RESIDENTS' EXPERIENCES OF ABUSE, DISCRIMINATION AND SEXUAL HARASSMENT DURING RESIDENCY TRAINING

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Abstract • Résumé

Objective: To assess the prevalence of psychological abuse, physical assault, and discrimination on the basis of gender and sexual orientation, and to examine the prevalence and impact of sexual harassment in residency training programs.

Design: Self-administered questionnaire.

Setting: McMaster University, Hamilton, Ont.

Participants: Residents in seven residency training programs during the academic year from July 1993 to June 1994. Of 225 residents 186 (82.7%) returned a completed questionnaire, and 50% of the respondents were women.

Outcome measures: Prevalence of psychological abuse, physical assault and discrimination on the basis of gender and sexual orientation experienced by residents during medical training; prevalence and residents' perceived frequency of sexual harassment.

Results: Psychological abuse was reported by 50% of the residents. Some of the respondents reported physical assault, mostly by patients and their family members (14.7% reported assaults by male patients and family members, 9.8% reported assaults by female patients and family members); 5.4% of the female respondents reported assault by male supervising physicians. Discrimination on the basis of gender was reported to be common and was experienced significantly more often by female residents than by male residents ($p < 0.01$). Ten respondents, all female, reported having experienced discrimination on the basis of their sexual orientation. Most of the respondents experienced sexual harassment, especially in the form of sexist jokes, flirtation and unwanted compliments on their dress or figure. On average, 40% of the respondents, especially women ($p < 0.01$), reported experiencing offensive body language and receiving sexist teaching material and unwanted compliments on their dress. Significantly more female respondents than male respondents stated that they had reported events of sexual harassment to someone ($p < 0.001$). The most frequent emotional reactions to sexual harassment were embarassment (reported by 24.0%), anger (by 23.4%) and frustration (20.8%).

Conclusion: Psychological abuse, discrimination on the basis of gender and sexual harassment are commonly experienced by residents in training programs. A direct, progressive, multidisciplinary approach is needed to label and address these problems.

Objectif : Évaluer la prévalence des abus psychologiques, des agressions physiques et de la discrimination fondée sur le sexe et l'orientation sexuelle, et examiner la prévalence et l'impact du harcèlement sexuel dans les programmes de formation en résidence.

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Conception : Questionnaire à remplir soi-même.

Contexte : Université McMaster, Hamilton (Ont.).

Participants : Résidents de sept programmes de formation en résidence au cours de l'année scolaire de juillet 1993 à juin 1994. Sur 225 résidents, 186 (82,7 %) ont renvoyé un questionnaire rempli et 50 % des répondants étaient des femmes.

Mesures des résultats : Prévalence des abus psychologiques, des agressions physiques et de la discrimination fondée sur le sexe et l'orientation sexuelle vécus par les résidents au cours de leur formation en médecine; prévalence du harcèlement et fréquence du harcèlement perçue par les résidents.

Résultats : Les résidents ont fait état d'abus psychologiques dans 50 % des cas. Certains des répondants ont signalé des agressions physiques, commises surtout par des patients et des membres de leur famille (14,7 % ont signalé des agressions commises par des patients masculins et des membres de leur famille, 9,8 % ont signalé des agressions commises par des patientes et des membres de leur famille); 5,4 % des répondantes ont fait état d'une agression commise par des médecins superviseurs de sexe masculin. On a signalé que la discrimination fondée sur le sexe était répandue et que les résidentes en étaient victimes beaucoup plus souvent que les résidents ($p < 0,01$). Dix répondantes ont signalé avoir été victimes de discrimination fondée sur leur orientation sexuelle. La plupart des répondants ont été victimes de harcèlement sexuel, particulièrement de blagues sexistes, de flirt et de compliments indésirés sur leur tenue vestimentaire ou leur physique. En moyenne, 40 % des répondants, et surtout des femmes ($p < 0,01$), ont signalé avoir vécu des cas de langage corporel offensant et reçu du matériel pédagogique sexiste et des compliments indésirés sur leur tenue vestimentaire. Beaucoup plus de répondantes que de répondants ont déclaré avoir signalé des cas de harcèlement sexuel à quelqu'un ($p < 0,001$). Les réactions affectives les plus fréquentes au harcèlement sexuel ont été l'embarras (signalé par 24,0 %), la colère (par 23,4 %) et la frustration (20,8 %).

