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# **‘Am I being over-sensitive?’ Women’s experience of sexual harassment during medical training**

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**ABSTRACT** Despite larger numbers of women in medicine and strong statements against gender discrimination in written policies and the medical literature, sexual harassment persists in medical training. This study examines the everyday lives of women and men resident physicians to understand the context within which harassment unfolds. The narratives explored here reveal how attention is deflected from the problem of sexual harassment through a focus on women’s ‘sensitivity’. Women resist by refusing to name sexual harassment as problematic, and by defining sexual harassment as ‘small stuff’ in the context of a rigorous training program. Ultimately, both tactics of resistance fail. Closer examination of the relations shaping everyday actions is key, as is viewing the rigid hierarchy of authority and power in medical training through a gender lens. I conclude with a discussion of how reforms in medical education must tend to the gendered, everyday realities of women and men in training.

**KEYWORDS** *gender; hostile environment; medical training; physicians; sexual harassment*

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The focus of this article is how women medical students and residents experience harassment in the context of a training environment often

characterized as abusive.<sup>1</sup> Sexual harassment (both *quid pro quo* and hostile environment) has been prohibited since 1980 (EEOC, 1980), but continues to persist.<sup>2</sup> Women in male-dominated occupations are especially at risk (Gruber, 1997). In the past three decades, the courts have worked to refine the law. Most workplaces have instituted a variety of policies and practices aimed at reducing or eliminating harassment; medicine is no exception. However, as Quinn asserts, the connection between law, policies and everyday practice is 'contradictory and incomplete' (2000: 1182). Understanding the persistence of sexual harassment requires understanding the everyday realities of the harassed.

Rising from 5 percent of medical students in 1960 (Martin et al., 1988) to 46 percent by 2001–2 (*JAMA*, 2002), women are relatively recent entrants into the occupation of physician.<sup>3</sup> Hence, researchers have only recently begun systematic examination of women physicians' experience with sexual harassment (Grant, 1988; Baldwin et al., 1991; Cotton, 1992; Komaromy et al., 1993; Eckenfels et al., 1997; Frank et al., 1998). Until the last decade, studies quantifying the sexual harassment of physicians were scarce; most had small samples and/or low response rates. Many studies on harassment have been conducted by researchers and medical administrators within the medical arena. A review of these studies reveals, first and foremost, that harassment is relatively common, ranging from 25 percent to 70 percent of physicians or physicians in training reporting harassment (Sheehan et al., 1990; Lenhart et al., 1991; Komaromy et al., 1993; Lillemoe et al., 1994; Eckenfels et al., 1997). The rates of harassment are consistent with general workplace studies of harassment (Hinze, In Press) and the gap in prevalence (45 percent here) is due largely to variation in methodology.

Results from the largest, most representative and detailed survey on sexual harassment and gender-based harassment among physicians ( $N = 4501$ ; 59 percent response rate) indicate fairly high levels of harassment (Frank et al., 1998). Overall, 47 percent of women physicians (aged 30 to 70) reported ever experiencing gender-based harassment (defined as harassment related to being female in a traditionally male environment) while 37 percent reported experiencing sexual harassment (defined as harassment having a sexual or physical component). Significant for the present study, women physicians reported harassment as more common during training (i.e. medical school, residency or fellowship) than during the post-training period. This suggests close examination of the training environment is crucial.<sup>4</sup>

Quantitative studies of women physicians reveal that despite larger numbers of women in medicine and strong statements against harassment and gender discrimination in written policies and the medical literature (e.g. Shrier, 1990; Cotton, 1992), harassment rates remain fairly high. What is missing in most previous research is an understanding of the everyday lives of women and men in medical training. Estimates of prevalence do not reveal much about the context within which harassment unfolds.<sup>5</sup>

Increasingly, scholars recognize that a process-oriented understanding of harassment is important (Quinn, 2002). This study seeks to capture the production of knowledge, identities and meaning at the site of the everyday, in order to understand why harassment persists in medical training.

According to Dorothy Smith, we must rely on 'what people tell us, about what they do and what happens' (1987: 110) in order to understand the everyday worlds they occupy. For the purposes of this study, the language of the participants is important for understanding the world inside medical training. However, Smith contends also:

We cannot rely upon them for an understanding of *the relations that shape and determine the everyday*. Here then is our business as social scientists for *the investigation of these relations*, and the exploration of the ways they are present in the everyday are and must be a specialized enterprise, a work, the work of a social scientist. (1987: 110, emphasis added)

In this article, I argue that 'the relations that shape and determine the everyday', in this case, are structured around a rigid hierarchy of authority and power. Physicians in training learn to normalize their experiences of mistreatment and abuse, to see it as 'routine' and even a necessary right of passage for a prestigious and demanding occupation.<sup>6</sup> Right or wrong, it is clear that the hierarchy of authority and power in medicine is gendered. To quote Riska: 'Medicine is not a gender neutral enterprise but characterized by gendered processes and social practices' (2001: 31). As the narrative suggests, hostile environment harassment is just one type of abuse women residents feel they must 'put up with' if they want to succeed. After describing the research process and providing descriptive statistics on the experience of harassment, I explore two interconnected themes: (1) the pressure on women to manage 'sensitivity'; and (2) tactics of resistance used by women to deal with hostile environment harassment. The article concludes with a discussion of the hierarchical nature of medical training and the value of using a gender lens to understand women's reactions within the medical hierarchy.

## **The research process**

The research study reported here was not designed to examine women's experience of sexual harassment. Rather, I conducted a study of factors related to medical specialty choice (see Hinze, 1995) and questions on sexual harassment were included in this study because of evidence that hostile environments might discourage women from certain specialties. After briefly describing the original research project with the full sample of 405 women and men physicians, I provide an overview of Phase I of the research (telephone interviews with the 99 women resident physicians) and Phase II of the research (follow-up face-to-face interviews with 18 of the women and men from the full sample). The 18 participants were asked to

reflect upon their medical specialty choices and experiences during medical training. Again and again, the resident physicians I interviewed returned to the subject of harassment. In particular, residents focused on how 'sensitive' women were to harassment and on strategies 'to deal' with it. In order to understand the everyday realities of the harassed, the primary focus of this article is on the narrative (Phase II) supplied by the study participants.

### ***Full sample of women and men physicians***

The data were collected at a major medical research institution during the spring of 1992 (Hinze, 1995). Participants in the original study were in their residency training program at Southern University and came from 116 different medical schools. Most (70%) had attended medical schools in the US South. In the first phase of the research, telephone interviews (averaging 25–35 minutes) were successfully conducted with 405 resident physicians, both women and men (response rate = 84%). The original telephone survey had a total of 74 closed-ended questions and 36 open-ended questions. For more information on the study of medical specialty choice and a full sample description, see Hinze (1995).

