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Perpetrators of Gender-Based and Sexual Harassment in the Field of Orthopaedic Surgery

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Background: The prevalence of gender-based and sexual harassment in the field of orthopaedic surgery in Canada is high. Previous research in other jurisdictions has identified the most common perpetrators of harassment to be senior surgeons or directors. We aimed to identify the most frequent perpetrators of gender-based and sexual harassment in orthopaedic surgery in Canada.

Methods: We conducted a Canada-wide survey of all orthopaedic surgeons registered with the Canadian Orthopaedic Association and the Canadian Orthopaedic Residents’ Association. The development of our 116-item questionnaire was informed by a review of the literature and other published gender-based and sexual harassment surveys. Descriptive analyses, including frequency counts with associated 95% confidence intervals (CIs), are reported for all data.

Results: Of the 465 survey respondents, the median age was 43 years (interquartile range, 35 to 59) and respondents were most commonly male (72%), White (81%), married (77%), and staff orthopaedic surgeons (68%). Peers were identified as the most common perpetrators of gender-based harassment (55%, 95% CI, 50 to 59), and patients were identified as the most common perpetrators of sexual harassment (48%, 95% CI, 43 to 52). Women were more likely to report direct supervisors or patients as the perpetrators of gender-based and sexual harassment, and men reported peers as the most common perpetrators.

Conclusion: Orthopaedic surgery peers and patients are the most commonly reported perpetrators of gender-based and sexual harassment in Canada. The results of this study may be helpful to institutions in designing and focusing educational programs and/or policies and procedures to help reduce harassment incidents in the training and work environment.

Introduction

Although workplace harassment is illegal within Canada, it nevertheless persists and can have serious and significant consequences to both the individual experiencing harassment and the workplace as a whole. Previous research has demonstrated that both gender-based and sexual harassment are high...
within the field of orthopaedic surgery. Gender-based harassment occurs when a person experiences discrimination or unequal treatment based on their gender or gender identity. Sexual harassment is bullying or coercion of a sexual nature or the unwelcome or inappropriate promise of rewards in exchange for sexual favors. A survey distributed to members of the Canadian Orthopaedic Association (COA) revealed that 76% of the respondents reported at least 1 occurrence of gender-based harassment and 74% of the respondents reported at least 1 occurrence of sexual harassment. Similarly, a recent survey distributed to women and underrepresented minority members of the American Academy of Orthopaedic Surgeons (AAOS) reported that 79% of the members had been exposed to discrimination, 55% had been exposed to bullying, 47% had been exposed to sexual harassment, and 40% had been exposed to harassment.

Previous research has alluded to the possibility that harassment may be contributing to the enduring gender gap within this orthopaedic surgery. The Canadian Medical Association’s 2018 report on the number and percent distribution of physicians by specialty and sex revealed that orthopaedic surgery has one of the lowest proportions of female physicians in all specialties, at only 12%. Similarly, data from the American Medical Association in 2015 reported that women accounted for only 5% of orthopaedic surgeons in the United States. Therefore, further investigations into harassment behaviors and their impact on medical trainees’ choice of specialty are warranted.

It is important to understand who the perpetrators of harassment behaviors are to develop effective policies addressing harassment behaviors. A recent systematic review and meta-analysis conducted on discrimination, bullying, and harassment in surgery revealed that the most common perpetrators of harassment were consultant surgeons. Similarly, within the field of orthopaedic surgery, a survey conducted on women and underrepresented minority members of the AAOS revealed that attending orthopaedic surgeons were the most commonly cited perpetrators of harassment behaviors. However, the perpetrators of harassment behaviors in Canadian orthopaedic surgery have yet to be reported. The aim of this study was to determine who are the most frequent perpetrators of gender-based and sexual harassment in orthopaedic surgery in Canada.

Methods

In partnership with the COA, we conducted a Canada-wide cross-sectional survey of all active members of the COA. All levels of membership were included (trainees, practicing surgeons, and retirees). The protocol for this study was previously published as a preprint (https://osf.io/e5c6m/). The definitions of gender-based and sexual harassment used throughout the survey and the primary outcome of this survey quantifying the prevalence of gender-based and sexual harassment were previously published. This study was approved by the Hamilton Integrated Research Ethics Board (Project #4848).