Conclusion : Les résidents des programmes de formation sont régulièrement victimes d'abus psychologiques, de discrimination fondée sur le sexe et de harcèlement sexuel. Une démarche directe, progressiste et multidisciplinaire s'impose si l'on veut identifier ces problèmes et y donner suite.

Physicians are susceptible to experiencing and perpetrating abuse and discrimination, which may be subtle or overt, intermittent or pervasive. Abuse and discrimination may negatively affect the ability of physicians-in-training to learn. Abuse in medicine has been recognized in various settings.[1-9] In one study, 81% of senior medical students reported having been abused (defined as harmful, injurious or offensive treatment, verbal attacks or harsh, insulting or unjust comments), and 69% reported at least one incident as being of major importance and very upsetting.[4] The frequency of abuse was highest in the year in which students had clinical specialty rotations in medicine. In another study general internists stated that they commonly experienced psychological abuse in the workplace, in most cases by patients (reported by more than 75%). Approximately 40% to 50% stated that they experienced abuse from supervising physicians, peers and nurses.[9]

A large proportion of students (36% to 52%[10-12]) have reported experiencing some form of sexual harassment during medical school, with reports by women having been more frequent than those by men.[1,3,11,12] In one study, 75% of female residents and 25% of male residents reported that they had been sexually harassed at least once during their training.[6] Such harassment creates a high level of stress among students and residents and a hostile learning environment.[3,12,13]

We surveyed residents at a Canadian medical school to determine the frequency during residency training of psychological abuse, physical assault, discrimination on the basis of gender and sexual orientation, and sexual harassment. We also explored the impact of sexual harassment on the quality of life of residents and on their work environment, examining different residency training programs in the same institution.

Methods

Questionnaire development

We developed the questionnaire in several stages.[14] First, in an investigator focus group, we generated candidate items that were augmented by data from a MEDLINE search for articles published from 1966 using the text words "residency," "training," "career," "stress" and "women." We reviewed studies on physician job satisfaction, stress and gender issues. Further items were generated through semistructured interviews with residents in seven residency training programs at four teaching hospitals affiliated with McMaster University. We removed duplicate items and modified the questionnaire according to feedback from a pretesting exercise with residents from each program.

Residents were asked to record the frequency with which they had ever experienced psychological abuse, physical assault and discrimination on the basis of gender or sexual orientation, as perpetrated by supervising physicians, peer residents, nurses and other allied health

care workers, and patients and their family members. We defined psychological abuse as behaviour that made people feel hurt, devalued or incompetent; such behaviour could include shouting, uttering insults, ignoring or making disrespectful comments. Physical assault was defined as behaviour such as rough handling, hitting or pushing. We defined discrimination on the basis of gender and discrimination on the basis of sexual orientation as less interest in or less respect for one's opinion or authority, less attention to one's needs, denial of opportunities or different standards of evaluation on the basis of one's sex or one's sexual orientation.

We also asked residents to record the frequency with which they experienced events of sexual impropriety and sexual transgression. In keeping with the College of Physicians and Surgeons of Ontario's Sexual Abuse Recommendations,[15] we defined sexual impropriety as gestures or expressions that demonstrated a lack of respect for privacy or were sexually demeaning. We defined sexual transgression as inappropriate touching of a sexual nature. Fourteen events were then described in the questionnaire that could be experienced by residents as consistent with sexual harassment. Respondents were asked to record whether they had experienced these events, whether they reported them (if Yes, to whom they reported them; if No, why they did not report them), and the personal and professional impact of the most distressing of these events.

Finally, we asked residents to indicate how frequently they felt that residents were treated differently on the basis of gender by supervising physicians, nurses and patients. A 5-point Likert-type scale was provided (1 = never or very rarely, 5 = very often or always).

Questionnaire administration

We identified all residents working in four hospitals who were enrolled in seven residency training programs at McMaster University during the academic year from July 1993 to June 1994. The protocol was approved by McMaster's Institutional Review Board. We handed out the questionnaire at academic half days; residents who were not in attendance were mailed a copy of the questionnaire. Up to three reminder letters, each with a duplicate copy of the questionnaire, were sent to residents who did not return a completed questionnaire. Completion of the questionnaire was voluntary, and individual responses were kept confidential.