***Phase I: women only*** In the telephone survey, *only women* were asked a series of questions concerning their experiences with sexual harassment. Although there is evidence that men are harassed in medical training (by both men and women), the reported incidence was too low to warrant such sensitive questions for male respondents. Furthermore, because the focus of the survey was on reasons for specialty choice, and because the literature did not suggest that sexual harassment might influence men's choices, I chose to eliminate these questions for male respondents.

Approximately 23 percent of all residents at Southern University were women, and 24 percent of my respondents ( $N = 99$ ) were women.<sup>7</sup> For this analysis, responses from the 99 female residents to approximately 15 closed-ended items and two open-ended items are used as *backdrop for the narrative*.

Twenty-two percent of the 99 women interviewed are located in pediatrics, 20 percent are in internal medicine and 12 percent are in residency training in psychiatry. Nine percent of the women are located in surgery, 9 percent in obstetrics and gynecology, 7 percent in anesthesiology, 6 percent in dermatology, 5 percent in neurology, 4 percent in pathology and 4 percent in ophthalmology (one respondent marked the other category). (This particular program did not offer a family practice residency during the time of this study.) Approximately 88 percent of the residents are of various European American ethnicities; only 2 percent report being African-American. Eighty-six percent graduated in the top half of their medical school classes and participants have a mean debt of slightly over \$30,000. Nineteen percent of the women grew up in physician families and most have highly educated parents. Mean age of the respondents is 31 years,

51 percent are married and 21 percent have one or more children. In general, compared with women residents nationwide, this sample has fewer surgeons (about 15 percent of general surgery residents nationwide are female) and no family practice residents (about 36 percent of family practice residents nationwide are female). The sample is also more homogeneous in terms of reported 'race' and ethnicity. Finally, the sample of residents is slightly younger than residents nationwide (Hinze, 1995).

In the telephone interview, women were asked five separate questions about their experience of sexual harassment as medical students. Since reliance on single-item measures of harassment is flawed, I followed MacKinnon (1979) and the 1980 Equal Employment Opportunity Commission guidelines to measure 'hostile environment' harassment, which includes uninvited sexual advances, derogatory comments (either overtly or subtly sexual in nature), jokes about women and displays of pornographic materials in working areas.<sup>8</sup> Hostile environment refers to a type of sexual harassment that makes the workplace intimidating, hostile or offensive (EEOC, 1980). Hostile environment harassment is much more common than *quid pro quo* sexual harassment ('this for that'; submission to such advances or favors is either explicitly or implicitly used as a term or condition of employment). Although *quid pro quo* was certainly a possibility, pilot testing and conversations with resident physicians convinced me that a hostile environment was key to specialty choice decisions, an important consideration given that specialty choice was the major focus of the original study. Consequently, I based my questions on the hostile environment principle, but deliberately avoided using the terms sexual harassment or gender discrimination primarily because, as the narrative makes clear and as I sensed during the pilot study period, women were invested in avoiding or downplaying issues related to gender.<sup>9</sup>

Table 1 provides details on exact question wording for the sexual harassment items, and percentages of women who experienced each type of treatment. At a purely descriptive level, I find fairly high levels of harassment, which is consistent with findings from other studies, noted earlier. Also consistent with other studies, levels of harassment vary by type. Note that most women have experienced the less personal forms of sexual harassment, while fewer have experienced the more personal forms. For example, 83 percent of women regularly heard jokes about women told in their presence (a less personal form of hostile environment sexual harassment) while 22 percent experienced unwanted sexual advances (a more personal form of sexual harassment). Overall, 96 percent of the women surveyed reported at least one form of 'hostile environment' harassment during medical school.

Turning to Table 2, note that the modal category for the experience scale is three types of sexual harassment. Approximately 59 percent of respondents reported experiencing three or more types of harassment.

In addition, also from Table 1, note that 74 percent of those who

**Table 1** Descriptive statistics for experience of and discomfort with sexist treatment variables

Item	Experience		Discomfort	
	Percent Yes (N = 99)	Number (N = 99)	Percent Yes	Number
As a medical student, do you recall experiencing:				
1. any uninvited <i>sexual advances</i> ?	22%	(22)		
[IF YES] Did this make you feel uncomfortable?			82%	(18 of 22)
2. how about <i>overt sexual comments</i> ?	62%	(61)		
[IF YES] Did this make you feel uncomfortable?			71%	(43 of 61)
3. any <i>subtle sexual comments</i> ?	71%	(70)		
[IF YES] Did this make you feel uncomfortable?			64%	(45 of 70)
4. did you see <i>magazines</i> like Playboy, <i>pin-up posters</i> or the like in working areas?	36%	(36)		
[IF YES] Did this make you feel uncomfortable?			44%	(16 of 36)
5. did you ever hear <i>jokes about women</i> told in your presence?	83%	(82)		
[IF YES] Did this make you feel uncomfortable?			56%	(46 of 82)
	<i>Percent Yes</i>	<i>Number</i>		
[IF YES TO ANY OF ABOVE] Were people in certain services more likely to exhibit this kind of behavior than people in other services?	84%	(76)		
[IF YES] Which service or services? <sup>a</sup>				
1. surgery	74%			
2. ob/gyn	14%			
3. internal medicine	3%			
4. anesthesiology	2%			
5. radiology	1%			
6. other	6%			

<sup>a</sup> This was an open-ended question, not a forced choice question. Interviewers coded as many responses as respondents wanted to give; figures include all specialties mentioned.

experienced sexual harassment identified surgical services as the place where sexual harassment was most likely to occur.<sup>10</sup> Obstetrics and gynecology was second on the list, identified by 14 percent of respondents. In summary, most women experienced some form of sexual harassment during medical training and most women report surgical services as the most common site for sexual harassment.

