EDITORIAL

Sexual harassment in neurosurgery: #UsToo**Douglas Kondziolka, MD, MSc, FRCSC,¹ and Linda M. Liau, MD, PhD, MBA²**¹Department of Neurosurgery, NYU Langone Health, New York University, New York, New York; and ²Department of Neurosurgery, David Geffen School of Medicine, UCLA Health, University of California at Los Angeles, California

ON behalf of the One Neurosurgery Summit and the Neurosurgery Professionalism Taskforce, Benzil et al.¹ conducted a survey that looked into a wide array of issues and concerns around the topic of sexual harassment. The work serves us well, providing meaningful data that could benefit our personal and professional lives. Although previous studies have provided data on the extent of sexual harassment in other surgical specialties, this is the first study to measure this within neurosurgery specifically. Accurate and comprehensive data are needed in order to make thoughtful, data-driven decisions about policies, safeguards, and training that can decrease the incidence and impact of sexual harassment in our field.

There are many concerns regarding workplace behavior relating to sexual conflicts, race or gender diversity, and professionalism. This report lays out some of the issues in detail. It is important that we understand the culture of neurosurgery training and practice, which exists within the higher framework of a medical center and/or university. Reports on sexual harassment detail well the tremendous negative effects on the personal and professional growth of an individual, and that this problem increases in certain cultural frameworks, particularly one with historical male dominance, intrinsic hierarchical pedagogy, and reluctance to acknowledge misconduct. One might think that given the media attention to this issue, the frequent mandated training modules we are asked to take, and the “modern era” in which we live, with increasing numbers of women in neurosurgery, that the problem would be a lesser one. This study shows that this problem has not gone away, and perhaps has not lessened. Although overt sexual harassment is now vilified publicly, implicit gender biases and covert sexual harassment still persist at all levels of the neurosurgical hierarchy (from neurosurgical trainees to department chairs), and this insidious culture can sometimes cause even greater personal and professional harm. Indeed no one is immune. Harassment was

noted from medical professionals, hospital administrators, other residents, industry staff, and even patients and patients’ family members.

Surveys were emailed to 5166 CNS or SNS members and 622 responded (12%), in line with the typically low response rate for practice surveys. We hope that this does not represent a degree of apathy to this topic. Twenty percent of responders were female (121 respondents), which is higher than the total percentage of women in neurosurgery (currently 8% of practicing neurosurgeons). It would be interesting to see if the majority of the female respondents were in training or in practice, and/or what percentage of each of the age groups of respondents were made up of women. There is a wealth of demographic data in Table 1 of the manuscript, and more granularity about the demographics of the respondents to this survey will better inform where/when we should be targeting our interventions.

Some form of sexual harassment was noted during training in 80% of respondents, nearly half during postresidency employment, and 17% at a national meeting or other educational program. Of great concern was that more than one-third had experienced this behavior more than 10 times. As one might expect given our male-dominated specialty, 72% attributed the harassment to a male, although 23% reported harassment by persons of both genders. Female neurosurgeons reported more concerns about the work environment in terms of support, respect, civility, and inclusiveness, as well as safety. They had less confidence in safety from reprisal when reporting harassment. Older cohorts of responders reported less harassment during training, although they reported more during postresidency employment. Younger surgeons reported a higher number of occurrences. It may be that younger surgeons are simply more vocal in this regard, or that the data reflect the fact that the younger cohorts had a higher percentage of female neurosurgeons, and women are more likely to

get sexually harassed than men are. Thus, given the small numbers of women in the older cohorts of responders, it is not surprising that there would be fewer reports of occurrences of sexual harassment among this group—although the severity of the problem certainly existed in the past and was probably more blatant.

From our own experience as recent leaders of the American Board of Neurological Surgery (ABNS), we have worked to improve the accreditation process all the way from the primary examination through the last step, which is the oral examination. In the last several years, we have asked our examinees to comment anonymously about the entire oral board process. Unlike a traditional neurosurgery survey with a low response rate, almost every examinee provided their comments. We learned much about efficiency, examination fear, stress, means to improve the process, and also about perceived sexual harassment. Some examiners, who were very senior and respected neurosurgeons, were called out in this process. Together with our staff and our Executive Director, the ABNS Directors worked to inform examiners on complaints about their conduct, and limited their exposure to future examinations and to specific examinees. This is a work in progress of course, but we agree with the authors that the reduction of inappropriate behaviors in this realm must start with leadership.

What is the good news? Fortunately, most of those surveyed felt that people they worked with were respectful and civil (i.e., their colleagues, faculty leadership during training, and industry personnel). But when we yearn for zero tolerance, we have to do better than “most.” The authors discuss the fact that the risk of sexual harassment within a system is associated with 3 factors: male dominance, a strong hierarchical structure, and a permissive environment.