Statistical analysis

Continuous variables were expressed as means and standard deviations (SDs). We used the Student's *t*-test to compare continuous variables and the χ^2 test to compare proportions or distributions. Responses about experiencing psychological abuse and discrimination were categorized as "Never," "Ever" and "At least three times during residency training." When responses differed between the male and female residents we presented data for each group separately; otherwise we combined all responses.

We used the Mantel–Haenszel χ^2 test to examine the relation between the residency program and the frequency of six events that we considered to be forms of sexual harassment (sexist teaching material, sexist jokes, sexual comments, flirtation, verbal sexual advances and offensive body language), after adjusting for the sex of the resident.

Log-linear modelling was used to explore relations between the sex of the residents and the frequency with which they felt that residents were treated differently by supervising physicians, nurses and patients.

We considered a p value of less than 0.01 to be statistically significant.

Results

Characteristics of the respondents

Residents from all seven programs participated. Of 225 sent the questionnaire 186 (82.7%) responded. The response rates by residency program were as follows: anesthesia 100% (16/16), family medicine 69.0% (58/84), internal medicine 100% (39/39), obstetrics and gynecology 88.2% (15/17), pediatrics 88.0% (22/25), psychiatry 80.8% (21/26) and surgery 83.3% (15/18). The mean age of the respondents was 30.5 (SD 5.0) years (median 30, interquartile range 27 to 33 years), and 50.0% were women. A similar proportion of male (83.8% [93/111]) and female (81.6% [93/114]) residents responded. Most (82.0%) of the respondents were graduates of Canadian medical schools; 29.2% were in postgraduate year 1 (PGY1), 38.4% in PGY2, 9.7% in PGY3, 11.9% in PGY4 and 10.8% in PGY5 or beyond.

Psychological abuse

Psychological abuse during residency training was reported by 93.4% (171/183) of the residents (Fig. 1). The proportion of those who reported such abuse by male and female supervising physicians did not differ significantly (74.7% and 61.5% respectively), nor did the proportion of those who reported abuse by male and female peers (51.9% and 44.5% respectively). A total of 77.6% of the residents reported psychological abuse by female nurses. Patients and their families were another source of such abuse, reported by two thirds of the residents.

Physical assault

Physical assault during residency training was reported by 19.6% (36/184) of the residents. The most common perpetrators were male patients and family members, reported by 14.7% of the respondents; 9.8% of the respondents reported being assaulted by female patients and family members. Most of the other incidents of physical assault were committed by male supervising physicians (reported by 5.4% of the female respondents).

Discrimination on the basis of gender

Overall, 75.3% (137/182) of the residents reported having experienced discrimination on the basis of gender; more were female than male (89.1% [82/92] v. 61.1%

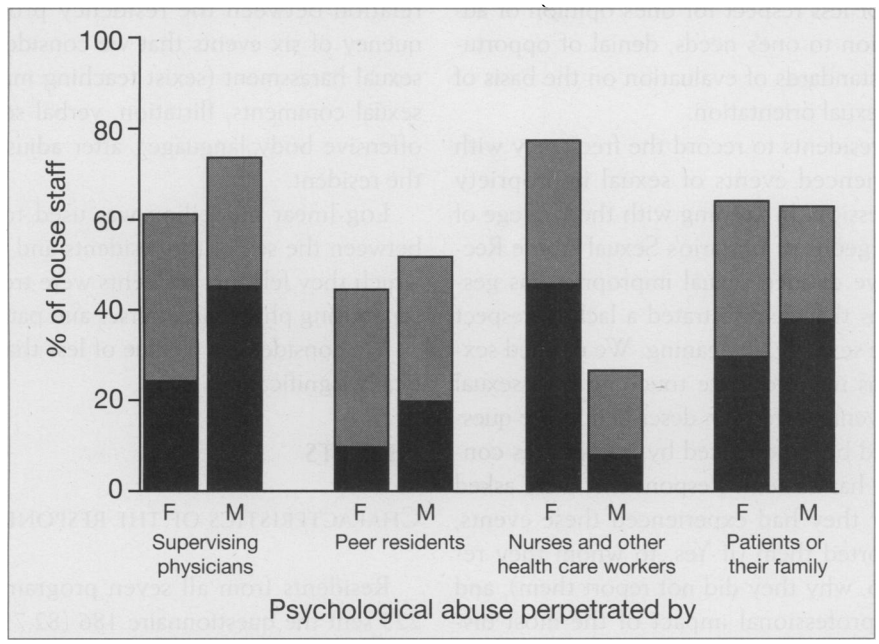

Fig. 1: Proportion of residents at McMaster University who reported having experienced psychological abuse by health care professionals and by patients and their families during their residency training. F = female perpetrators, M = male perpetrators. Black portions of bars represent residents who experienced psychological abuse at least three times.