In the past, researchers have found that women who report experiencing behaviors that fit the formal definition of harassment often do not view their experiences as problematic (Lafontaine and Tredeau, 1986; Grieco, 1987). Thus, in addition to asking whether a study participant experienced a given behavior, I asked women whether the behavior caused them

**Table 2** Experience of and discomfort with sexist treatment scales (N = 99)

	Value	Frequency	Percent
<i>Experience scale</i>			
no experiences	0	4	4.2
1 type	1	12	12.5
2 types	2	23	24.0
3 types	3	31	32.3
4 types	4	20	20.8
5 types	5	6	6.3
	.	3	Missing
<i>Discomfort scale</i>			
Experienced treatment but no discomfort	0	27	28.4
Experienced treatment and discomfort	1	68	71.6
	.	4	Missing

discomfort.<sup>11</sup> Specifically, women who responded yes to any of the five questions listed in Table 1 were asked a follow-up question: Did this make you feel uncomfortable? Responses to these questions are shown in Table 1 in gray scale. In terms of discomfort, Table 1 reveals that a high percentage of women who experienced the most personal forms of harassment reported being uncomfortable while a lower percentage of women who experienced less personal forms of harassment reported being uncomfortable. For example, 82 percent of those who experienced unwanted sexual advances were uncomfortable compared with 56 percent of those who heard jokes told about women. Perhaps this is not surprising, since less personal forms of harassment are easier to ignore or overlook than more personal forms. But why are women so divided on the discomfort question? About half of women who heard presumably sexist jokes reported discomfort, and about half did not. And while 71 percent of women were uncomfortable with 'overt sexual comments', about 30 percent were not. The narratives from Phase II of this research process may help us understand more about why women acknowledge behaviors that fit the category of sexual harassment, but do not report 'discomfort' with the behaviors. Perhaps, in the words of one respondent, 'you can't sweat the small stuff' when going through an intense training program in which general mistreatment is not an uncommon experience. Perhaps acknowledging 'discomfort' with hostile environment sexual harassment would make one seem 'too sensitive' and thus not tough enough to occupy the (formerly male) role of physician.

### **Phase II**

The narratives emerged during open-ended one and one-half to two and one-half hour face-to-face interviews with a small sample (N = 18) of female and male respondents who also participated in the telephone survey. To be

selected as subjects for the open-ended interviews, respondents: (1) gave their permission to be recontacted (76 percent of the 405 persons interviewed volunteered); and (2) were representative by sex and specialty. The subjects were not randomly selected, but were selected through a rating system established during the quantitative study. Interviewers were asked to rate every interview based upon interest of the interviewee and level of engagement (not based upon particular answers given or opinions offered). My goal was to secure reflective informants. Unengaged respondents (those who dutifully answered questions in the telephone survey, but rarely offered additional remarks or insights or seemed bored during the process) would likely not have offered deep insights. Hence, those with the highest engagement rankings were stratified by sex and specialty and 20 were recontacted. Face-to-face interviews were successfully completed with 18 participants (two interviews fell victim to scheduling problems).

In this second phase of research women and men resident physicians were asked open-ended questions designed to elicit reflections on their medical specialty choices. Those interviewed determined the time and place for interviews. Some occurred in a private office convenient to the residents; others occurred in their homes after hours or in their call rooms during their nights 'on'. One interview took place in a café, and another took place in a quiet, private hospital space convenient for a resident waiting to assist a delivery. All interviews were taped with the written consent of participants. However, technical problems resulted in successful transcriptions for only 12 participants; hence, the narrative analysis that follows is built upon only completed transcriptions. Seven of the transcribed interviews were with women from the following specialties: obstetrics and gynecology, surgery, psychiatry, anesthesiology, pediatrics and dermatology and five were with men from the following specialties: surgery, obstetrics and gynecology, radiology, internal medicine and pathology. Because medical training varies greatly by specialty, it is important to have a range of specialties represented. However, since all residents rotate through several specialties during their training, the experiences reported below may not have occurred in their specialty area.

Field notes were produced immediately after the interviews. After transcription, I manually coded the transcripts with a focus on factors related to specialty choice. Since all respondents were not specifically asked about their experiences of sexual harassment, observations on sexual harassment and women's 'sensitivity' were often spontaneous and occurred during different points of the interview. Careful textual analysis of the narratives revealed two distinct patterns or themes around the issue of sexual harassment. First, participants in Phase II of the research (both women and men) repeatedly brought up the issue of women's 'sensitivity' to hostile environment sexual harassment. Second, participants also spoke at length about tactics used by women (or tactics women should use) to resist sexual harassment.

In the narrative excerpts that follow, names have been changed and significant identifying features altered to protect the identities of participants. In the discussion section that follows a closer examination of women's sensitivity and tactics of resistance, I argue that any kind of sensitivity is viewed as weak in a training environment emphasizing toughness. Consequently, women who experience sexual harassment learn, as the title of this article implies, not to be 'over-sensitive'. However, as Quinn (2000) asserts, the most common tactic of resistance (not being 'too sensitive') ultimately serves to reproduce women's disempowerment and deflects attention from the problem of sexual harassment.

## **Stories of sensitivity and resistance**

The narrative analysis underscores what much prior work in medicine has already shown: that medicine remains a gendered world with a climate often hostile to women (Lorber, 1997; Conley, 1998; Riska, 2001). The data presented here reveal a range of ways that resident physicians make sense of this hostile environment, and provide valuable insights for use in future research.

### ***Sensitivity exposed***

The theme of women's 'sensitivity' permeated interviews with both women and men resident physicians, whether or not they characterized behaviors as harassment. For many study participants, the focus of their stories of sexist treatment and sexual harassment was less on the incidents themselves and more on women's reactions to the incidents. Even in cases where behaviors are consistent with legal definitions of sexual or gender-based harassment, residents wondered if they were too sensitive. Consider the following. A resident rotating through surgery early in her training was repeatedly 'patted on the butt' by an anesthesiology attending physician. She described standing near the sink with her freshly scrubbed hands held high and, as she said:

You are kind of vulnerable . . . and you can't really do anything . . . and he patted me on the butt . . . and that, the first time I thought, maybe he was just slipping a hand, or that, *maybe I was just being too sensitive*, but then it just like went on and it went on and it went on like several times and I really felt uncomfortable and I didn't know what I should do, what should I say? I didn't know what to do because like if I like say something, they're going to go, 'whoa, she's a real bitch, she's sure uptight, she's sure sensitive . . .'. (emphasis added)

Notice that this resident initially gave the offender the benefit of the doubt ('maybe he was just slipping a hand') and blamed herself ('maybe I was just being too sensitive'). It was not until the behavior 'went on and it went on like several times' that discomfort registered and then an action was taken. In the next section, I discuss tactics of resistance used by women to manage sexist treatment and sexual harassment.

During the course of face-to-face interviews, several women expressed extreme ambivalence about their reactions to the incidents they described, reporting discomfort or anger but also worry that they were being overly sensitive. The following description of an incident was offered by a woman resident:

... somebody said something to me. I want to hear how you would react to it. Do you see ... this little black shirt underneath my scrubs? ... I walked into ... the recovery room and one of the anesthesiologist attendings was there ... And I walk in and he goes, 'What's that sexy thing you're wearing underneath your shirt?' ... my reaction was that I thought that was inappropriate and a sexist comment. And he was just like, 'Oh, come on ... I meant it as a compliment. That was a compliment ... Lighten up.' But do you think that was sexist, what he said? Would that have bothered you? God, it just offended the hell out of me and I don't know if I'm wrong. Am I being over-sensitive?