Survey Development and Administration

Survey development has been previously published in detail. Briefly, we developed a unique 116-item cross-sectional survey to assess the prevalence of gender-based and sexual harassment within orthopaedic surgery and investigate details on these harassment behaviors, including who the perpetrator(s) was/were and when the behavior(s) occurred (Appendix). The survey was informed by a review of the literature and is an adaptation of preexisting questionnaires. The draft survey was reviewed by experts in health research methodology and pilot tested with surgeons from other specialties to ensure face and content validity.

The REDCap online survey tool was used in individually distributing the questionnaire through e-mail to all 1783 active members of the COA and the Canadian Orthopaedic Residents’ Association (CORA). Two reminder e-mails were distributed every 3 weeks after the initial invitation, with the survey closing 9 weeks after the initial invitation. Anonymity of the questionnaire responses was maintained in the REDCap platform, and completion of the questionnaire was voluntary. Consent was implied on submission of the questionnaire, and participants maintained the ability to skip questions.

Analysis

Individuals reporting gender-based or sexual harassment behavior were directed to additional branching questions on (1) the perpetrator(s) of the behavior, (2) timing of the behavior, and (3) how frequently the behavior occurred. Response options can be found in the survey (Appendix). Respondents had the ability to select more than 1 response for the perpetrator and timing questions.

The perpetrators of specific gender-based harassment behaviors were assessed in 6 questions. To quantify the most common perpetrators of gender-based harassment behaviors, we combined all perpetrator responses from each behavior question. A respondent could report more than 1 harassment behavior by the same perpetrator; however, a positive response of the perpetrator was only counted once per respondent. The perpetrators of specific sexual harassment behaviors were assessed in 14 questions. To quantify the most common perpetrators of sexual harassment behaviors, we combined all perpetrator responses from each behavior question. A respondent could report more than 1 harassment behavior by the same perpetrator; however, a positive response of the perpetrator was only counted once per respondent.

Data were analyzed using SPSS version 25.0 (SPSS). Descriptive analyses, including frequency counts with associated 95% confidence intervals (CIs), are reported for all collected data. To protect anonymity, we omitted any analyses of all groups and subgroups that had less than 10 respondents. Open-ended questions were allowed for respondent comments, which are presented as direct anonymous quotes.
Results

Demographics

Four hundred sixty-five individuals consisting of 334 men (72%), 130 women (28%), and 1 nonbinary individual responded to the survey, resulting in a response rate of 26%. The median age of respondents was 43 years (interquartile range, 35 to 59), and respondents were most commonly White (81%), married (77%), and staff orthopaedic surgeons (68%). Of the 433 individuals who responded to questions about gender-based harassment, 331 individuals (76%) reported at least 1 instance of gender-based harassment. Of the 423 individuals who responded to questions about sexual harassment, 315 individuals (74%) reported at least 1 instance of sexual harassment. Demographics of respondents are summarized in Table I.

Perpetrators of Gender-Based Harassment

Two hundred thirty-seven respondents (55%, 95% CI, 50 to 59) reported peers as the perpetrators of gender-based harassment (n = 237 of 433). Men reported peers as the most frequent perpetrators of gender-based harassment (47%, 95% CI, 41 to 52; n = 145 of 310); however, women reported both direct supervisors (80%, 95% CI, 72 to 87; n = 97 of 122) and patients (80%, 95% CI, 73 to 87; n = 98 of 122) as the most frequent perpetrators. Table II presents the results of the perpetrators of gender-based harassment.

Perpetrators of Sexual Harassment

Two hundred one respondents (48%, 95% CI, 53 to 52) reported patients as the perpetrators of sexual harassment (n = 201 of 423). Conversely, men reported peers as the most frequent perpetrators of sexual harassment (45%, 95% CI, 39 to 50; n = 135 of 303). Women reported both patients (57%, 95% CI, 48 to 66; n = 68 of 119) and direct supervisors (57%, 95% CI, 48 to 66; n = 68 of 119) as the most frequent perpetrators. Table II presents the results of the perpetrators of sexual harassment.

Timing of Harassment

Two hundred ninety-five survey respondents reported that gender-based harassment behaviors occurred during residency (68%, 95% CI, 64 to 73; n = 433). Two hundred sixty respondents reported that sexual harassment behaviors occurred during residency (61%, 95% CI, 57 to 66; n = 423). Both gender-based and sexual harassment behaviors were least commonly experienced during fellowship. Table III presents the results of the timing of gender-based and sexual harassment behaviors.

Thoughts and Opinions

When asked to share any additional comments, many respondents recounted concerning behaviors from patients, peers, and supervisors, including the following:

Much of the gender “harassment” I experienced in residency was either patient’s thinking I was a nurse or patient’s stating they didn’t realize women could do orthopaedics.