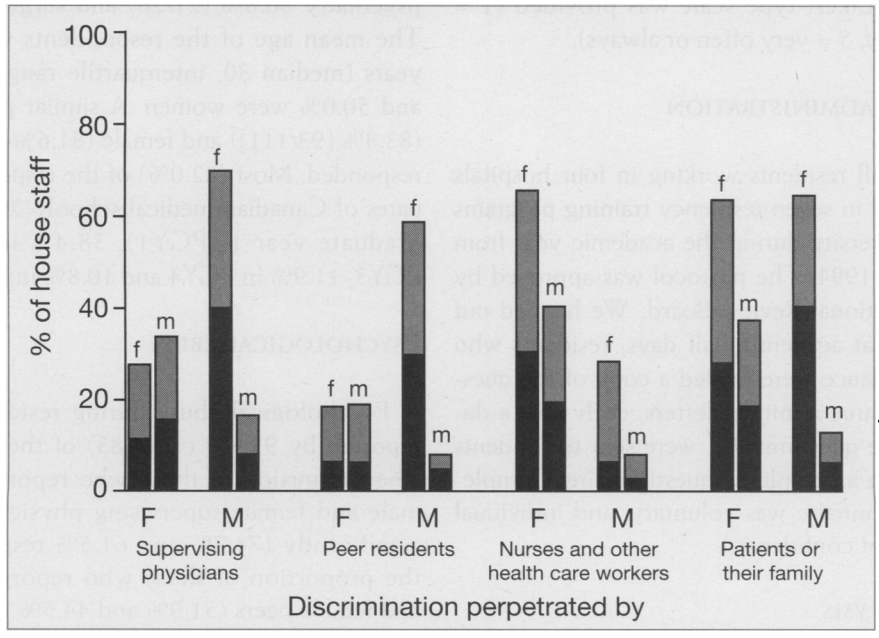

Fig. 2: Proportion of residents who reported having experienced discrimination on the basis of gender by health care professionals and by patients and their families during their residency training; f = female residents, m = male residents. Black portions of bars represent residents who experienced discrimination at least three times.

[55/90]; $p < 0.01$) (Fig. 2). Significantly more female respondents than male respondents reported such discrimination by male supervising physicians (70.0% v. 16.7%) ($p < 0.01$). Nearly 60% of the female residents reported having experienced it by male peers, whereas only 18.9% of the male residents reported having experienced it by female peers. The female residents were significantly more likely than the male residents to have experienced it by either male or female nurses or other health care workers or by either male or female patients ($p < 0.001$).

Discrimination on the basis of sexual orientation

We did not ask respondents to indicate their sexual orientation. Nineteen (10.2%) of the 186 residents responded to this section of the questionnaire. Of the 10 who were women, 1 reported discrimination on the basis of sexual orientation by a male supervising physician, 1 by a female peer and 1 by a male patient or family member; the other 7 reported no such discrimination. None of the nine male residents responding to this section reported experiencing discrimination on the basis of their sexual orientation.

Sexual harassment

Most (92.9% [171/184]) of the respondents reported experiencing one or more of the events listed in Table 1 during their residency training. The events reported most often were sexist jokes, compliments on the body or figure, flirtation and offensive body language. Sexist jokes were more commonly reported by female respondents than by male respondents ($p < 0.05$), as were offensive body language, sexist teaching material and unwanted compliments on dress ($p < 0.01$ for each comparison). More male respondents than female respondents reported explicit sexual propositions in the workplace (11.0% v. 6.5%); however, the difference was not statistically significant. We found no relation between the residency training program and the frequency of any of these events.