In this example, the study participant identified the offending comment as 'inappropriate' and 'sexist' but then second-guessed herself after the offender claimed to be complimenting her. This study participant is also trying to decide whether she should be 'bothered' by the exchange. She worries she is 'wrong' and asks the interviewer (me) if she is being too sensitive. The findings here are consistent with work by Hanrahan (1997) on nurses. Women in Hanrahan's study doubted their own perceptions and wondered if they 'overreacted', a word that emerged in 90 of 129 incidents.

In another case, a woman resident asked a fellow man resident whether he noticed how 'hard' the attending physician seemed to be on her. The male resident described the situation, which unfolded during his third year of medical training.

There was myself, another young, white male and a female during the rotation. And my attending could never get the girl's name right. It's like he always got our names right, and she's the only girl. And the guy and I actually sort of looked alike. I mean, you possibly could've mistaken us for one another, sort of the same features. And she was sort of dark and short, just different, and a female on top of that! You'd think that'd be the one name he could remember ... I mean, how hard is Ann? He called her Mary and Amy – you know, he seemed to give her a particularly hard time as well. He gave all of us a hard time, sort of, but to her, he was really grueling.

This resident noted the importance of validating 'Ann's' experience of sexism, so she could not be accused of being too sensitive. In his view, his observation of the sexism was reassuring for 'Ann'.

In a couple of interviews, men who observed incidents of harassment passed judgment on whether women's 'sensitivity' was justified. One man gave an example of an incident that *should* provoke outrage. He tells of an attending physician giving a lecture on breast disease '... and he told one of the female residents, "you know, you are Oriental, you have such small breasts that we'd never find the disease" ... totally inappropriate'.<sup>12</sup> In this

case, a woman is justified for being 'sensitive'. However, in another example he thinks some women over-react to what he perceives as innocent banter:

There is one surgeon at Southern Hospital who is excellent . . . he's one of the best teachers in any of the hospitals and he'll call female medical students, little girl, 'Hey little girl, what is this? What is that?' And I think that offends a number of medical students, the female medical students. Umm . . . but he calls me son, what is the difference between son and little girl? . . . But it's interpreted as being offensive and I . . . disagree with that, I really do . . . maybe I just . . . cannot appreciate what a female goes through in medical training . . . because I'm a man, but it seems to me that there's all these little, the nerve endings are absolutely naked and they are hypersensitive to any kind of assault upon gender . . . and maybe they are too sensitive to it.

His choice of words deserves further comment. He recognizes the 'assault' but focuses more on the 'hyper' sensitivity of women. He also questions the interpretation of women medical students: 'I disagree with that, I really do' and equates 'son' with 'little girl'. Given the equivalence of those terms for him, he believes the reactions of women medical students are invalid. In another case, a woman resident explains why the term 'little girl' seems offensive to her. As a medical student, she served on a faculty committee. While attending one of their meetings, she was sitting on a couch shivering from the cold and a male faculty member walked up and said, 'Oh, I wish I could just take you on my lap like I would my little girl, and hold you tight and warm you up'. The resident asked the interviewer (me), 'What the hell was he doing saying that to me?' She continued:

I mean, that bothered me so much. I mean, he wouldn't have turned if there'd been a guy sitting next to him, chilling and shaking . . . that was inappropriate. I'm not his little girl. Some people, 'Oh, you just reminded him of his daughter, that's OK'. I'm not here to remind him of his daughter. I've gotten this far in life and I remind him of his little daughter?

Several *women* suggested that some women were too sensitive and did not know how to 'take' what they interpreted as joking. A dermatologist claimed:

But I think a lot of women don't know how to handle – kind of jerk around and be one of the boys. I mean, I don't know that I'm all that good at it, but I'm better at it than a lot of other women that I know.

In her view, women need to 'be one of the boys' and she was 'good' at it but other women were not. The message seems to be that women are expected to adjust to the (male) gendered hierarchy. In a similar vein, a woman obstetrician/gynecologist argued that you have to know how to 'take' it. She said,

But anyway, when we would be rounding [making medical rounds] – I mean, it would be more out of fun. I think it's the way you take it. If you were very offended by the sort of remarks – like, they'd get off on it . . .

In sum, fears of being perceived as 'too sensitive' kept some women from viewing sexist behaviors as problematic. However, the last two quotations suggest that one strategy for reducing the sexist comments or harassment is to ignore them altogether, which brings us to tactics of resistance. Given the focus on sensitivity, one choice for women was to refuse to be 'too sensitive' or, in Quinn's words, to refuse to 'take it personal' (2000: 1168).

### ***Tactics of resistance***

When asked how they handled incidents of sexism and harassment, women in my study said the best strategy was to ignore the incidents, a finding consistent with Gruber's (1989) and Quinn's (2000) work on sexual harassment.<sup>13</sup> Findings from a meta-analysis suggest that most women deal with harassment by dismissing it or downplaying it; the least common tactic of resistance is direct confrontation (Gruber, 1989). Several women I interviewed expressed fear of being labeled 'a bitch' if they confronted harassers or reported the behavior to authorities; other women, like those quoted above, feared drawing attention to the inappropriate comments and remarks would allow men to 'get off on it' and perhaps encourage more inappropriate comments or behavior. From other research, we know that active resistance can have potentially severe consequences, such as physical injury, loss of job or poor performance reviews (Heming, 1985). Hence, women's reactions make sense in the face of inadequate policies and in the absence of strong institutional norms discouraging harassment.<sup>14</sup>

***Refusing to name*** Before participants can resist, they must name the behaviors as discomfiting. Many chose not to. In previous analyses of the Phase I survey research of 99 women (data not shown), I found that women who identified as politically conservative were less likely to report discomfort with harassing behaviors than were women who identified as politically liberal. Narrative excerpts from two women illustrate this pattern. First, a self-described conservative woman resident remarked,

There's this whole victimization thing that people are into these days. 'I can't do this because I'm a victim of this, that or the other.' And I think that is crap. I mean, if something happens to you, you have to be able to walk away from it and go ahead and do what you want to do.

This study participant firmly resists the label of victim. In her view, acknowledging discomfort with harassing behaviors suggests victimhood. She, along with others interviewed, is determined to see herself in a more positive light, as a survivor. The same resident relates the story of a surgery program where every woman was dropped by their third year (surgical residencies are at least five years long), including one who had scored the best on an in-service exam. She comments,

... it's absolutely idiotic to say that would keep me from going into surgery. I mean, all I have to do is find another program where they don't do that ... I

have found generally that I have been able to do whatever I want. And I think that's the sort of thing that women have a tendency not to realize, is that we can do anything we want.