…but the vast majority of harassment that I’ve experienced is from patients/patients family. We have no recourse in those incidences. I feel that if I raised a stink about it, I would be rated poorly on rateMDs or receive a college complaint.

Female-to-female harassment can be just as big of an issue as male-to-female…

| Respondent Characteristics | N (%) |
|---------------------------|-------|
| Total                     | 465 (26)†|
| Age, median (IQR) (n = 454) | 43 (35-59) |
| Gender (n = 465)           |       |
| Man                       | 334 (72) |
| Woman                     | 130 (28) |
| Nonbinary                 | 1 (0)   |
| Race/ethnicity (n = 461)  |       |
| African/Caribbean         | 3 (1)   |
| White                     | 375 (81) |
| East Asian                | 24 (5)  |
| Hispanic/Latino           | 5 (1)   |
| Middle Eastern            | 19 (4)  |
| Mixed                     | 11 (2)  |
| Native/Aboriginal          | 2 (0)   |
| South Asian               | 17 (4)  |
| Other                     | 5 (1)   |
| Marital status (n = 464)  |       |
| Common law                | 28 (6)  |
| Divorced                  | 12 (3)  |
| Married                   | 356 (77) |
| Separated                 | 5 (1)   |
| Single                    | 59 (13) |
| Widowed                   | 4 (1)   |
| Current occupation (n = 465) |       |
| Resident                  | 57 (12) |
| Fellow                    | 32 (7)  |
| Staff                     | 318 (68) |
| Retired                   | 58 (13) |
| Experienced gender-based harassment (n = 433) | 331 (76) |
| Men (n = 310)             | 211 (68) |
| Women (n = 122)           | 119 (98) |
| Experienced sexual harassment (n = 423) | 315 (74) |
| Men (n = 303)             | 215 (71) |
| Women (n = 119)           | 99 (83)  |

* IQR = interquartile range. † The denominator for each question (the number of people who responded to the respective question/section in the survey) is reported beside the characteristic. ‡ A total of 465 individuals responded to at least 1 question within the survey, providing a response rate of 26%.
Finally, the people who were the biggest offenders along gender/sexual harassment lines during my training (i.e., staff surgeons) were also awful to everyone. They were bullies, they disrespected people based on gender, ethnicity, etc.

Respondents’ suggestions on how training institutions or workplaces can minimize the risk of harassment within the training or work environment included the following:

Make disclosure more accessible and anonymous as victims often want privacy in order to maintain trust in the work environment.

Make a formal mandatory module for completion. Live, not online, bring in survivors or experienced professionals in the field to make it less abstract.

Improved reporting system to avoid reporting a person in a position of power over you.

I think more people need to identify when peers and colleagues make inappropriate comments or behaviour. Peers need to make it known to each other that these comments and behaviour are not acceptable.

### TABLE II Perpetrators of Gender-Based and Sexual Harassment in Canadian Orthopaedic Surgeons*

| Perpetrators of Gender-Based Harassment | Overall (n = 433) | Men† (n = 310) | Women† (n = 122) |
|----------------------------------------|------------------|----------------|------------------|
| Direct supervisor                      | 213 (49, 44-54)  | 116 (37, 32-43)| 97 (80, 72-87)   |
| Someone more senior but not a direct supervisor | 201 (46, 42-51) | 118 (38, 33-43)| 83 (68, 60-76)   |
| Peer                                   | 237 (55, 50-59)  | 145 (47, 41-52)| 92 (75, 68-83)   |
| Supervisee                             | 83 (19, 15-23)   | 55 (18, 13-22) | 28 (23, 15-30)   |
| Someone less senior but not a supervisee| 102 (24, 20-28)  | 66 (21, 17-26) | 36 (30, 21-38)   |
| Patient                                | 208 (48, 43-53)  | 110 (35, 30-41)| 98 (80, 73-87)   |
| Allied health professional             | 151 (35, 30-39)  | 78 (25, 20-30) | 72 (59, 50-68)   |
| Other                                  | 12 (2, 1-4)      | 1 (0, 0-0)     | 11 (9, 4-14)     |