Of the 171 residents who experienced sexual harassment 165 completed the question on telling someone about the harassment. Of these, 79 (47.9%) stated that they had told someone. Significantly more female residents than male residents stated they had done so ($p < 0.001$). Seventy-eight of the 79 residents who stated that they had told someone about the event(s) indicated who that person was (Table 2). Another resident, a friend and a partner or family member were the most common confidantes; a supervising physician was chosen by only 23.1%. None of the residents reported these events to the sexual harassment officer. There was no significant difference in the proportion of female and male residents reporting to any particular confidante.

Table 1: Events of of sexual harassment experienced by residents at McMaster University, Hamilton, Ont.

Event	Group; no. (and %) of residents	
	Female residents *n = 93**	Male residents *n = 93**
Sexist joke†	73 (79.4)	58 (64.4)
Compliment on body or figure	58 (62.4)	51 (56.0)
Flirtation	53 (57.0)	51 (56.0)
Offensive body language‡	52 (56.5)	28 (30.8)
Sexual comment	40 (43.5)	27 (29.7)
Sexist teaching material‡	36 (38.7)	17 (18.9)
Unwanted compliment on dress‡	35 (37.6)	15 (16.5)
Verbal sexual advance	27 (29.0)	29 (31.9)
Suggestion to dress in a gender-appropriate fashion	18 (19.4)	9 (10.1)
Adverse criticism on body or figure	17 (18.3)	21 (23.1)
Display of sexist pictures or posters	15 (16.1)	9 (10.0)
Unwanted sexual contact	12 (12.9)	10 (11.0)
Explicit sexual proposition	6 (6.5)	10 (11.0)
Sexual bribery	0	2 (2.2)
No response	7 (7.5)	6 (6.5)

*Not all respondents indicated whether or not they had experienced each event (the denominator in some cases was as low as 89).
†$p < 0.05$ for difference between female and male residents.
‡$p < 0.01$ for difference between female and male residents.

When asked to consider the most distressing event experienced from those listed in Table 1, the reasons why 123 residents did not report the event are given in Table 3. Most did not consider the event to be a problem or of sufficient importance to concern them, and one quarter stated that their coming forward would not accomplish anything. More female residents than male residents thought that reporting the event was more trouble than it was worth ($p < 0.05$), were afraid that reporting would affect their evaluation ($p < 0.01$) and were afraid that their report would not be kept confidential ($p < 0.05$). More male residents than female residents did not think that the behaviour was a problem ($p < 0.01$).

As for how these events of sexual harassment affected the professional lives of the residents who experienced them, 26.3% expressed that they had a general negative effect on their work, 16.4% subsequently avoided the offenders at work, and 7.9% felt that these events created a hostile environment for residency training. Other adverse effects included impaired performance (reported by 3.3%), a changed work routine (by 2.6%) and withdrawal from one's peer group (by 0.7%). The remainder did not state how the events affected their professional lives.

Table 4 lists the emotional reactions reported by 154 of the residents who experienced events of sexual harassment. Embarassment, anger and frustration were reported most often (by 24.0%, 23.4% and 20.8% respectively). More female residents than male residents reported having felt angry, frustrated, violated and helpless, whereas more male residents stated that the events had no emotional impact on them ($p < 0.01$ for all comparisons).

Table 2: People in whom residents confided experiences of sexual harassment

Person	No. (and %) of residents* *n = 78*
Another resident	55 (70.5)
Friend	51 (65.4)
Partner or family member	42 (53.8)
Supervising physician	18 (23.1)
Support staff	2 (2.6)
Authority figure	1 (1.3)
Therapist	1 (1.3)
Sexual harassment officer	0

*Sum of numbers exceeds number of residents because some residents reported more than one confidante.

Table 3: Reasons given by residents for not reporting sexual harassment

Reason	No. (and %) of residents* *n = 123*
Did not think that the behaviour was a problem	56 (45.5)‡
Thought that event was too minor a problem to worry about	38 (30.9)
Did not think that reporting sexual harassment would accomplish anything	31 (25.2)
Thought that reporting sexual harassment was more trouble than it was worth	23 (18.7)§
Dealt with problem directly	17 (13.8)
Was afraid that reporting sexual harassment would adversely affect evaluation	17 (13.8)‡
Did not want to be labelled	10 (8.1)
Sexual harassment stopped	10 (8.1)
Was afraid that the report would not be kept confidential	8 (6.5)§
Was afraid of retribution or punishment	8 (6.5)
Did not think that problem would be dealt with fairly	7 (5.7)
Did not know to whom sexual harassment should be reported	6 (4.9)
Was afraid of not being believed	3 (2.4)
Was concerned about being blamed	2 (1.6)
Other†	9 (7.3)