Clearly, there has been an increase in the number of female neurosurgeons over the last several decades.² Indeed, at the medical school level it has risen over 50%. But we strive for even more diversity in our specialty. When we started training, only about 5% of neurosurgery residents were women. Now in 2020, females comprise 19% of neurosurgery residents in the United States, but still only comprise 4% of full professors (n = 16), < 1% of tenured professors, and 2% of department chairs.^{3,4} Studies in politics on proportional representation show that when a minority group reaches 20% of the population, they can more meaningfully influence the majority. Women in neurosurgery training are just now on the brink of a tipping point.

Also, our own hierarchy should have levels where open discussion can occur and fear of reprisal is mitigated. Hierarchy has been the standard in education and practice for centuries but it need not be static. Neurosurgery has relied on hierarchy, because so much is at stake. But neurosurgery as a job is hard enough without creating an unpleasant or threatening work experience. The risk, as the authors discuss, is burnout.

Finally, to mitigate a permissive environment, we agree with Benzil et al.’s comment that appropriate planning of social events is one step to reduce opportunities for harassment. A zero-tolerance statement for neurosurgery is important to be sure. Certainly neurosurgery will not have

all the answers for an improper societal dynamic between individuals. But to start, we need to provide everyone with the opportunity to speak freely, to share their concerns or feelings when problems might be smaller in scope and larger issues prevented. Unconscious bias is a frequent problem that can lead to an uncomfortable personal dynamic. Even at perhaps what may seem a harmless level, the telling of a joke can be illuminating. Laughter is a hard-to-mask indicator. “It’s funny because we think it’s true.”⁵

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Disclosures

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Response

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Across the spectrum of my neurosurgical career, I have had the privilege of being involved in several notable basic science and clinical research efforts, including work done as part of one of the first spine stereotactic radiosurgery teams in the world. However, I have come to learn that the publication of the white paper on the recruitment and retention of women in neurosurgery¹ has probably had the greatest impact on the practice of medicine since that time and for the greatest number of individuals. It has only been in the last 5 years, through invitations to speak at large meetings for women in medicine, that I have become aware of how far-reaching the impact has been of the concepts raised in that landmark article. The current study on sexual harassment, completed on behalf of the One Neurosurgery Summit and the Neurosurgery Professionalism Taskforce, carries the same potential and I know it will stand at the conclusion of my career as one of the works for which I am most proud to have been a key player.

I genuinely thank Drs. Kondziolka and Liau for their thoughtful editorial regarding this work and its implications. They have captured and highlighted the key ele-

ments that the study revealed including the extent of the problem, its ongoing occurrence, and the considerable impact in terms of both personal and professional harm. They have further added their extensive experience as leaders within neurosurgery to the actions that are required to address this considerable problem. Lending their voice to this is invaluable, especially their critical statement that “the reduction of inappropriate behaviors in this realm must start with leadership.” Endorsing the need for neurosurgery to have a zero-tolerance statement is one important step that all neurosurgical organizations can accomplish today. They further emphasize that the traditional hierarchy within neurosurgery may no longer be optimal and need not be rigid nor static. Beyond sexual harassment, there is increasing evidence that alternative organizational structures may enhance job satisfaction, productivity, and patient safety, as well as quality and value! A real WIN-WIN.

Indeed, as they point out, there is more we need to know and understand. It was certainly our hope to achieve a high response rate so that more detailed analysis could be completed. Some additional subgroup analysis is currently being performed and will certainly be published to supplement the data contained in this paper. Drs. Kondziolka and Liao also astutely connect this specific issue to the wider and challenging need to achieve real diversity within neurosurgery. On an intensely personal note, I realize it is impossible to describe the burden of entering into a specialty with such a small percentage of women.

Nor can I adequately relate the slow but palpable change that has come with time and as the number of women approaches that magical 20% that allows meaningful influence. My experience, however, allows me to empathize with the many other minority groups who continue to struggle to gain a foothold within specialties such as neurosurgery. Already, individuals have reached out to me to request permission to modify this survey vehicle to study the status of harassment as it relates to sexuality and race. If this work helps empower other groups to raise their voices and bring meaningful change—that would make me incredibly proud.

After more than 3 decades in neurosurgery, it has been my pleasure to work with many supportive, accomplished, innovative, and talented individuals who helped open doors for others and move our specialty forward. I have always endeavored to work within neurosurgery and to seek out these individuals to challenge the status quo—to make neurosurgery even better because, in the end, our patients and their families need us to be not just good but great.

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