| Perpetrators of Sexual Harassment      | Overall (n = 423) | Men† (n = 303) | Women† (n = 119) |
|----------------------------------------|------------------|----------------|------------------|
| Direct supervisor                      | 161 (37, 33-42)  | 93 (31, 25-36) | 68 (57, 48-66)   |
| Someone more senior but not a direct supervisor | 153 (36, 32-41) | 99 (33, 27-38)| 54 (45, 36-54)   |
| Peer                                   | 197 (47, 42-51)  | 135 (45, 39-50)| 61 (51, 42-60)   |
| Supervisee                             | 61 (14, 11-18)   | 48 (16, 12-20) | 13 (11, 5-17)    |
| Someone less senior but not a supervisee| 82 (19, 16-23)   | 67 (22, 17-27) | 15 (13, 7-19)    |
| Patient                                | 201 (48, 43-52)  | 133 (44, 38-49)| 68 (57, 48-66)   |
| Allied health professional             | 126 (30, 25-34)  | 101 (33, 28-39)| 24 (20, 13-27)   |
| Other                                  | 8 (2, 1-3)       | 3 (1, 0-2)     | 5 (4, 1-8)       |

*Results are presented as frequency and percentages with 95% confidence intervals (CIs). Respondents could select more than 1 perpetrator; therefore, percentages will not add to 100%. A respondent could report more than 1 harassment behavior by the same perpetrator; however, a positive response of the perpetrator was only counted once per respondent. †Respondent gender, not the gender of the perpetrator.

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**Discussion**

**Summary of Findings**

This study revealed that peers are the most frequent perpetrators of gender-based harassment and patients are the most frequent perpetrators of sexual harassment in orthopaedic surgery in Canada. Men most commonly reported peers as the perpetrators of harassment behaviors, whereas women most frequently reported direct supervisors and patients as the perpetrators. Both gender-based and sexual harassment most frequently occurred during residency. Respondents provided valuable, experience-based insight into how to minimize the risk of harassment within the training or work environment.

**Relation to Previous Literature**

Identifying both the perpetrators and the timing of harassment behaviors is crucial in developing effective policies against these behaviors. The results of our survey reveal both similarities and differences of previously identified harassment perpetrators in the field of orthopaedic surgery. In a survey conducted on women and ethnic minorities of the AAOS in 2018, attending orthopaedic surgeons were revealed as the most common perpetrators of both sexual and gender-based harassment. This is consistent with our data that women reported direct superiors as the most frequent perpetrators of sexual harassment. Conversely, the most common perpetrators...
TABLE III Timing of Gender-Based and Sexual Harassment in Canadian Orthopaedic Surgeons*

| Questionnaire Responses          | Overall N (%), 95% CI |
|---------------------------------|-----------------------|
| Gender-based harassment (n = 433) |                       |
| Medical school                   | 211 (49, 44-53)       |
| Residency                        | 295 (68, 64-73)       |
| Fellowship                       | 145 (33, 29-38)       |
| Current profession               | 192 (44, 40-49)       |
| Sexual harassment (n = 423)      |                       |
| Medical school                   | 161 (38, 33-43)       |
| Residency                        | 260 (61, 57-66)       |
| Fellowship                       | 112 (26, 23-31)       |
| Current profession               | 187 (44, 39-49)       |

*Results are presented as frequency and percentages with 95% confidence intervals (CIs). Respondents could select more than 1 timing; therefore, percentages will not add to 100%. A respondent could report more than 1 harassment behavior at different times; however, a positive response of the timing was only counted once per respondent.

reported by men in the AAOS survey, attending orthopaedic surgeons, differed when compared with the results from our study where peers were identified as the most common perpetrators. Although the AAOS study evaluated discrimination, bullying, sexual harassment, and harassment (DBSH) in orthopaedic surgeons in the AAOS, it was only distributed to women and ethnic minorities. Therefore, a large subset of the orthopaedic surgeon population was not included in this survey. Moreover, patients were not listed as a perpetrator response option, potentially excluding a frequent group of perpetrators.

Similar to the AAOS survey, a survey conducted on DBSH of surgeons in Australasia reported that surgical consultants were the most frequent perpetrators of all aforementioned behaviors. Moreover, this study went on to identify the gender of the perpetrators to most commonly be male, at 79%. These data contrast with ours in which patients were found to be the most common perpetrators of overall sexual harassment. Although the Australasian survey provides insight into the perpetrators of DBSH behaviors in the entire surgical field, this survey was not directed toward orthopaedic surgeons and can therefore not be directly compared with ours. Furthermore, independent genders were not appraised when identifying the most frequent perpetrators of DBSH behaviors in the Australasian survey.