*Sum of numbers exceeds number of residents because some residents gave more than one reason.
†Included feeling uncomfortable in addressing problem and being concerned that reporting sexual harassment would limit career advancement.
‡$p < 0.01$ for difference between female and male residents (fewer female residents considered sexual harassment not to be a problem and more were afraid that reporting it would affect their evaluation).
§$p < 0.05$ for difference between female and male residents (more female residents believed that reporting sexual harassment was more trouble than it was worth and were afraid that the report would not be kept confidential).

Table 4: Emotional responses to sexual harassment

Emotional response	No. (and %) of residents* *n = 154*
Embarrassment	37 (24.0)
Anger	36 (23.4)‡
Frustration	32 (20.8)‡
Anxiety	25 (16.2)
Feeling of being violated	17 (11.0)‡
Helplessness	11 (7.1)‡
Feeling of being threatened	10 (6.5)
Depression	9 (5.8)
Guilt	4 (2.6)
Feeling of being alone	3 (1.9)
Other†	23 (14.9)
None	59 (38.3)§

*Sum of numbers exceeds number of residents because some residents reported more than one response.
†Included feeling annoyed, uncomfortable, objectified, discriminated against or disgusted.
‡$p < 0.01$ for difference between female and male residents (female residents were more likely to report response).
§$p < 0.01$ for difference between female and male residents (male residents were more likely to report that event had no emotional impact).

Frequency of differential treatment of residents on the basis of gender

Overall, 98.4% (181/184) of the respondents believed that residents were treated differently on the basis of gender by supervising physicians, nurses and patients (Table 5). More female residents than male residents stated that residents were treated differently often, very often or always by physician supervisors (33.4% v. 17.6%), by nurses (54.4% v. 40.7%) and by patients (53.3% v. 35.2%); however, none of these differences in distribution between female and male residents was significant.

Discussion

Psychological abuse, discrimination on the basis of gender and sexual harassment were common in the residency training programs we surveyed at McMaster University. Our results concerning sexual harassment are consistent with those from other studies[1,3,6,10–13] and suggest that residency training programs may not actively encourage the reporting, labelling and addressing of such problems. Moreover, female residents in our study were often afraid of retribution if they reported harassment.

Sexist jokes, sexist teaching material, unwanted comments about dress and figure, and offensive body language appeared to be common forms of sexual harassment. Our results suggest different tolerance thresholds of female and male residents in this regard. Presumably having been exposed to the same teaching materials, over one third of the female residents but not quite one fifth of the male residents who reported experiencing sexual harassment stated that it was in the form of sexist teaching material.

Some of the residents in our survey also reported physical assault, mostly by patients and their family members. The 5% of female residents who reported physical assault by a supervising male physician is a troubling and unexpected finding; that the male residents reported no such experience may indicate an absence of this behaviour directed toward men, or perhaps rationalization or denial by male residents. Issues of physicians' physical safety have only recently been studied; 40% of Canadian psychiatric residents reported having been physically assaulted at least once in the workplace, resulting in requests for improved security by 37% of the respondents.[16]

A small number of residents in our study completed the section of the questionnaire on discrimination on the basis of sexual orientation. None of the nine men indicated that they had experienced such discrimination. Although it is possible that none of them was exposed to heterosexist or homophobic attitudes or conversations, this is unlikely. Another explanation could have been their fear of revealing their sexual orientation on the questionnaire or at work. Homophobia among physicians is a prevalent problem that has had a negative impact on the care of lesbians,[17] gays[18] and patients with HIV infection or AIDS,[19] and on gay, lesbian or bisexual medical students[20] and physicians.[21] Ideally, professional behaviour would be guided by a progressive, unbiased code of ethics; however, caregivers appear to be influenced by the ideology and values of the prevailing culture.[22–24] Integration of teaching about homosexuality and homophobia in medical school,[25] residency training programs and continuing medical education for practitioners[26] is necessary.