In her interpretation, women who were dropped from their surgery programs should just find another program and not see themselves as victims. In this case, the resident recognizes the behaviors as inappropriate, but takes credit for not letting the behaviors hold her back. Furthermore, note that in her interpretation, women become the problem for not realizing they can do anything they want. Men who unfairly drop women from the program are exempt from criticism. The same woman notes that: 'if you look kinda blonde and stupid, you can sort of say whatever you want'. In what she acknowledges is an ironic twist, her traditionally feminine looks prove empowering.<sup>15</sup>

In the second example, a self-described liberal woman was offended at the degree to which her colleagues took sexual and sexist comments in their stride. After having attended medical school in another part of the country, she conducted her residency at the institution I studied. She said,

But it's just the stupid comments that people make and sexism is just looked at as being okay, or funny, or silly . . . And like the people that I worked with in internal medicine that were really, incredibly, sometimes almost objectionably sexist, you know, everyone was like, 'Oh yeah. That person. He's really sexist.' And they would treat it like, you know, 'Oh, isn't he silly. Isn't he funny,' you know? Whereas I would be like, I'm offended . . . isn't anyone else offended?

Philosopher Iris Young (1988) argues that the language of individualism dominates political discourse and keeps Americans from recognizing or acknowledging the existence of 'oppression'. From social science research (e.g. see Kluegel and Smith, 1986; Lee et al., 1990), we know that self-described conservatives are less likely than liberals to view social class, race or gender as important elements of social structure that impinge upon individual life chances. Hence, it makes sense that the conservative women report less discomfort with sexual harassment.<sup>16</sup> But in general, the women physicians interviewed here also refuse the mantle of victimhood. Carter and Kirkup (1990) offer some insight into why some women refuse to 'admit' sexual harassment. They are surprised to find that the women engineers they studied 'repeatedly denied any suggestion that . . . their lives are made more difficult by daily doses of sexism' and speculate that '[t]o admit the occurrences of harassment to themselves and to others is to admit that some colleagues do not recognize their professional status' (1990: 96). According to Bumiller (1988), there may be other processes at work that hinder claims of sexual harassment or discrimination. Namely, society views victims in a negative light – as powerless outsiders or potential zealots – and imposes burdensome legal barriers for those claiming a civil rights violation. Hence, individuals find it easier to ignore harassment and discrimination, or blame themselves for the 'problem'.

**Not sweating the small stuff** Several women insisted that harassment and discrimination were just part of what one must go through to make it in medicine; hence, they did not feel ‘uncomfortable’ with it. Also, because women learned to ‘put up’ with harassing behaviors, they did not report them to the authorities. Despite hearing several stories of sexual harassment, I found that not one respondent who told a story filed a report with authorities. The following quotation from a woman resident reveals how her initial reaction to inappropriate sexual banter (‘kind of embarrassed and kind of surprised’) gave way to humor (‘I just thought it was mildly humorous’):

But especially in one of my surgical rotations as a third year medical student, most of the surgery residents were urologists and I think they’re probably the most sexist and worst about – you know, just making jokes about everyone’s private parts but men’s in particular. And so, I mean, I can remember so well – we would go on rounds and we would – whenever we’d see a new patient, somehow they, like, always got down to how big their penis was; theirs was versus the patient’s . . . Then they would all – since I was the only woman in there, they’d be, like, ‘Well, you’re the only real judge, so what do you think?’ . . . At first I was kind of embarrassed and kind of surprised . . . It was a six-week rotation and this happened daily . . . *I just didn’t say anything*. It didn’t make them stop . . . probably by the end, I mean, I just thought it was mildly humorous just ‘cause they were such stupid guys. (emphasis added)

This woman’s tactic of resistance is to ignore the sexist comments. By the end of her rotation, she may have even been laughing along with ‘the guys’.

One woman, who reported experiencing several types of hostile environment sexual harassment remarked: ‘I’m in surgery; I can’t sweat the small stuff.’ The following story illustrates a more severe form of sexual harassment and one woman’s reaction to it; the experience occurs in surgery, which most women identified as the site where sexual harassment was most likely to occur. A surgical sub-specialist was called to the men’s bathroom by a female secretary in her department. The two women entered a men’s room so the secretary (whom a male restroom patron had confided in) could show the resident a picture drawn on the wall. The resident says:

there was this picture drawn [resident draws picture for interviewer] of this like female body with boobs . . . like bent over and then this male body standing behind with this penis, you know, either butt fucking or regular fucking, I don’t know, and on it was written my name . . . and then X [name omitted] written as the person, that’s my boss, that’s my mentor, that’s the person who teaches me and is good to me but it’s not a sexual kind of relationship at all . . . then, to top it off, there was another arrow and it had written that one of the X residents had wished it was him . . . But I thought, this just really sums up . . . my position in the department of X surgery, something I’ve worked for for a lot of years, not my whole life, but a lot of years, and they reduce all my hard work and all my sacrifice and my brains and my technical abilities and everything that I’ve done

to this, you know, like this is how they perceive, you know, me. [R becomes visibly upset, begins crying]

After regaining composure, the resident then says the picture is 'hostile' or 'violent' and argues it is a tactic used by insecure men to reduce her (and any woman in a position of power and authority) 'to nothing, to a plaything for men'. Her interpretation of the message is that her male peers believe powerful women only attain high status by engaging in sex with their bosses. The interviewer (myself) asked the resident whether or not she did anything about it and she said:

Ummm, I got the . . . cleaning ladies in there to get it off . . . it really irritated me a lot and then, I just thought, I might as well just get over it because it's there, it's gone, and you just have to know it may go back up at some point, and that's how men are, that's how men perceive things . . .

Although clearly angered, hurt and disturbed by the incident, the resident does not view the incident as serious enough to warrant action other than having the picture erased and working on her own attitude. Interestingly, this particular resident repeatedly stressed the importance of playing along with 'the boys' and not letting sexism bother you. Indeed, she argued several times during her interview that sexual harassment was just a part of what one goes through to become a surgeon and that it was not a serious impediment to her. Her reaction is consistent with Fine's (1987) research on women in male-dominated workplaces who accept male dominance and the harassment that goes with it in order to become 'one of the boys'.

**Direct confrontation** Although the face-to-face interviews were not designed to obtain information on how women responded to harassment, stories about women's sensitivity and sexism in medicine revealed a range of responses. Only one story contained direct confrontation. A woman related the following:

One time I was in the clinic and I had on a skirt that was a little a bit above the knee and he [an obstetrics and gynecology resident] just, like, reached out and swatted me on the butt. And I was, like, 'Excuse me?' And he was, 'Well, you didn't mind that' and I said, 'Yes, I did. Don't do that again.' And he didn't.