A recent survey on sexual harassment distributed to all Canadian medical students revealed that patients were the most common perpetrators of sexual harassment experiences, followed closely behind by peers. These results are consistent with our survey; however, differences in career stages between our survey and the aforementioned survey prevent a direct comparison. Nevertheless, this survey, along with ours, highlights concerning data that patients in Canada are frequent perpetrators of inappropriate harassment behaviors.

A systematic review and meta-analysis recently demonstrated that harassment and discrimination among medical trainees are high. In the meta-analysis, the pooled prevalence of harassment during residency training was 63.4%, similar to the reported timing of harassment behaviors presented within our study. Previous research has demonstrated that exposure to gender discrimination and sexual harassment can influence both men’s and women’s specialty choices and can even result in trainees leaving their current specialty programs. Therefore, exposure to discrimination and harassment in both medical school and residency can be detrimental to a trainee and substantially influence their choice and/or completion of specialty training programs.

Implications
Exposure to harassment behaviors early in one’s medical career can have a significant impact on both job satisfaction and the specialty a trainee chooses to pursue. The results presented herein may be used to target groups that were revealed as the more common perpetrators of harassment. The power imbalance between trainees and supervisors could inhibit the reporting of harassment behaviors. This study highlights the need for improvements in the reporting system, so trainees are not reporting behaviors to someone in a position of power over them but to someone who is objective and removed from the situation. Recurring training for those in a position of authority could be a requirement to maintain credentials. This will ensure that supervisors are aware of what harassing behaviors are and what they can do to promote a more inclusive, safe environment. Moreover, if peers continue to reinforce the harassment behaviors demonstrated by those in a position of authority, this intensifies a damaging workplace culture for both men and women alike. The use of continuous, interactive anti-harassment training at all levels of education could be implemented, which should also include bystander training to better recognize and address peer-based harassment.

A recent commentary published in The Lancet observed that patient-initiated sexual harassment has historically been dismissed as a “hazard of the job.” However, as revealed in our survey, these instances are common and should not be ignored because they can have negative consequences for the physician and physician-patient relationship. The authors of The Lancet commentary developed a decision-guiding algorithm to assist physicians experiencing patient-initiated sexual harassment. At the forefront of this algorithm, physicians should ask themselves, “do you feel safe?” If yes, the physician can address the behavior with the patient and continue care. If no, or if the harassing behavior persists, the physician should quickly remove him/herself from the situation, report the
behavior to appropriate leadership, record it within the patient’s medical chart, and transfer care of the patient to another physician. Moreover, patients should also be educated on harassment policies within the medical workplace on consenting to treatment, and policies should be in place to reprimand any patients guilty of displaying these damaging behaviors.

**Limitations**

Although this was a comprehensive survey evaluating many components of gender-based and sexual harassment in the field of orthopaedic surgery within Canada, it does pose some limitations. First, harassment questionnaires have an inherent response and recall bias. This could lead to an overestimation of harassment behaviors and inaccuracies in the recalled perpetrators if the harassment behavior occurred many years ago. Our survey revealed that harassment behaviors most frequently occur during residency; however, trainees were underrepresented within our survey. Therefore, the results of this study may not accurately represent the perspectives of those most likely experiencing harassment at the current time, further enhancing the recall bias. Second, respondents had the option to skip any questions that they did not feel comfortable answering because of the sensitive nature of the topic, which may have contributed to a further response bias. Third, we did not identify the gender of the perpetrators. This information could be relevant in the development of appropriate policies and training and should be evaluated in future studies. Finally, 28% of the survey respondents were female, double the current proportion of Canadian female orthopaedic surgeons, and the percentage of invited female members from the COA and CORA. This could lead to an overrepresentation of perpetrators reported by women, which is not an accurate representation of the Canadian orthopaedic surgery community.

**Conclusions**

Our study revealed that peers are the most frequent perpetrators of gender-based harassment and patients are the most frequent perpetrators of sexual harassment of orthopaedic surgeons in Canada. This damaging workplace culture fostered by superiors, peers, and patients alike may be contributing to the enduring gender gap in the field of orthopaedic surgery, particularly when experienced early on in medical training. As indicated by respondents, improved systems for reporting these behaviors and training throughout the continuum of one’s medical career are required to foster an inclusive, equitable workplace.

**Appendix**

Supporting material provided by the authors is posted with the online version of this article as a data supplement at jbjs.org (http://links.lww.com/JBJSOA/A353). This content was not copy-edited or verified by JBJS.

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