbian house staff in Canadian residency training programs.

Appropriate feedback about patient management can make house staff feel incompetent. We asked residents about their feelings in the context of a questionnaire that explicitly addressed inappropriate behaviour that residents felt was devaluing, abusive and harassing. In contrast to Dr. Kravcik, we credit house staff with the ability to distinguish between appropriate feedback that draws attention to their educa-