Later, the same woman says: 'I hope that eventually men change and I think they will eventually. But, if you blow up every little comment that somebody makes to you . . . you're too sensitive.' This woman speaks up only when the behavior seems egregious. Her strategy is to ignore 'little' offensive comments and only react to major incidents. Her preference was to minimize discomfort and, perhaps, deal with episodes of harassment on a one-by-one basis.

In sum, the narrative data described here offer a glimpse into a highly gendered world in which neither men nor women have a clear sense of

appropriate reactions to hostile environment sexual harassment. Goffman's (1963) work on stigma is useful for understanding the strategies that women employ to protect themselves from being devalued or 'stigmatized'. Specifically, denying and ignoring the harassment, escaping the situation or going along with it are all responses used by the stigmatized.<sup>17</sup> However, only 'sensitive' women risk stigmatization. To understand why women fear the potentially stigmatizing label of 'over-sensitive' requires a closer look at the culture of medical training and gendered organizational features of this culture.

## Discussion

Recall Dorothy Smith's (1987) assertion that our business as social scientists is to investigate the relations that shape and determine the everyday. The narratives explored here reveal an approach to sexual harassment among resident physicians that grants legitimacy to the perception that such behavior is benign or innocuous. This perception contributes to the maintenance of sexual harassment. Interviews with this small sample of women and men residents reveal glimpses into an everyday world in which women's sensitivity is often constructed as 'the problem'. In addition, the narratives reveal that because of this framing of 'the problem', women choose tactics of resistance that are minimal at best and ineffective at worst. Frances K. Conley, a prominent neurosurgeon who resigned from the Stanford Medical School faculty in June of 1991, chronicles her experiences with hostile environment sexual harassment in her book, *Walking out on the boys* (1998). Conley freely admits that her own actions contributed to a hostile environment for women, because it was easier to 'put up with it and shut up' (1998: 48). She writes: 'For years I had been an "enabler", choosing to ignore sexist insults because no harm was really intended, not realizing that to endure meant to condone' (1998: 136).

Echoing Smith, what set of relations shape and determine the reactions uncovered here? To answer that question requires an exploration and explication of the relations in which the everyday world of medical training are embedded.

For over four decades, medical sociologists have contributed to a vast literature on the socialization of medical students, interns and residents into the values and attitudes they must internalize to become successful physicians (Fox, 1957, 1989; Merton et al., 1957; Miller, 1970; Mumford, 1970; Becker et al., 1977; Light, 1979; Mizrahi, 1986; Hafferty and Franks, 1994; Hafferty, 2000). In recent years, medical educators and researchers from the health sciences have jumped into the fray, reporting on student experiences during medical training (Sheehan et al., 1990; Silver and Glickin, 1990; Baldwin et al., 1991; Eckenfels et al., 1997). One commonality bridging these literatures (see Hafferty, 2000 for an important review

of the differences) is the recognition that a tradition of hierarchy in clinical training can lead to desensitization or, in the words of some, abuse.

At the level of physician–patient interaction, physicians in training learn to depersonalize the patient (Anspach, 1988) and begin to express ‘detached concern’ (Fox, 1989). Conrad (1988) argues that the emphasis in training is overwhelmingly on instrumental rather than interactional patient care. He writes: ‘There is almost nothing in medical training that encourages compassion, empathy, and “care” for the patients; indeed there is a great deal that militates against those qualities’ (1988: 329). Students learn how to be ‘tough’ or develop ‘thick skins’. As Klass (1987), herself a physician, points out, the worst insult is to be seen as ‘weak’. All physicians in training, including women, strive to be ‘macho’ docs. Particularly salient for the present work, when Klass expresses reservations about operating on an anesthetized dog who will die as a result of the operation, her peers accuse her of being ‘too sensitive’ and question her ability to be a doctor. She writes:

*Some of the women in my class* are particularly vulnerable to this kind of reasoning; they worry that they aren’t tough enough, that they cannot afford to pass up any opportunity to prove, to themselves and to everyone else, that they have what it takes. (1987: 32, emphasis added)

Beyond physician–patient interaction, depersonalization and detached concern are evident in relations between physicians in training and their superiors. Light (1988) maintains that the deep-seated tradition of hierarchy in clinical training fosters an abusive environment in which those higher up on the ladder are expected to be arrogant to those on the lower rungs. Klass (1987) describes the rigid hierarchy of a large, teaching hospital where medical students train. The student or ‘scut-puppy’ is at the bottom of the hierarchy and abuse flows from the highest levels (attending to fellows to senior resident to junior resident to intern and finally to medical students) down. Within this hierarchy, medical students are ‘the lowest of the low’ (Stein, 1990: 201). According to Stein, an anthropologist, medical students often describe their training experience in terms of excremental symbolism. For example, they feel they are treated like ‘shit’, they are often asked to do ‘shit work’ and they learn who gets to ‘shit on’ whom. He quotes an intern as saying: ‘Internship is to learn to take all the abuse in the world. You learn to take forty tons of shit on you, so that later twenty tons of shit feels moderate’ (1990: 200). As Light notes, the ‘sheer pace of work and the quasi-military hierarchy are two frequently observed attributes of medical training that help make it a bruising experience’ (1988: 314).

Eckenfels et al. (1997) view the hierarchy of positions of authority and power as part of medical culture reproduced in the process of medical training. Drawing on Hafferty and Franks’ (1994) work on the hidden curriculum, Eckenfels et al. argue that physicians in training must find their place in a highly stratified system ‘by learning and internalizing the subtle

and not so subtle clues, commands, taboos and other cultural configurations of the hidden curriculum' (1997: 15). For Hafferty and Franks, this means that:

One of the functions of professional training, particularly as it relates to the internalization of feeling rules and the general process of emotional socialization, is to transform that which is startling, disquieting, and/or morally unsettling into something that is routine, acceptable or perhaps even preferred. (1994: 864)

Harassment or general mistreatment becomes a 'tool of medical socialization' that is 'transmitted intergenerationally as part of acquiring the professional identity' (Eckenfels et al., 1997: 15). The irony here, as Eckenfels et al. note, is that a 'boot camp' mentality is incongruent with the goal of training empathetic, compassionate physicians. Returning to Smith (1987), 'the relations that shape and determine the everyday', in this case, are structured around a rigid hierarchy of authority and power. Physicians in training learn to normalize their experiences of mistreatment and abuse, to see it as 'routine' and even a necessary rite of passage for a prestigious and demanding occupation. Perhaps one element missing in the observations of Hafferty and Franks (1994), Eckenfels et al. (1997) and others is the extent to which this hierarchy is gendered.