The strengths of our study include the following: residents contributed to the development of the questionnaire, there was a high response rate among residents in each of the seven training programs surveyed, the definitions of abuse and discrimination were standardized in the questionnaire, we obtained data on who the perpetrators were, and we obtained information on the impact of sexual harassment on the residents' quality of life and work environment.

There are several limitations to our study. The data may have been subject to recall bias, which could have inflated or deflated the estimated event rates. We did not evaluate the impact of these stresses on physicians' career choices, nor did we attempt to validate the reported

Table 5: Respondents' perceptions of how frequently residents were treated differently on the basis of gender by supervising physicians, nurses and patients

	By supervising physicians*		By nurses*		By patients*	
Frequency of treatment	% of female residents	% of male residents	% of female residents	% of male residents	% of female residents	% of male residents
Never/very rarely	13.0	20.9	5.4	15.4	4.4	13.2
Rarely	14.1	14.3	3.3	9.9	7.6	11.0
Sometimes	40.2	43.3	37.0	34.1	34.4	40.7
Often	20.4	12.1	18.5	20.9	27.2	18.7
Very often/always	13.0	5.5	35.9	19.8	26.1	16.5

*For difference in distribution between female and male residents, $p = 0.048$ for treatment by supervising physicians, 0.008 for treatment by nurses and 0.02 for treatment by patients.

abusive episodes. Nevertheless, in interpreting these data, it is the perception of the event and not the event itself that may have the greatest impact on the individual.[4] Another limitation is that our study was conducted at one academic centre. To what extent might our results be idiosyncratic to our centre? Aside from a more intense commitment to evidence-based medicine in several of our postgraduate programs, McMaster University seems similar to other Canadian postgraduate training institutions, and our focus on psychosocial issues is at least as prominent. Since our results are consistent with those from other reports in the literature, it is unlikely that these experiences would differ dramatically from those in other institutions. Nevertheless, the inferences from our study would be stronger if similar surveys were conducted elsewhere. Research into the experiences of nurses and patients would also add to the body of knowledge in this area.

One of the most striking findings of our survey was how frequently the respondents felt that residents were being treated differently on the basis of gender. Over 70% of the female respondents and over 60% of the male respondents felt that residents were sometimes, often, very often or always treated differently by supervising physicians. The corresponding figures for different treatment by nurses (over 90% and 75% respectively) and patients (over 85% and 75% respectively) are even more remarkable. It would be worth while to explore the nature of this perception of different treatment further.

Issues of psychological abuse, discrimination and sexual harassment now draw more societal attention than in the past. Several approaches are necessary to address and better understand these behaviours (Table 6). They may include program initiatives for educating house staff on these issues, helping them deal with their stress,[27–30] creating broader discussion in multidisciplinary forums, incorporating humanist attributes into house-staff evaluations, attending evaluations and program accreditation, and conducting additional participatory research. Adoption of contemporary, inclusive language in the workplace may also be helpful, given the way that language both shapes and reflects society's attitudes and beliefs. Labelling and addressing abuse and discrimination in residency programs starts with documenting existing problems and their impact. Other potential solutions include establishing support groups for residents, appointing a program ombudsperson, offering confidential counselling, establishing a well advertised sexual harassment office and issuing corporate policies on human rights[31] and sexual harassment.[32] Complementary strategies to sensitize health care professionals to attitudes and behaviours that may be considered abusive, discriminatory or harassing may prevent the perpetuation of these attitudes and behaviours in future generations.[33]

Table 6: Suggested initatives for improving the climate of residency training programs

Educational initiatives
• Include issues of abuse, discrimination and harassment in formal and informal curricula
• Raise consciousness of these issues through participatory research
• Incorporate humanist qualities in house-staff and supervisor evaluations
Behavioural initiatives
• Promote contemporary, inclusive language
• Label and address sexist teaching materials, sexist jokes, etc.
• Label and address discriminatory and abusive events
• Issue corporate policies concerning sexual harassment and human rights
Structural initiatives
• Appoint a residency-program ombudsperson
• Offer accessible, confidential counselling
• Encourage support groups for residents
• Establish and promote an institutional office to deal with problems of sexual harassment
• Establish and promote an institutional office dedicated to women's health

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Appendix 1: Directors of the McMaster University residency training programs and people involved in conducting the study

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