A voluminous literature exists on the shift in gender scholarship from seeing gender as an individual-level characteristic to one embedded in the structure of organizations (Kanter, 1977; Acker, 1990; Ferree et al., 1999), including those in science (Keller, 1992; Rosser, 2000) and medicine (Lorber, 1997; Hinze, 1999; Riska, 2001). Women in this rigid hierarchy of authority and power have traditionally been located at the bottom of the hierarchy (Lorber, 1997; Hinze, 1999; Riska, 2001). Despite the greater numerical representation of women, medicine is still a male or masculine arena, in which masculine culture is taken as universal. Here, the 'symbolic work of gender' (Keller, 1992: 17) unfolds during the course of training and travels along the fault lines that demarcate positions of power. Light's (1988) gendered metaphor, the 'quasi-military' hierarchy, proves important in two ways. First, it suggests a hierarchy of command, with those (whether male or female) at the bottom most subject to mistreatment or harassment. Second, the 'militaristic' image (documented elsewhere in some detail, see Cassell, 1998; Hinze, 1999) is a masculine one. The 'feminine', in such arenas, is out of place. Cassell (1998), in her work on women surgeons, cites Bourdieu:

The ultimate values, as they are called, are never anything other than the primary primitive dispositions of the body, 'visceral' tastes and distastes, in which the group's most vital interests are embedded . . . The sense of distinction . . . which demands that certain things be brought together and others kept apart . . . responds with visceral, murderous horror, absolute disgust, metaphysical fury, to everything which lies within Plato's 'hybrid zone,' everything which passes understanding, that is, the embodied taxonomy, which, by challenging the

principles of the incarnate social order, especially the socially constituted principles of the sexual division of labour and the division of sexual labour, violates the mental order, scandalously flouting common sense. (Bourdieu, 1984: 474–5)

While perhaps overly graphic for my purposes, Bourdieu's insight, combined with the insights from those writing about the culture of medical training and gendered organizational features of this culture, helps us understand women's everyday experience of harassment. At some level, women and men are conditioned to view mistreatment and harassment as 'routine'. But at another level, women are reminded, through sexist humor or inappropriate sexual behaviors, that their bodies are out of place. Women's bodies symbolize intrusion into male territory. They challenge the sexual division of labor. Hostile work environments are produced as a necessary part of masculine identity performance (Quinn, 2000, 2002) and women located within a hierarchical training program are taught or pressured to think this is a 'normal' part of medical socialization.<sup>18</sup> Hence, women learn to 'not take it personal' (Quinn, 2000) and work on not being 'too sensitive'. However, as Quinn asserts, the counter tactic to sexism and harassment of 'not taking it personal' serves to 'manipulate gendered identities through deflection' (by not drawing attention to distinction) but ultimately fails as a strategy of resistance (Quinn, 2000: 1176). By minimizing the mistreatment, male identity is bolstered and women's outgroup status is more strongly reinforced. Furthermore, not taking it personal interrupts the naming of sexual harassment, a consequence ensuring its continuance.

While the findings and interpretations presented here are consistent with other studies of sexual harassment (e.g. Frank et al., 1998; Quinn, 2000, 2002), they must be viewed with caution. First, generalizations beyond the everyday worlds exposed by the study participants interviewed here are necessarily limited<sup>19</sup> because: (1) the data were gathered from resident physicians in one institution in one region of the country (recall that 70 percent of the residents completed medical school in the South); (2) only 24 percent of the residents at Southern University were women (compared with 30 percent nationwide in 1992); and (3) the narrative analysis was built upon a small sub-sample of residents chosen because of their level of engagement in Phase I of the research process. It is possible that the experience of hostile environment sexual harassment and reactions to it differ for Southern residents (compared to those from the Northeast or West) and for participants in a medical training program where women are under-represented (compared to programs with higher percentages of women). Perhaps the most serious problem for generalizability is the small sample size and selection of 'highly engaged' residents for the face-to-face interviews.<sup>20</sup> The possibility for bias exists if we assume a larger sample or a sample of 'unengaged' residents would put forth a different view of the medical world than the world described by 'engaged' respondents. The only way to test such an assumption would be to randomize a larger

selection of residents for a qualitative study with questions about sexual harassment, and sensitivity in particular, at the forefront. Since sexual harassment was not the focus of the original, larger study on medical specialty choice, it was not possible to work to theoretical saturation. Recall that insights into harassment experiences emerged spontaneously at different points of the semi-structured face-to-face interview process. Perhaps a more directed qualitative study of hostile environment harassment with a larger, more randomly selected sample would unearth a wider range of responses.

## Conclusion

What is missing in previous research on the sexual harassment of women in medical training is an emphasis on the everyday lives of women and men. This study seeks to capture the production of knowledge, identities and meaning at the site of the everyday, in order to understand why harassment persists. Perhaps Paludi says it best: harassment results from ‘the confluence of authority (power) relations and sexuality (sexism) in a culture stratified by sex’ (1996: 5). Viewing the hierarchical system of medical training through a gender lens reveals a great deal. Men enact gender in formerly male-dominated territory by creating environments hostile to women. Recall that 96 percent of women surveyed here reported at least one form of hostile environment harassment during medical training. Also note that 74 percent of those who experienced sexual harassment identified surgical services – the most male-dominated specialties – as the place where sexual harassment is most likely to occur. Women learning to become physicians, especially in male-dominated specialties, have an additional burden of dealing with sexism and harassment. But the numbers collected during the quantitative phase of the interview process do not tell the whole story. The narratives reveal that some women and men together learn to downplay the incidents and view them as a ‘normal’ part of a bruising training experience. Women who admit discomfort with sexual harassment, women who name the problem and women who protest, fear being viewed as ‘weak’ in a masculine culture in which toughness is valued.

Quinn (2000) asks what the value of sexual harassment law is, given the ‘everyday tactics’ employed in the management of sexual harassment. Since many of the women and men in this study view women’s sensitivity as ‘the problem’ and minimize discomfort, the naming of harassment may be interrupted and the power of the law diluted. Research by Bumiller (1988) offers additional insights: those who experience discrimination are hesitant to appeal to the power of the law because of its potential to disrupt their daily lives. Establishing the burden of proof is burdensome, especially given the subtle nature of hostile environment harassment.<sup>21</sup>

Does this mean hostile environments in medical training are inevitable and will continue to be reproduced? I think not. Work from medical

sociologists on the culture of medical training, combined with the work of gender scholars, offers some solutions.

Medical sociologists and medical educators of late have been calling for reforms in medical education. At the heart of such reforms is moral education (Hundert et al., 1996) and the need to integrate ethical principles into the student's professional identity (Hafferty and Franks, 1994) with the ultimate goal of creating more sensitive, empathetic and compassionate physicians. Policy suggestions along these lines include: (1) offering more ambulatory care training to avoid the hierarchical hospital environment; (2) promoting voluntary community service programs focused on the moral development of student participants; and (3) an emphasis in training on social and cultural factors that influence the health of individual patients (Eckenfels et al., 1997).

While necessary steps in the right direction, the reforms suggested here do not alter the gendered power dynamics of medical training. Currently, all medical students and residents have to deal with the mistreatment that being the 'lowest of the low' incurs, but the gendered nature of the mistreatment reinforces women's status as women first and physicians second. Gender-neutral reforms aimed at reducing mistreatment will miss the mark.

Quinn's (2000) work marches us further down the path toward gendered reforms that need to be integrated with reforms aimed at moral education of medical students and residents. She suggests that we must do more than implement educational policies aimed at promoting gender sensitivity. In her own work, Quinn (2002) finds that anti-sexual harassment training programs neglect the extent to which some forms of sexually harassing behaviors 'are mechanisms through which gendered boundaries are patrolled and evoked and by which deeply held identities are established' (2002: 399). Hence, we must tend to *process*, which allows us to explore, uncover, examine and share the everyday lives of women and men in medical training. We must expose the lived actualities of women's lives.<sup>22</sup> Research grounded in the everyday makes visible the silent, symbolic world of gender and raises consciousness about the relations that shape and determine the everyday. If we take Quinn's assertions further, as sociologists we must do justice to the sociological imagination (Mills, 1963) by revealing how the private worlds of women and men in training are rooted in the larger, structural context of a gendered, hierarchical medical culture. Certainly sexual harassment is in the public consciousness, but as Quinn asserts, the connection between the law, policies and everyday practice is incomplete so long as we ignore the everyday realities of the harassed. Bringing those realities into public focus reveals a common set of experiences rooted in the structural. Reforms designed to take on the hierarchical structure of medical training must be grounded in the everyday, gendered realities of women and men in training. Perhaps only then can the question asked by one of the participants in this research shift from, 'Am I being too sensitive?' to, 'Am I being sensitive enough?'

## Notes

1. See Hafferty (2000) for a sociological counter to the 'abusive environment' characterization.
2. More recently, the EEOC specified harassment need not be sexual in nature, but can be 'harassment due to gender-based animus' (1993: 51267).
3. However, only 24 percent of all physicians were women in 2000 ([www.ama-assn.org](http://www.ama-assn.org) [2000]).
4. One survey of hospital human resource managers (Kinard et al., 1995) shows an increase in formal charges of sexual harassment (over 80 percent were 'hostile environment' allegations) between 1980 and 1994. However, most complaints were filed by nurses, followed by (in order) clerical/secretarial personnel, technicians, custodial workers, food service personnel and therapists. Physicians do not make the list as victims (although in 10 percent of cases, physicians were perpetrators).
5. See Giuffre and Williams (1994) on how the highly sexualized context of restaurant work interrupts the naming of sexual harassment.
6. Evidence suggests that the most prestigious specialties subject trainees to the toughest treatment (Hinze, 1999).
7. Thirty percent of all resident physicians in the USA in 1992 were women, so the Southern residency program has fewer women as a percentage than the national average. Currently 39.5 percent of residents nationwide are women (*JAMA*, 2002) and 32 percent of residents at Southern University are women (personal conversation, 10 February 2003).
8. Since the focus of the study was on specialty choice, the measurement of sexual or gender based harassment was not as rigorous as it would be for a study focused on harassment. See Gruber (1990) for criticisms of existing sexual harassment measures.
9. Other research suggests that prevalence is lower if one asks directly about sexual harassment, and higher if the concept is operationalized as particular behaviors (Gruber, 1990; Quinn, 2000).
10. All residents passed through a variety of rotations as medical students. Consequently, women in my survey who are pediatricians or psychiatrists spent some time as medical students on surgical rotations.
11. After beginning the survey, I noticed that some women were reluctant to admit that the treatment they had received made them uncomfortable and would rather have expressed anger and/or indignation at the sexist treatment. Unfortunately, my closed-ended response categories did not allow for this possibility, which would have been an important distinction. Following Lafontane and Tredeau (1986), perhaps feminist women would respond with anger or indignation while less feminist women would respond with vague discomfort. Another flaw in my survey design is the neglect of some kinds of sexist treatment. For example, the AMA pilot study (Sheehan et al., 1990) reports that women frequently felt ignored by male faculty and other residents.
12. It is unclear whether this resident recognized the racist tone of the comment.
13. In Schneider's study of workplace assaults, only 21 percent of those assaulted complained through appropriate workplace channels, a finding which highlights 'the process by which informal deviance defining occurs in everyday interactions at work' (1991: 533).
14. Thank you to Reviewer C for pointing out the potentially harmful

consequences of more active resistance. Certainly, news reports of reprimands for women cadets who reported rapes and assaults at the US Air Force Academy in Colorado Springs testifies to this reality.

15. In my ideal world, a wonderful follow-up question might have been: 'Does this mean that more "serious" looking women (especially the non-blonde) are not as free to speak their minds?'
16. It is notable that the men in our sample described themselves as conservative far more than did women (46 percent of men [ $N = 140$ ] vs. 25 percent of women [ $N = 24$ ] reported being conservative).
17. Sayce (1998) offers a critique of Goffman's work on stigma for users of mental health services. In short, she champions the term discrimination over the concept of stigma. The former has collective strategy implications while the latter may reinforce individual self-perception and individualistic strategies for change.
18. Women may be most vulnerable to abuse in the most male-dominated or macho specialties, like surgery, where toughness is key (Hinze, 1999) and women are constantly being tested for their suitability.
19. Smith (1987) contends that data gathered using feminist methodology cannot 'universalize' a particular set of experiences (much like the dominant approach in anthropology), and I make no claims about the universality of resident experiences in this article.
20. Recall that of the 405 residents interviewed by telephone for the quantitative portion of the study, a full 76 percent agreed to be recontacted for the face-to-face interviews. Those selected were representative by sex and specialty, and ranked 'highly engaged' by interviewers.
21. Bumiller argues that the 'paradox of a civil rights society' – the coexistence of an abiding faith in the law to resolve conflicts and the strong predisposition to avoid the intervention of law in our lives – 'operates in nonobvious ways to encourage people to accept unequal treatment they believe to be caused by their personal failures' (1988: 108).
22. Lee (2001) argues that we must tend to women's alternative interpretations of unwanted male sexual conduct. The term 'sexual harassment' does not always adequately describe women's experiences, and leads many women to reject the label, whereas a broader definition (e.g. sexism) might encourage women to name and hence challenge unwelcome experiences.

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